EXECUTIVE SUMMARY

Evaluation of the California Implementation of the SAMHSA Integrated Dual Disorders Treatment Model in Eight Programs

California Institute for Mental Health

Submitted by

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SECTION I: CALIFORNIA'S PARTICIPATION IN THE SAMHSA EFFORT TO DISSEMINATE EVIDENCE-BASED PRACTICES IN PUBLIC MENTAL HEALTH

The Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration (SAMHSA) is recommending five psychosocial service models as part of an initiative to increase the use of evidence-based practices in mental health services.

SAMHSA's purpose in funding the Round II demonstration projects—in which California participates— is to further understand the factors helping or hindering EBP implementation. California and other states are interested in what kinds of improvements in outcome are associated with the model.

The California IDDT demonstration is being jointly conducted by the state Department of Mental Health and the California Institute for Mental Health. Implementation of the IDDT model was supported by 48 hours of training, fidelity reviews, technical assistance, and a "development team.[1]"

The four participating counties volunteered to be part of the demonstration project.

Table 1: Participating counties and programs

County	*Program in Year 1*	*Program in Year 2*
Alameda	Bonita House	*Casa del Sol*
Los Angeles	Hollywood Clinic	South Bay Clinic
Stanislaus	Turlock Regional Center	West Modesto Regional Center
Ventura	Conejo Clinic	Oxnard Clinic

SECTION II: THE EVIDENCE BASE FOR IDDT

One of the activities of the project evaluator was to conduct an extensive literature review of the co-occurring disorders outcome literature. This review is summarized in the full report and is also available from CiMH at:

http://www.cimh.org/projects/evidence_based.cfm

The broad practice of integrating mental health and substance abuse services is rated in the review as Promising.[2] There are as yet no controlled studies with a general dual disordered

[1] CiMH has used development teams extensively in helping counties introduce evidence-based practices. The version used in the IDDT Project was an early variant and differs in major ways from the current model. See Todd Sosna and Lynne Marsenich, *The California Institute for Mental Health Community Development Team Model Supporting the Model Adherent Implementation of Programs and Practices,* 2006.

[2] We cited in the literature review above the developers' recent formulation: "…Integrated treatment is merely a rubric for sensible structural arrangements to ensure access, rather than a specific intervention…. The research on integrated treatment still lacks specific manualized interventions, studies of specific interventions, replications of positive studies, and a research consensus on key elements of fidelity…." Drake, R. E., Morrissey, J. P., & Mueser, K. T. (2006). The Challenge of Treating Forensic Dual Diagnosis Clients: Comment on "Integrated Treatment for

population that test the IDDT model specifically and no studies that use the IDDT Fidelity Scale, thus the IDDT model is rated as Emerging.

SECTION III: IMPLEMENTATION IN THE CALIFORNIA SITES

Site specific findings

All sites completed the initial year of training. However, implementation of elements of the IDDT model thereafter varied greatly by site. Only six of the eight sites sustained implementation.

Alameda County has initiated a comprehensive approach to co-occurring disorders. Both IDDT programs were successful in implementing the model to acceptable fidelity.

Bonita House. The IDDT model was implemented for case management services, but had substantial "spillover" effects on the Bonita House residential programs.

- The agency initially focused on improving the assessment process. Bonita House was successful in getting the county to permit use of a dual disorders-specific assessment instrument, but the process was draining and its implementation in the computer-based record system of the agency was arduous.

- A second stage focused on improving the clinical skills of non-licensed case managers.

- In the third stage the program has now been reorganized to have two teams, with two case managers on each team: one team focuses on outreach and engagement, the other on treatment and recovery.

To the fidelity reviewers, the two most striking things about implementation of IDDT at Bonita House were a) how difficult it was and how much time and effort it took considering the high initial fidelity, and b) how "right brain" the changes were. That is, introduction of IDDT thinking and procedures was not "linear."

At the final fidelity review, after three years, the overall fidelity scale rating had increased from 3.6 to 3.9. (It is a five point scale with higher indicating more fidelity and a 4.0 being considered a threshold level of fidelity.)

Casa del Sol at La Clinica. Alameda County Behavioral Health Care contracts with *Casa del Sol* to be a primary access point, as well as specialty clinic, for Alameda County residents who require linguistic (Spanish) or cultural (Latino) specialty mental health services.

- Screening. The first major change was to change the screening form. Staff report much higher rates of detection of co-occurring disorders using the new instrument.

Jail Recidivists with Co-occurring Psychiatric and Substance Use Disorders". *Community Mental Health Journal*, 42(4), 427-432.

- Institutionalizing the changes. IDDT elements are being embedded in clinic culture by a) incorporation into the mission statement and clinic forms, b) by monitoring and reinforcement in hour long weekly clinical supervision sessions, c) by on-going peer review and case presentations focusing on co-occurring disorders, and d) by training of new staff.

IDDT has increased clinical skills and clinic capacity overall to serve persons with co-occurring disorders.

The program was rated a 3.2 at the baseline fidelity review and a 4.1 at the final fidelity review two years later.

Los Angeles County has a long history of attempting to serve persons with co-occurring disorders. In neither of the two IDDT demonstration sites, however, has implementation been sustained.

A county-wide IDDT implementation committee was established at the onset of the project but met infrequently and has not had a role in promoting IDDT dissemination. Despite considerable enthusiasm by participants, it was not possible to resolve the difficulties encountered in implementation at either the Hollywood or South Bay site.[3]

In both Los Angeles sites, clinicians were extraordinarily pressed for time. They carry a caseload of over 100 clients each. While caseload is an imperfect measure of match of staff time to intensity of service need, interviews with staff at both sites confirmed that they do not have the ability spend the large amounts of time over a period of years that implementation of IDDT requires.

Stanislaus County has a history of integrating substance abuse and mental health services. One of the two sites implemented to a fairly high level of fidelity; the other to a lower level. There are strong on-going efforts to incorporate IDDT in all adult services.

Since the 1970s Stanislaus county has had an integrated mental health and substance abuse administration. Despite strong leadership, commitment to integration, and a proactive approach, the Stanislaus IDDT implementation suffered from funding cuts to the county at a critical time. In addition to the project's two demonstration project sites, IDDT is now being implement in other programs and has strong administrative support. Ancillary services like a dual diagnosis track in the Stanislaus substance abuse residential treatment center have also been established.

The Turlock Regional Center. There is evidence from leader, staff and client interviews that integrated treatment of dual disorders is embedded and part of the culture at Turlock Regional

[3] In part, the problem was that the level of commitment required for a county to agree to submit a grant application is lower than the level of commitment required to successfully implement a demonstration program with acknowledged implications for system change. This was a particular problem because the Los Angeles Department of Mental Health District Chief who chose the two study sites retired prior to implementation. In Ventura County and Stanislaus County the project was viewed as the start of a system-wide change rather than as a time-limited demonstration. Alameda County took an intermediate position.

Services despite funding cuts and personnel changes. The initial fidelity rating was 2.75; at the final fidelity visit implementation appears to be back on track with a fidelity rating of 3.4.

The West Modesto Regional Center. The West Modesto site had a very strong tradition of co-located parallel treatment for persons with co-occurring disorders, which initially kept many staff from recognizing the nature and value of IDDT. Training was completed and tools implemented but there was then some erosion of the model due to major budget reductions.

The initial fidelity rating was 2.7.The final fidelity rating after two years was 3.1.

Ventura has made a strong commitment at all administrative levels to implementing IDDT in all its mental health outpatient clinics. Implementation at one of the two IDDT project sites is to a very high level of fidelity while the other site has improved substantially.

- The Conejo clinic, a small outpatient clinic with a low initial fidelity rating (2.4), was chosen for the first site. For a year after the training was completed, virtually no other steps were taken toward implementation of the IDDT model. At that point the IDDT team was put under the direction of the manager of the Oxnard IDDT team and the Conejo team made large strides at implementing what they had previously been trained to do (fidelity rating of 4.0 at the final rating).

- The approach taken in implementing IDDT in Oxnard was unique in California's eight sites and can provide a model for other counties in California and, indeed, any program wishing to implement IDDT with high fidelity. The Oxnard IDDT Team was created from scratch rather than by adaptation of existing program elements and staff. Experienced dual disorders clinicians were recruited, either for new hires or by asking for volunteers to transfer from other programs. The program manager, herself a dual disorders specialist with many years of experience, used the IDDT Fidelity Scale as a template for designing the program. Because she was given broad authority to implement IDDT, the manager was able to develop forms and systems to embed the implementation into on-going clinic procedures. The Oxnard team was implemented to a very high level of fidelity (4.3 at the initial rating four months into the program and 4.8 at the most recent rating).[4]

Project-wide findings

While individual county and site characteristics account for much of the variability in implementing IDDT, there are factors which appear to be common to several sites or counties.

- High staff turnover threatens implementation of projects like IDDT that take substantial periods of time to get up to speed.

- Sites that chose not to create a specialized team generally had more difficulty with implementation than sites having a small specialized team.

[4] For the purposes of the outcomes study, this in effect meant that Conejo became a second year site. A new study cohort was assigned at the same time the study cohort for the Oxnard site was assigned.

- Consistent with the organizational change literature, sites that had the most difficulty were generally lacking a strong leader/proponent at several levels in the organization.

- The intensity of services required by the IDDT model may not be possible in programs with high caseloads.

- The IDDT model was developed prior to recent research showing the effectiveness of residential services for persons with dual disorders. Three sites successfully created or used such residential services in conjunction with the IDDT programs.

- In general, IDDT takes much longer to implement to high fidelity in existing programs than the CiMH project team anticipated—even when a program has an initial fidelity rating of around a "3."

- All but two of the programs were rated low on the provision of education and support services to family members and did not for the most part have peer-led groups as part of the program. The service limitation is in large part due to reimbursement difficulties that may be eased with Mental Health Services Act funding. None of the sites included family members or consumers on a site implementation committee.

The IDDT model was implemented with high fidelity in the Latino Casa del Sol program. However, the training, tools, and approaches of IDDT required significant modification by clinic staff.

When we attempted to implement IDDT at Casa del Sol, a clinic serving only Latinos and for the most part persons who are monolingual in Spanish (and many of whom are undocumented), we found that the IDDT model is culturally competent in only a very limited sense (even though some of the elements in the Toolkit are available in Spanish translation). *Casa del Sol* did an outstanding job of "translating" the training and tools they were given so that the tools were more effectively used with primarily immigrant Latino clients.

As a result of this trial, we have learned that the IDDT model can be appropriate and useful for Latino clients and staff, but to achieve optimal effectiveness it needs significant adaptation to make it more compatible with Latino culture.[5] Staff saw no conflict with the overall elements of the IDDT model—but the use of the model with Latino clients and its presentation to Latino staff must be significantly adapted to Latino culture and values, and culturally based learning traditions, which is a complex and time-consuming task.

[5] *Casa del Sol* staff emphasize that a culturally competent approach must consider that Latinos are from many countries and backgrounds and the adaptations must address the particular client populations being served.

Institutionalizing IDDT changes depended in the more successful sites on a) one-on-one clinical supervision to the model, and b) embedding concepts and practices in standard forms and processes.

- Fidelity reviewers were impressed that the sites with most success in achieving and maintaining fidelity were the sites that used individual supervision to reinforce IDDT concepts and improve clinical skills.

- While changing forms has proven an ineffective way of *causing* change, forms can and should *reflect* change that has been made. Successful sites went to great efforts to develop forms that reinforce and support IDDT practices and to get them accepted by the various forms committees governing clinics operation.

SECTION IV: MEASURING AND ACHIEVING "FIDELITY" TO THE IDDT MODEL

The SAMHSA fidelity scale

The SAMHSA fidelity scale as a whole is not yet validated by correlation with successful programs. In a study of 11 IDDT programs in the national EBP demonstration, inter-rater reliability was .90.[6] In the California IDDT implementation study, there was high inter-rater reliability but validity has been questionable on some items: California raters agreed which of 5 scores to apply but found that descriptions embedded in the "anchors" of the fidelity scale items did not always match the range of variability they found in different programs.

With permission of the SAMHSA contract monitor, we created a "California version" of the fidelity scale. The revised scale and the rationale for the changes are available from CiMH.

California also used the General Organizational Index developed in the national EBP project.

The general organizational index was developed by the National EBP Project, Round 1. It is a general scale intended to be used with *all* of the EBP implementations, not just IDDT. It covers elements that the national EBP designers believed were related to the capacity to successfully implement any evidence-based practice.

Fidelity increased over time for all sites.

Figure 1 shows the overall increase in fidelity for all sites combined by round. This includes two ratings for Hollywood and three for South Bay, which did not sustain implementation. All others were rated four times at six month intervals. The average rating for the 6 sites that continued implementation for all 24 months was a 3.9—up from a 3.0 at baseline. This is slightly below the threshold of 4.0 that Gary Bond, fidelity scale evaluator for the national Round 1 study, has said represents an acceptable level of fidelity.

[6] Presentation by Gary Bond, who is responsible for testing of the SAMHSA EBP fidelity scales, at the National EBP Meeting, Baltimore, MD, November 4, 2003.

Figure 1: Increase in Fidelity by Round, All Sites Combined

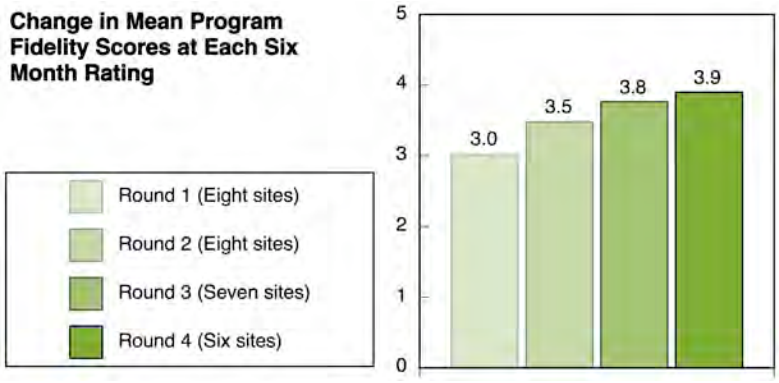
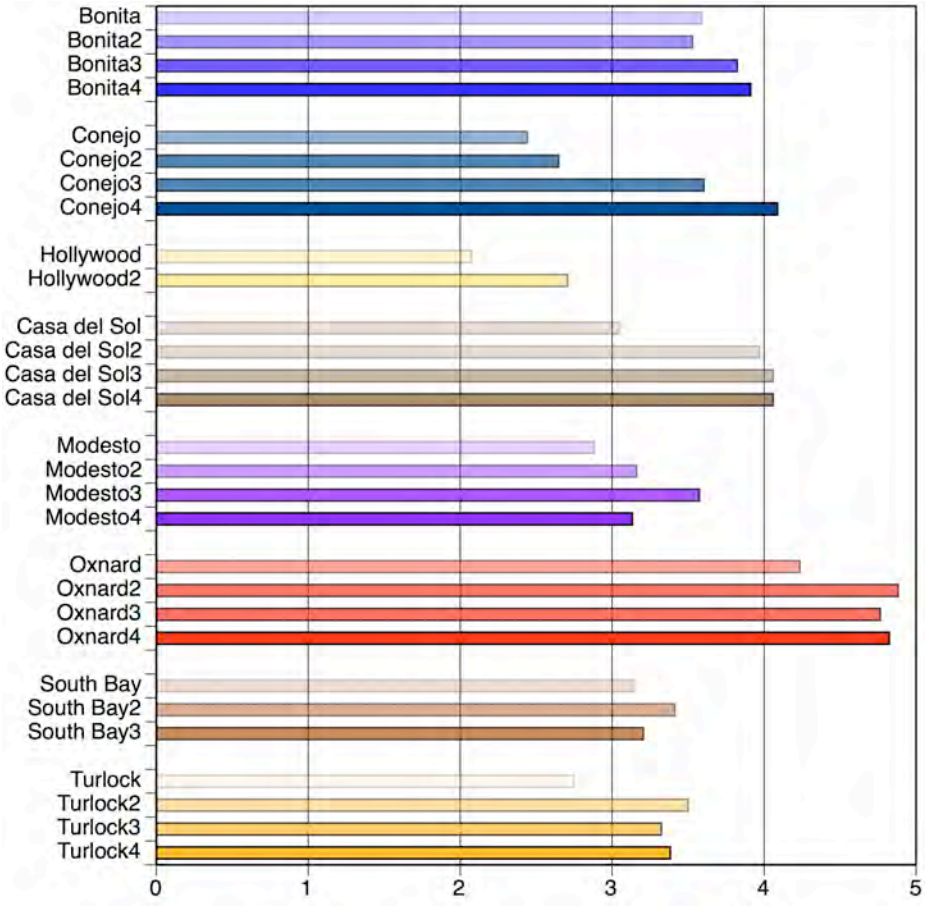


Figure 2 shows the change by round at each site, thus disaggregating Figure 1. Three sites achieved the standard of "4" while one came very close. Patterns of change were not uniform. In particular, in Stanislaus where large-scale funding reductions cause major reorganization in both the West Modesto and Turlock programs, the final score was lower than at least one intermediate score. Clinical elements across the board were the most likely to change during the implementation period.

Figure 2: Mean Fidelity Scores Over Four Rounds of Ratings, by Site



California General Organizational Index scores

GOI scores increased over time.

Figure 3 shows the overall increase in GOI scores for all sites combined by round. This includes two ratings for Hollywood and three for South Bay; all others were rated four times at six month intervals. The average rating for the 6 sites that continued implementation for all 24 months was a 4.2—up from a 3.0 at baseline. This is slightly above the threshold of 4.0 that Bond has said represents an acceptable level of fidelity.

Figure 3: Increase in GOI Scores by Round, All Sites Combined

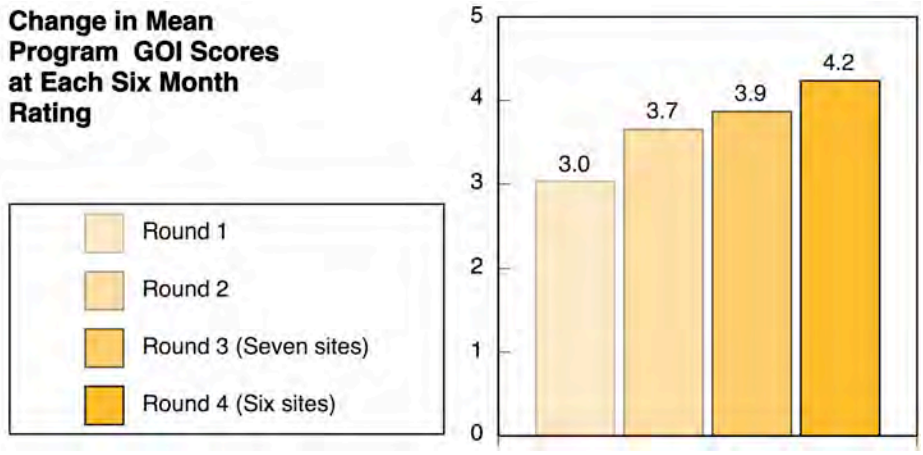
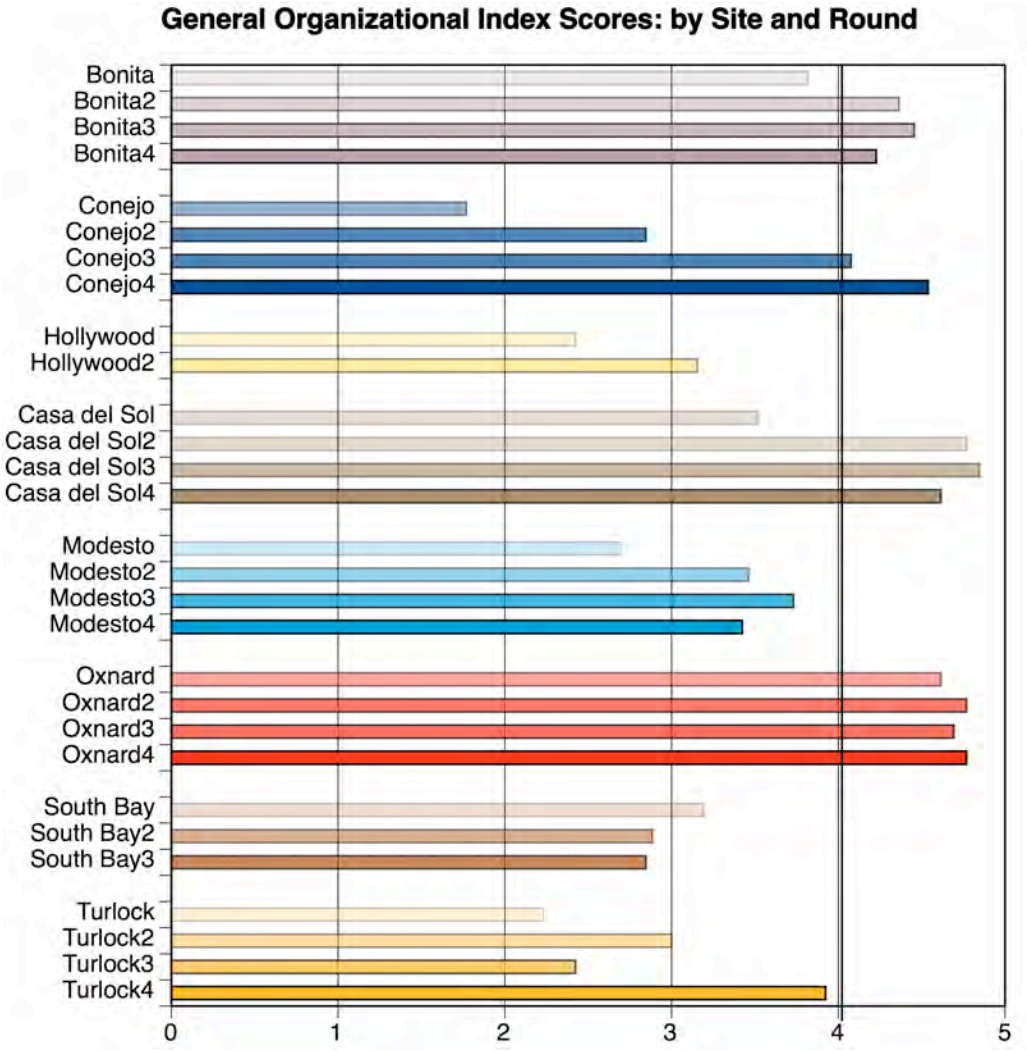


Figure 4 on the next page shows the change by round at each site, thus disaggregating Figure 3. All six of the sites with sustained implementation achieved (or came very close to achieving) an average score of "4." As with the fidelity scale, clinical elements across the board were also the most likely GOI elements to change during the implementation period. Similarly, patterns of change were not uniform: in several programs the final score was lower than at least one intermediate score. In fact, Conejo was the only program to show progress at each review.

Figure 4: Mean GOI Scores Over Four Rounds of Ratings, by Site



Association of fidelity and GOI scores with other process measures

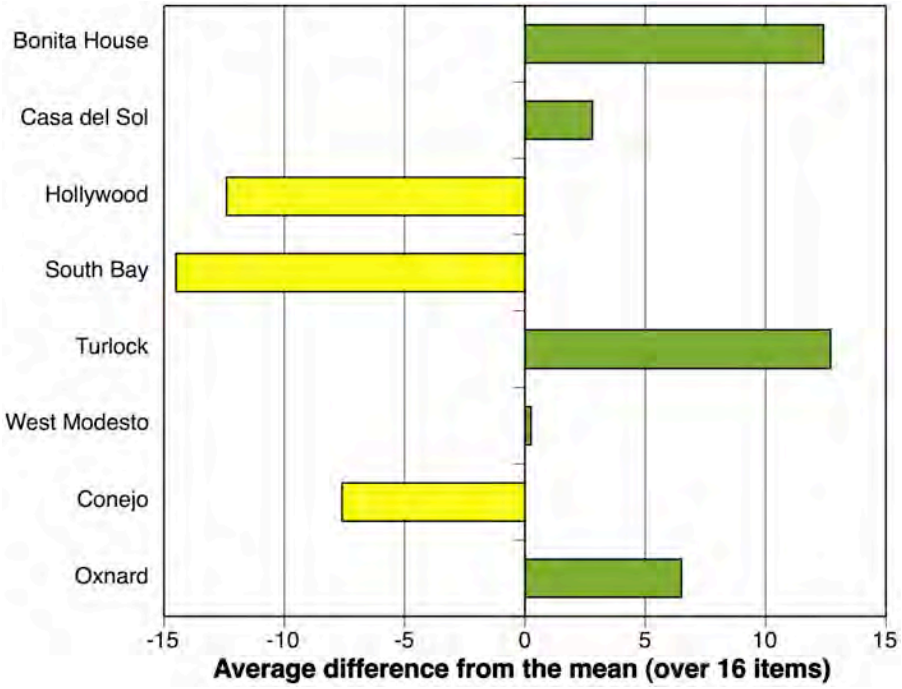
The Organizational Readiness for Change scale scores predicted very accurately the overall dimensions of implementation success.

During the first six months of the implementation, staff at each site filled out the Organizational Readiness for Change Scale (social organization version). This is a scale developed at Texas Christian University to facilitate technology transfer in the substance abuse field.[7]

We attempted to summarize the data for the 8 programs and 16 scales by determining the 8 site mean for each item, then subtracting each site's score from the mean and converting to a percentage difference from the mean.

[7] Simpson, D. D. (2002). A conceptual framework for transferring research to practice. *Journal of Substance Abuse Treatment, 22*(4), 171-182.

Figure 5: Difference of Each Site From an 8 Site Mean, Averaged Over 16 Organizational Functioning Subscales



The organizational functioning scores are highly predictive of the overall outcomes of attempting to implement IDDT. The one subscale in which each of the non-sustaining programs scored 20% below the mean of all eight programs was Leadership; in fact, they were the only three programs not to have a score higher than the mean on this subscale. As we suggest in the recommendations, an overall organizational functioning score of 3.0 or less would indicate a great deal of caution about moving ahead with implementation of a complex and time-intensive process like IDDT.[8]

SECTION V: CLIENT OUTCOMES

Methodological issues:

Lack of randomized control groups makes it difficult to assess the significance of outcomes.

In addition to not having randomized control groups, our outcome measurement has a number of methodological limitations.

- Most of the clients were receiving treatment already when the study cohort was chosen (rather than being new referrals). Thus it is hard to say what change might have occurred absent IDDT.

[8] Conejo is a special case. It's original implementation resulted in very low fidelity, but it got a second life when Dr. Gertson became leader of the program. Thus, the organizational factors that obtained at the beginning, particularly a very low rating for leadership, did not obtain when fidelity scores went up.

- Many clients were selected for IDDT at "peak" times in their substance use, so we would expect to see some improvements just due to the statistical phenomenon of regression to the mean.

- Because the periods during which we measure outcomes are very limited (a year and two years rather than 3 or 10 years), it is difficult to know how stable outcomes will be.

There is no way to present data from all eight of the programs without seeming to suggest comparisons, but in fact the only relevant outcome comparison is the change over time within programs.

Because samples were chosen to fit the needs of each clinic, the study cohorts differ significantly. Differences by site are substantial on many dimensions.

Table 2: Baseline Characteristics of the Study Cohorts

Program	Number	Multnomah Mean Score*	SATS Mean Score*	Age at Start of IDDT	Female	White	Schizophrenia Spectrum Dx
Hollywood	57	51	3.0	39	NA	NA	NA
S. Bay	76	56	4.4	35	NA	NA	NA
Conejo	39	57	4.0	39	54%	77%	16%
Oxnard	69	55	3.7	38	46%	52%	32%
Casa del Sol	28	59	4.0	36	19%	4%	57%
W. Modesto	54	53	3.1	35	41%	57%	37%
Turlock	69	51	3.4	42	46%	86%	23%
Bonita	145	52	4.5	40	54%	51%	60%

*Higher on the Multnomah means better functioning; higher on the SATS means more success in treatment.

We used two types of outcome measurement:

Attrition and baseline and follow-up measures for clients who remain engaged are based on ratings by clinicians. The include the Multnomah Community Ability Scale for psychiatric status and the Stages of Treatment Scale (SATS) for substance abuse status.

Outcome measures based on administrative data (crisis, inpatient and costs) provide extensive baseline profiles and capture outcomes even for those not engaged.

Outcomes for the six sites with sustained implementation show a largely positive pattern.

Table 3: Summary of Fidelity, Organizational Functioning, and Statistically Significant Outcome Measures for Six Sites (☑ Indicates Statistically Significant Positive Change ☒ Indicates Lack Of Statistically Significant Positive Change)

MEASURE	Bonita	*Casa del Sol*	Conejo	Oxnard	Turlock	West Modesto
Final Fidelity Score	3.9	4.1	4.1	4.8	3.4	3.1
Organizational Functioning Scale	3.5	3.2	2.8	3.3	3.5	3.5
Negative Attrition %	11%	5%	19%	44%	37%	32%
Increased Multnomah if engaged	☑	☒	☒	☑	☒	☒
Increased SATS if engaged	☒	☑	☒	☑	☑	☑
Reduction in crisis visits	☑	☒	☒	☑	☑	☑
Reduction in crisis hours	☑	☒	☒	☑	☑	☑
Reduction in inpatient episodes	☑	☒	☒	☑	☑	☑
Reduction in inpatient days	☑	☒	☑	☑	☑	☑

As we have stressed before, it is important to see these results in terms of the specific characteristics of each site, including the characteristics of the client population. Here is a site by site summary:

- *Bonita House* achieved close to a 4.0 on fidelity, had a 3.5 on organizational functioning, had low negative attrition, and had positive outcomes on each of the other measures, with the exception of Stages of Treatment.[9]

- *Casa del Sol* achieved a 4.1 fidelity rating, had a 3.2 organizational functioning rating, and had *very* low negative attrition; status on the Stages of Treatment improved.

[9] This may be due a time in the final year when due to high staff turnover the staffing was quite low.

- *Conejo* achieved a 4.1 fidelity rating but had a low 2.8 in organizational functioning; clients showed reduced inpatient days, and sustained engagement was high.

- *Oxnard* achieved a very high 4.8 on the fidelity scale, a 3.3 on the organizational functioning scale, and positive change on all of the outcomes; this was balanced by a low sustained engagement.

- *Turlock* had a 3.4 fidelity rating, but a 3.5 organizational functioning rating. There was some lack of sustained engagement, but clients showed positive change on Stages of Treatment and all but one of the administrative data-based outcomes.

- *West Modesto* had a relatively low final fidelity score (3.1) but a high organizational functioning score. There was moderately high negative attrition, but positive change on Stages of Treatment and on all but one of the administrative data-based measures.

Despite possible caveats, the overall pattern is of improved outcomes at each site for a very difficult to serve population.

Fidelity ratings correlate to some extent with mental health treatment outcomes but not with improvement on the substance abuse treatment scale or sustained engagement.

The overall fidelity scores for the six sites correlated positively with a reduction in crisis visits and with a positive change in Multnomah Community Ability scale scores. The overall fidelity scores were *negatively* associated with a reduction in inpatient utilization. There was virtually no correlation between fidelity scale scores and the two outcomes most germane to the IDDT model: SATS change (-0.01) and sustained engagement (0.02).

Further analysis (presented in Appendix 7) suggests that some elements in the fidelity scale correlate well with mental health outcomes and that other elements correlate only with substance abuse improvement. The latter include:

- Multidisciplinary team composition and functioning

- Group dual disorders treatment

- Dual disorders counseling

- Outreach

While it is important that some of the fidelity items correlate with substance abuse improvement, it is also disconcerting that the fidelity scale as a whole does not. All in all, however, it is a complex picture with different fidelity items being related in multiple ways to the different outcomes and the different outcomes themselves lacking consistency. In addition, there are only six sites and the difference between sites is not large on most fidelity items, so the stability of

these findings is uncertain.[10] While not strong proof that fidelity is *not* associated with consistent positive outcomes, the results do not confirm the relationship we hoped to find.[11]

SECTION VI: IDDT, CULTURAL COMPETENCE, AND OUTCOMES FOR MINORITIES[12]

In the California SAMHSA grant proposal, the "cultural competence" of the IDDT model was identified as an important factor we wanted to test. Aside from introducing the model at the all Latino *Casa del Sol,* a second approach was to compare outcomes for minority and majority group members as an initial test of whether the IDDT model could be used with minority clients in programs with a mixed population. In programs in which non-white clients and/or staff make up only a segment of the population, the first step in testing the "cultural competence" of the model, is determining *whether* outcomes differ by race or ethnicity.

Overall, the four measures show that positive outcomes occurred for minorities about as often as they did for Caucasians. There is no evidence in the findings from these five sites that IDDT is less effective for minority clients being served in mixed ethnicity outpatient clinics.

Table 4: More, Less or Equal Positive Change Over Time for Minorities, by SIte (✚ = More Positive Change for Minorities, O = No Significant Association, and — = less positive Change for Minorities than Whites)

Site	Attrition	Multnomah	SATS	Hospital Admits
Bonita House	—	O	O	O
Turlock	O	✚	✚	O
West Modesto	O	O	O	—
Conejo	O	O	—	O
Oxnard	O	O	✚	—

[10] In addition, we included outcomes that did not attain a statistical significance of $p<0.05$, two-tailed. While this is appropriate given the purpose of the analysis, it contributes to the overall uncertainty regarding stability of findings.
[11] A recent study has shown that even the well-validated fidelity scale for ACT programs may be a relatively poor predictor of program outcomes. Bond, G. R., & Salyers, M. P. (2004). Prediction of outcome from the Dartmouth assertive community treatment fidelity scale. *CNS Spectator, 9*(12), 937-942.
[12] The Office of Minority Health and Health Disparities located in the Centers for Disease Control and Prevention defines minorities as: "Racial and ethnic minority populations are defined as American Indian and Alaska Native, Asian, black or African American, Hispanic or Latino, and Native Hawaiian and Other Pacific Islander." (http://www.cdc.gov/omhd/Populations/definitions.htm) We follow this usage, and following the Census Bureau we refer to the "majority" population as "White." (The White Population, 2000, available at: http://pdfdownload.capt.de/pdf2html.php?url=http%3A%2F%2Fwww.census.gov%2Fprod%2F2001pubs%2Fc2kbr01-4.pdf&images=yes

SECTION VII: RECOMMENDATIONS

1. **Although this would not work with some other SAMHSA EBPs (particularly supported employment and ACT), the IDDT model lends itself to partial implementations as well as high fidelity implementations.**

   - Mental health authorities implementing integrated treatment for Quadrant IV clients might decide to implement only certain elements of the model rather than attempting to achieve high fidelity on all. Because IDDT puts together a number of distinct practices having separate evidence bases (including stage-based treatment, motivational interventions, and a harm reduction approach), it is possible to "pick and choose" components. In fact, the separate components have significantly more evidence supporting them than does the combined model defined by the fidelity scale.

   - In particular, it is possible and useful to train clinicians in integrated recovery clinical skills without adopting the whole model. The clinical skills are integrated assessment and treatment planning, stage-wise interventions, substance abuse counseling (group and individual), and motivational interventions. Please see Appendix 6 for a grid developed by the Development Team showing the relationship between the full model and a more limited implementation.

   - If full-fidelity is the goal, the program must be able to provide *intensive* services. The level of intensity embedded in the fidelity scale is considerably more than most outpatient programs may have resources for, since it includes multiple client and family groups, individual counseling, and extensive outreach.

2. **The field of co-occurring treatment is evolving, and it is important not to "freeze" integrated treatment into the confines of the existing fidelity scale. Mental health authorities should be encouraged to look to other evidence-based approaches to serving those with co-occurring disorders.**

   - While progress on evidenced-based treatments for co-occurring disorders is limited,[13] there has been substantial progress made since the fidelity scale was developed in at least two areas: residential treatment of co-occurring disorders and contingency reinforcement for staying clean. Integrated treatment is a general rubric that can incorporate such elements. As both the Stanislaus and South Bay experience with specialized residential treatment show, these added elements can be very valuable.

   - While there is strong evidence for some integrated treatment, there are virtually no

[13] We cited in the literature review above the developers' recent formulation: "…Integrated treatment is merely a rubric for sensible structural arrangements to ensure access, rather than a specific intervention…. The research on integrated treatment still lacks specific manualized interventions, studies of specific interventions, replications of positive studies, and a research consensus on key elements of fidelity…." Drake, R. E., Morrissey, J. P., & Mueser, K. T. (2006). The Challenge of Treating Forensic Dual Diagnosis Clients: Comment on "Integrated Treatment for Jail Recidivists with Co-occurring Psychiatric and Substance Use Disorders". *Community Mental Health Journal*, 42(4), 427-432.

research comparisons of high quality integrated vs. parallel interventions.[14] Most county systems will need to provide for closer ties between the existing mental health and substance abuse systems for Quadrant I, II and III populations. At least three of the counties are pursuing this path. In Stanislaus, coordinated parallel mental health and substance abuse treatment has been, and continues to be, used for Quadrant IV clients even while some clients receive integrated treatment. So even for this population, consideration of a range of coordinated and integrated options should not be precluded.

3. **We learned through experience, that comprehensive planning should be required *before* initiating implementation and at each stage of implementation.**

The key element in implementing IDDT—as the Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence has emphasized—is comprehensive planning.[15]

- The Ohio SAMI technical assistance project, which has published a highly useful manual on implementing IDDT, advocates for an extensive planning process, often of over a year. Training does not occur until the fourth of a five step sequence.

- In a number of other attempts to help counties implement evidence-based practices, CiMH has required an acceptable plan for implementation be submitted at the onset of the project (providing technical assistance for the planning process if necessary). Circumstances did not allow this approach with IDDT, but it would have eliminated many of the problems we encountered. The initial plan could then have been updated after each fidelity review.

4. Organizational capacity, particularly leadership, is critical to implementation of a project like IDDT which is complex, clinically challenging, and requires a multi-year implementation process.

We have noted the many turnovers of staff that occurred in each county and in our own project team as well as the difficulties of implementing IDDT to high fidelity. In these circumstances, and to avoid the high costs of implementations attempts that are not sustained or effective, it is necessary to screen applicant agencies. The TCU Organizational Capacity Scale used in this project clearly discriminated the sites that would later be successful from the others. An average score of 3.0 or above appears initially to be a reasonable threshold to require before investing in IDDT implementation.[16]

5. Training (of inexperienced staff) and using staff experienced in treating co-occurring disorders both have roles *within* a planned implementation process.

[14] As noted in the literature review, there are even a couple of instances in which parallel services did better than integrated services.
[15] Kruzynski, R., Kubek, P., & Boyle, P. (2006). *Implementing IDDT: A step-by-step guide to stages of organizational change*. Cleveland: Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence at Case Western University.
[16] The theoretical range is 1 to 5. In practice, the range for our eight sites was 2.7 to 3.5.

There exist several models for implementing IDDT. Serendipitously, the California project—which formally adopted a "train all existing staff first" approach—also included an almost diametrically opposed model of starting a team *de novo* staffed with experience co-occurring disorders professionals. The IDDT literature suggests other approaches as well.

- Because of the emphasis in the SAMHSA RFP on training and technical assistance, the CiMH approach was basically to provide extensive training to an entire team, or more often, an entire clinic. There are circumstances where that may be the only option. However, we found that it usually delayed comprehensive planning for implementation until training was over (a year in our case).[17] Further, it led to selective implementation rather than comprehensive implementation as sites picked and chose from the elements presented in training, focusing most attention on clinical skills. (Rarely did sites revamp structural elements such as outreach or introduce previously missing elements such as family psychosocial education.) Finally, spreading basic implementation out over a year or more made programs vulnerable to staff changes before IDDT had been fully embedded.

- In contrast, in the Oxnard site, the fidelity scale was used as a planning blueprint for developing a comprehensive program. Although staff attended the training, implementation did not wait for it (which was possible because experienced co-occurring disorders staff were hired or transferred to the team). This was the California site that achieved highest fidelity and did so in the shortest period of time. As shown by Oxnard, it is also highly valuable to have an experienced co-occurring disorders clinician be the team leader, clinical supervisor, and lead planner.[18]

- When Kim Mueser, Ph.D., a developer of the IDDT model, presented his ideas to the California Development Team he suggested that the preferred implementation approach was to add a substance abuse or co-occurring disorders specialist to a multidisciplinary team—rather than training an entire team.[19]

- A middle ground, one that starts with comprehensive planning, does everything possible to include one or more experienced co-occurring treatment professionals, as team leader if possible, and provides training tailored to the particular needs of an IDDT team seems most desirable.

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[17] In Indiana, 16 rather than 48 hours of formal training was provided. Bond reports the greater effectiveness of concrete hands-on chances to learn the model by "shadowing" skilled practitioners, case conferencing, and direct modeling of an intervention by the trainer/clinician. Staff in California sites also were very appreciate of the chance to bring in their own cases (including assessments, case formulations, and treatment plans) for discussion with the trainer.

[18] Moser and Bond, op cit. also reported: " One IDDT site, which was headed by an effective leader, made excellent progress toward high fidelity within 6 months."

[19] Note, however, that in a Connecticut program for which the New Hampshire-Dartmouth Psychiatric Research Center provided technical assistance, substantial training was provided to staff—according to published accounts. (Essock, S. M., Mueser, K. T., Drake, R. E., Covell, N. H., McHugo, G. J., Frisman, L. K., et al. (2006). Comparison of ACT and standard case management for delivering integrated treatment for co-occurring disorders. *Psychiatric Services, 57*(2), 185-196.)

6. Learning collaboratives comprised of multiple counties and/or sites used as part of implementation should, if at all possible, include one of the developers of the EBP being implemented or others with extensive experience implementing the model.

- In the current model of development teams used by CiMH, the development team is led by (or attended by) one of the developers of the intervention. In the case of IDDT, having someone closely associated with the project who had extensive experience in implementing and operating a high-fidelity IDDT program or programs would have been very useful. Because Ohio, Kansas and Indiana had already had several years of experience with implementing the IDDT model, it might have been possible to find an experienced person to help us.

- A critical factor in making the IDDT development team successful was the attendance at one two-day meeting of Kim Mueser, a developer of IDDI and lead author of the handbook we used. One year into the IDDT project, implementation was proving difficult. There was also considerable concern about the process being used to help counties with implementation, including doubts about the value of the development team meetings and phone calls. After Kim Mueser attended a development team meeting, though, these doubts dropped away and there was a sense of common purpose and direction—almost like when light rays get polarized and line up. What appears to have made the difference was the clear sense obtained from Dr. Mueser that the IDDT intervention is worth while and has been conducted successfully elsewhere.

7. Other programs implementing IDDT might benefit by knowing some of the elements of the California approach that participants in the project felt worked well and those that were less successful.

Components that were deemed valuable:

- Most sites found the external fidelity reviews each six months to be helpful. Now that the implementation project is over, counties are beginning to think about how to provide this same relatively objective view for both on-going programs and new IDDT programs that are being implemented.

- Overall, participants in the four counties and eight sites valued the opportunity to be a learning collaborative, meeting quarterly and having a monthly conference call.

- Project staff and sites attempted, and for the most part were able, to view the implementation as a quality improvement process, focusing on what was learned rather than success or failure. For example, in Los Angeles, where two sites did not sustain implementation, what was learned is being put to good use in the process of implementing Mental Health Services Act programs.

Components that could have been improved:

- While rating the trainings highly, site staff felt that they could have been more flexible to accommodate their particular clinical needs. Flexibility was difficult to achieve because of the wide range of staff skills, knowledge, and experience at different sites—but important for the same reason.

- A critical element in quality improvement projects is selecting concrete changes to measure on a regular basis. Project staff could have worked with site staff to come up with these measures. An important focus, for example, might have been monitoring regular contacts with clients as a way of tracking and maintaining engagement.

- In some instances, particularly in the first year, project staff, site staff, and administrators all were being exposed to IDDT concepts at the same time. A better approach would have been to provide training for administrators and clinic and team leaders in advance of training line staff.

- The SAMHSA Toolkit could be made more useful by including more tools for implementation. Some tools were available in the Mueser et al. handbook, but many other ways of approaching implementation might have been provided.

7. The IDDT model needs adapting for clinics serving predominantly Latino clients with bilingual-bicultural staff. Whether IDDT is effective for this population in this type of clinic needs further exploration.

Casa del Sol staff needed to adapt the IDDT model to fit the needs and culture of their Latino clients. The adaptations have not been systematized and written down, however. So a more focused approach to creating a "Latino IDDT" is called for

Because, even with this adaptation, *Casa del Sol* Latino clients did not make much progress the effectiveness of IDDT with this population is still not established, and further study is necessary.

8. SAMHSA and entities wishing to adopt what is called the IDDT model at this point should consider a different name for the model—possibly "Integrated Recovery."[20]

- The term “dual disorders” has been superseded in the literature by "co-occurring disorders." On the latter point, even the IDDT developers, Kim Mueser and Robert Drake, have stated that "dual diagnoses and dual disorders are clearly *misnomers* [my emphasis], because the individuals with co-occurring severe mental illness and a substance use disorder typically have multiple impairments rather than only two illnesses and because there are several other groups with dual diagnoses such as people with developmental disabilities and mental illness."

[20] This issue was raised initially by a consumer staff member on the project team. Although the development team did vote to change the name to Integrated Recovery, two years had passed and the change did not stick.

- The emphasis on “disorders” and "treatment" are also out of step with current recovery-oriented thinking.

- Because "integrated dual disorders treatment" is a mouthful, it gets shortened in practice to the acronym of IDDT. Thus the value the name could have—reminding staff and clients of a mutual goal—is lost.

- Finally, if you observe yourself saying IDDT many times, you will notice that in some noticeable proportion it becomes a tongue twister. One site renamed the project IDIDIT in order to get past this flaw.