Implementing Change in Substance Abuse Treatment Programs

TAP 31

31

Technical Assistance Publication Series

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Chapter 1—Introduction

Technical Assistance Publication (TAP) 31: *Implementing Change in Substance Abuse Treatment Programs* offers guidance on how to integrate evidence-based practices (EBPs) for substance abuse treatment into clinical practice. Informed by the realities of many substance abuse treatment providers, it suggests efficient solutions for implementing change based on proven methods. Through a practical step-by-step narrative, it explains how to assess an organization's capacity to identify priorities, implement changes, evaluate progress, and sustain effective programs over the long run. This TAP complements the best practices offered to administrators in the Center for Substance Abuse Treatment's (CSAT's) Treatment Improvement Protocols (TIPs) and will be of use for any treatment program or agency implementing change or EBPs. The audience is administrators attempting to integrate EBPs into their programs.

Change is a reality for all substance abuse treatment agencies and organizations. Rates of substance abuse rise and fall, substances of abuse emerge or are rediscovered, science uncovers the mechanisms of addictions, and researchers identify effective interventions. Over the past two decades, EBPs for substance abuse treatment have shifted dramatically from 28-day, 12-Step-based programs to individualized treatment that addresses a client's multiple needs (Macmaster, Holleran, Chantus, & Kosty, 2005). Providers now implement increasingly specialized interventions, including pharmacotherapy, with fewer resources.

Challenges of Implementing Change in Substance Abuse Treatment

For underresourced substance abuse treatment organizations, attempts to integrate EBPs are sometimes performed piecemeal as resources allow. Compared with other healthcare sectors, substance abuse treatment is particularly slow in adapting EBPs (Sloboda & Schildhaus, 2002).

Responding to the dynamic landscape of substance abuse treatment is often complicated by organizational dynamics. The 2006 National Survey of Substance Abuse Treatment Services found that although the total number of substance abuse treatment facilities remained virtually the same between 2002 and 2006, there was considerable turnover (Office of Applied Studies, 2007). Each year, new programs began and between 10 and 17 percent of programs closed or stopped providing substance abuse treatment services altogether. Adding to the organizational upheaval, substance abuse treatment programs often lack sufficient staff to meet client needs. For many organizations, staff turnover is a constant. CSAT (2003) reports that staff turnover ranges from 19 to 33 percent per year.

Substance abuse treatment organizations must adapt to factors imposed by the healthcare system. Changes in managed care and reimbursement affect the entire substance

abuse treatment system and are keenly felt at the provider level. Healthcare systems expand and contract, compelling organizations to adopt new policies and procedures. Cuts in managed care reimbursement for substance abuse programs render substance abuse treatment facilities increasingly dependent on public funding (Macmaster et al., 2005, p. 70). New regulations are implemented, revised, and repealed, often imposing additional administrative burdens.

> Transferring "knowledge to practice" in the real world can be viewed as adding even greater pressure to do more with less.
>
> —*Simpson, 2002, p.172*

Pressures To Implement Change

Adding to the organizational and systemwide strain imposed on them, substance abuse treatment programs face increasing pressure from funding and regulatory agencies, insurers, researchers, consumers, and family members to implement EBPs. For substance abuse treatment organizations, adopting EBPs poses unique challenges. For example, substance abuse treatment programs typically serve diverse populations with complex problems that do not easily fit criteria for best programs and practices (Iowa Practice Improvement Collaborative Project, 2003). Moreover, most substance abuse treatment programs use a credentialed practitioner model that gives individual practitioners the freedom to adopt eclectic approaches. Supervision is often administrative, with limited feedback on clinical competence, and staff evaluations are not generally tied to the use of EBPs. Finally, funding is often based on reimbursable treatment hours, leaving limited resources for considering and implementing more effective practices (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

Despite these challenges, many agency administrators are committed to making improvements in their service delivery systems. They know that continuous improvement is essential to the long-term stability of their organization.

Why Implement EBPs?

Implementing EBPs can help overcome the financial and organizational challenges that make change so difficult. Implementing EBPs may:

- **Improve client outcomes.** EBPs are interventions shown to be effective with specific client populations. Adopting practices with a proven record improves chances of helping people within these populations recover from the devastating consequences of substance use disorders.
- **Increase access to effective treatment.** Implementing interventions and programs with proven effectiveness gives an organization the greatest chance of helping the most people.
- **Engage staff.** Implementing change involves the entire organization. Involving staff and key stakeholders in the process can improve buy-in, enhance motivation, and ultimately reduce turnover. Improved client outcomes can encourage staff members and make them feel better about their work.
- **Improve operating margins.** EBPs can reduce treatment costs while improving outcomes (Schneider, Peterson, Vaughn, & Mooss, 2006). More effective interventions and processes can reduce relapse and recidivism, requiring fewer treatment cycles. Proven, targeted treatments also may enable programs to eliminate less effective program elements and increase volume, thereby improving the bottom line.
- **Save time.** EBPs can streamline treatment, reduce duplication of services and strategies, and increase staff productivity. If planned well, implementation efforts can foster efficient tracking of clients and outcomes, setting

the groundwork for future change and adjustments.

- **Transform organizations from reactive to responsive.** Many organizations are plagued by crises that might have been prevented with thoughtful planning. Through the process of planning and implementing change, some organizations develop the infrastructure to readily identify and address problems and implement solutions.
- **Provide justification for funding.** Systematic data collection and the evaluation of outcomes are parts of the change process. Evaluation provides valuable information for grant and accreditation applications and documents outcomes to sell the program. Evaluation data also can be used to justify a shift in funding to practices that have proven outcomes.

Core Concepts Presented in TAP 31

Implementing change in substance abuse treatment programs is guided by a number of core concepts. Although precise definitions differ, the following terms are used throughout TAP 31.

Evidence-based practice (or best practice). Activity that is based on the best available research in the context of patient characteristics, culture, and preferences (Institute of Medicine, 2001, p. 147). Research consistently shows that EBPs have positive outcomes with similar techniques and similar populations (National Implementation Research Network, 2007). The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-based Programs and Practices (NREPP, 2007) defines EBPs as:

> Approaches to prevention or treatment that are validated by some form of documented scientific evidence. What counts as "evidence" varies. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Distinctions can be made among EBPs, clinical practice guidelines, and clinical pathways. Generally, EBPs are established through multiple randomized clinical trials that demonstrate positive outcomes for a particular intervention or practice in a number of settings. Clinical practice guidelines are based on current research findings and recommendations by consensus panels composed of experts in the field. They are general guidelines to help clinicians make better treatment decisions (Iowa Practice Improvement Collaborative Project, 2003). Likewise, clinical pathways are suggested courses of action based on specific clinical scenarios. Despite these differences, EBPs, clinical practice guidelines, and clinical pathways are all intended to translate research into practice and improve the effectiveness of treatment. TAP 31 uses EBPs broadly to refer to research-based practices or guidelines intended to improve substance abuse treatment outcomes.

Evidence-based program (or best program). A set of practices embedded within the larger service delivery structure and involving multiple best practices. Evidence-based programs incorporate best practices while maintaining the goals of the systems in which the services are delivered (National Implementation Research Network, 2007). That is, an evidence-based program uses many EBPs.

Diffusion (sometimes called technology transfer or dissemination). The process by which results (best practices) are dispersed to the field. It includes efforts to educate or inform, such as trainings, as well as disseminating documents for provider use (such as TIPs). Diffusion is not implementation;

rather, it is the process through which policymakers, clinicians, administrators, and others are made aware of best practices.

Implementation. The process of putting best practices in place. It can be a series of discrete steps, or it can be a single event. It can be ongoing, or it can have a limited duration. Implementation usually involves multiple people, systems, and processes.

Fidelity. The degree to which the clinician, substance abuse treatment organization, program, or administrator adheres to established guidelines, policies, or procedures for best practices. Generally, higher fidelity results in better outcomes (Gotham, 2004). In this TAP, fidelity refers to the degree to which the EBPs outlined in a TIP are adhered to by the target audience.

Reinvention. The process through which a best practice is modified to fit the individual program. Reinvention is sometimes necessary, and it can be positive if it demonstrates improved outcomes. For example, an 8-week program can be cut to 6 weeks to fit the typical stay in a residential treatment program. However, reinvention can be negative if it leads to worse outcomes (Gotham, 2004).

Purveyor. An individual or group of individuals that initiates and monitors change, such as an administrator or clinical supervisor or a group with a specific goal.

Change agents. Individuals in the organization who promote change by using a shared value system, institutional memory, or a particular skill set; individuals who influence colleagues.

Organizational change. An alteration in the culture, customs, values, practices, or protocols of an organization or agency directed at improving the organization's readiness for change and making the organization more amenable to implementing EBPs.

Models for Implementing Change[1]

No single conceptual model of change can adequately be applied to all real-world scenarios. However, theories of diffusion, innovation, or organizational change can provide useful ways to conceptualize the change process. The process through which research makes its way into clinical practice has been well described in the literature.

Online Resources

In *The Change Book: A Blueprint for Technology Transfer*, the Addiction Technology Transfer Center provides a step-based approach to implementation. It is available online at http://www.nattc.org/pdf/The_Change_Book_2nd_Edition.pdf.

TAP 21-A: *Competencies for Substance Abuse Treatment Clinical Supervisors* provides an overview of implementing change in supervisory practices. The document is available online at http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17601.

Implementation Research: A Synthesis of the Literature is available online at http://nirn.fmhi.usf.edu/resources/publications/Monograph/index.cfm.

SAMHSA developed NREPP—a searchable online database of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. To search NREPP, go to http://nrepp.samhsa.gov/index.htm.

The Network for the Improvement of Addiction Treatment (NIATx), a national initiative sponsored by the Robert Wood Johnson Foundation's Paths to Recovery program and CSAT's Strengthening Treatment Access and Retention program, offers tools and case studies specifically for substance abuse and mental health agencies seeking to improve outcomes. For more information, go to http://www.niatx.net.

[1]Generally, models are replications of processes or systems, and theories are abstract speculations. TAP 31 uses the two interchangeably.

Once researchers determine that a particular intervention, or combination of interventions, works better than treatment as usual (TAU) in specific populations, information about these EBPs must be distributed to the field through a variety of venues. Appendix B provides a list of resource publications for interested readers.

Diffusion of Innovations Theories

Rogers (2003) developed theories to explain how innovations become reality. After examining the mechanisms through which innovations (e.g., best practices) become standard practices, Rogers identified five stages in the adoption of new practices:

1. **Knowledge of the best practice.** Clinicians and administrators acquire knowledge through attendance at conferences and training seminars and by reading TIPs and journals.

2. **Persuasion of its value.** A change agent or purveyor convinces key people of the importance of changing the approach.

3. **Decision to adopt the innovation.** When general agreement is reached, the decision is made to implement the new practices.

4. **Implementation of the practice.** Best practices are put into effect.

5. **Confirmation to continue or reject the process.** Postimplementation assessment leads to embracing (institutionalizing) the practice or rejecting it.

In Rogers' (2003) model, individuals play one of several roles in responding to change:

- Innovators—the risk takers
- Early adapters—leaders
- Early majority—deliberate decisionmakers
- Late majority—traditionalists, skeptics
- Laggards—those fearful of change, unaware of trends.

Although Rogers' model has been widely embraced, it imposes limitations on substance abuse treatment organizations attempting to implement best practices. Rogers' model assumes that change is linear, following a natural progression from awareness to adoption (Gotham, 2004). For substance abuse treatment organizations, changes are rarely so clear-cut. Information is continually fed into the process. Old ideas and systems can be revisited and resurrected. Innovations must fit regulatory and financial realities and the existing organizational culture. Moreover, Rogers' model emphasizes the individuals who make concrete decisions to implement change. Although individuals may play key roles in implementing change, organizations and systems also play important roles. Finally, Rogers' model fails to account for education, training, supervision, and competency training required to sustain change.

Transtheoretical Models

Transtheoretical models stress the importance of the organization's readiness to change and the targeted strategies to improve readiness. These models place the organization—its culture, structure, and norms—central to the change process. Hence, any attempts to implement best practices must factor in the organizational context. Transtheoretical models rest on two key questions: Is the organization ready for change? If not, what organizational changes are needed to prepare it for change? Prochaska and DiClemente (1983) adapted the "stages of change" model for individual change to describe the process of organizational change. Organizations move through five stages in the change process:

1. Precontemplation
2. Contemplation

3. Preparation
4. Action
5. Maintenance.

Although organizations consistently complete each step, change is not necessarily a linear process.

Implementation Models

Recognition of the distinctions between dissemination and adoption has increased. Dissemination and training sow the seeds for change. Germination requires thoughtful planning and sustained effort. The literature strongly suggests that without specific strategies to implement change, EBPs are unlikely to find their way into clinical practice (Fixsen et al., 2005). Fixsen and colleagues maintain that the *implementation* component is precisely what has been missing in change models and in resource allocation. Compared with the resources allocated for identifying best practices and disseminating research results to the field, few resources are provided to show programs *how* to implement effective practices. In fact, implementation is the least researched component of the process whereby research makes its way into practice (Gotham, 2004).

Fixsen and colleagues (2005) maintain that an implementation model without a clear plan for change will not work. Basing their opinion on a review of the literature, they suggest that successful implementation is possible only through simultaneous interventions at practitioner, organization, system-of-care, Federal, State, county, and local levels. Fixsen and others have pointed out that implementation is not an event but a mission-oriented process involving multiple decisions, actions, and corrections. As Phillips and Allred (2006, p. 172) assert, implementation of best practices is "a form of propagation … similar to grafting."

NIATx (https://www.niatx.net) promotes a somewhat different implementation model. It focuses on organizational change and on small, manageable change measures that promote financial sustainability and lead to tangible results. NIATx has four aims:

- To reduce the wait time between a client's first request for service and the first treatment session
- To reduce client no-shows
- To increase treatment centers' admissions
- To increase the treatment continuation rate between the first and the fourth treatment sessions.

According to the NIATx model, the essential ingredients for successful process improvement are:

- **Understand and involve the customer.** The "customer" is defined broadly as clients, families and friends, referral sources, payers, and the community. Treatment providers should ask clients about what needs improvement and seek their advice on how to improve services.
- **Fix the key problems.** Focusing on the problems that worry the executive director helps garner support from the organization's leaders and ensure success.
- **Pick a powerful change leader.** Those in charge of organizational change must have authority, the respect of their colleagues, and sufficient time to devote to the initiative.
- **Get ideas from outside the organization or field.** Other organizations or even fields, such as the hospitality industry, can offer fresh perspectives.
- **Use rapid-cycle testing to establish effective changes.** The idea is to take one small change at a time and see how it works. After making the change, the team evaluates the results, modifies the change if necessary, tests it again, and repeats the process until the change is good enough to be made permanent.

The NIATx improvement model has five phases:

- Complete a walk-through to understand customer needs
- Pick a change goal
- Identify a simple data point (or points) that will help you determine whether you reached your goal
- Select and rapidly test relevant changes one at a time
- Sustain the gain.

For more information, see NIATx's *Resource Guide to Process Improvement* at https://www.niatx.net/Content/ContentPage.aspx?NID=232.

Principles of Implementing Change

Several principles guide TAP 31. All are directly analogous to principles of substance abuse treatment.

There is no single model for or approach to implementing a program of organizational change. A preconception about how change *should* occur or inflexibility during the change process is counterproductive if not fatal to meeting a program's change goals. Constant vigilance and in-course corrections are needed. Corrections should be made in consultation with the stakeholders who developed the original change plan. TAP 31 provides logical steps to implementing change. The document is not intended to be rigidly prescriptive; rather, it suggests how to go about the change process, with references to other resources to fill in the gaps. Programs will need to modify the process to succeed in changing or adapting.

The change program should be individualized to accommodate the specific needs, goals, culture, and readiness to change of an organization. For example, a suggested best practice may be to screen all clients for infectious disease. Limited resources may make this impossible. An alternative would be to screen for HIV and hepatitis and refer clients to a clinic offering screening for other infectious diseases.

The Implementation Headset

Dissemination and implementation are not the same things. Fixsen and colleagues (2005, p. 4) coined the phrase "implementation headset" to encourage a different kind of thinking about implementation. They postulate that, too often, researchers, policymakers, administrators, and managers assume that distributing information about best practices to the field is sufficient. Doing more or better research on a program or practice itself does not lead to a more successful implementation. Training providers in how to use a technique is not the same as incorporating proven interventions into clinical practice. Implementation is an entirely different enterprise, requiring an entirely different approach.

Change is not a linear process. Although TAP 31 outlines a step-by-step approach, sometimes it may be necessary to backtrack. Perhaps early evaluation results reveal that the new approach is not working. It may be necessary to revisit the planning phase to adjust the plan. Or it may become clear at a later stage that the new program is not sustainable when funding levels decrease, and adjustments will be necessary.

Change is ongoing. Change is not a discrete event. It is a process that requires careful planning, coordination, cooperation, evaluation, and followup. At least in the first few years after the implementation of an organizational change plan, continuing care of the organization's new accomplishments is critical to their long-term survival.

The ultimate goal is to create changes that can be sustained over time. Eventually, the changes will become a regular feature of the program's operation through a process called *institutionalization*. Institutionalization has occurred when the "new practices" introduced have become the

"everyday practices" of the agency. Even after institutionalization occurs, however, a commitment to continuous quality improvement ensures the program's ability to respond to future changes in the needs of the client population and community.

Organization of TAP 31

The remaining chapters of TAP 31 suggest a step or stage approach in which one component logically follows another.

Chapter 2—Preplanning. At this stage, decisionmakers determine whether best practices are worth implementing. The chapter suggests practical ways to compare best practices with TAU, evaluate outcomes, and realistically assess whether change is possible or desirable.

Chapter 3—Planning. Implementation requires forethought and planning. This chapter suggests factors that should be considered in planning for implementation. It recommends strategies to involve stakeholders, anticipate problems, and align the organization with the impending changes.

Chapter 4—Implementation. With proper planning, implementation is a matter of following the established course. This chapter suggests ways to execute plans, monitor progress, and make adjustments, if necessary.

Chapter 5—Evaluation. Much of the work for this step is done in the planning and implementation stages. Evaluation is the process of appraising or measuring outcomes, comparing outcomes with baseline measures, and determining what, if any, adjustments need to be made.

Chapter 6—Sustainability. The best programs and practices will be of little use without a plan to sustain them over time. This chapter introduces strategies to garner the financial, political, and systemic support to make the progress permanent.

Although there is a logical flow to the steps, each stage depends on subsequent stages. Evaluation components should be built into the planning stage to establish the baseline and assess what the change process should address. Sustainability may be a large factor in deciding whether to move forward with the change plan and should be considered along with other factors in the preplanning stage.

Chapter 2—Preplanning

Hypothetical Scenario

You are an administrator at a small intensive outpatient substance abuse treatment program. Twenty percent of the funding for your organization comes from a block grant. To qualify for renewed funding, the grantee must demonstrate that activities or projects that are funded by monies used for substance abuse and mental health treatment include an evidence-based component for family members. Your organization generally follows evidence-based practices (EBPs) but does not currently offer comprehensive family services. Clients in need of intensive family therapy are referred to a community health facility, but there is no coordination of care between your facility and family therapy. You are exploring the feasibility of adding an evidence-based family component.

An organization facing this scenario is in the preplanning stage of implementing change. At this juncture, no decision has been made to commit to change. Rather, the program is in the exploratory phase in which you ask key questions:

- What are the current practices?
- How do outcomes from best practices compare with outcomes from treatment as usual (TAU)?
- Does the new target practice match client/community needs?
- Could the new target practice be realistically accommodated?
- If so, what elements of the program need to change?
- What data can you collect to establish a baseline?

Answers to these questions will decide whether to move forward with implementing change and set the stage to address anticipated barriers.

What Are the Best Practices/Programs?

The best practices and programs recommended in Treatment Improvement Protocols are based on research and clinical expertise. They are interventions that have yielded the best outcomes in a given population. However, not all recommendations will be possible or even desirable for your specific situation. When considering EBPs, evaluate the fit with your program. Factors to consider are noted below.

Populations served. Practices that have proved effective with urban adolescents will not necessarily work for a substance abuse treatment program for adults in rural or remote areas. Likewise, EBPs developed for White women may not be as effective in a program that serves racially and ethnically diverse groups. A good fit for your population is the EBPs that most closely fit your organization's client base in terms of age, gender, race, ethnicity, socioeconomic status, education, and co-occurring disorders.

Program type. A specific intervention or treatment component for an intensive inpatient program may not be a good choice for another type of setting. Consider whether research on the intervention was conducted for organizations that are similar to yours.

System of care. EBPs may be based on research conducted by a State agency, with partnerships with mental health services, housing, and child welfare. Practices provided in an integrated system may not be effective in your organization.

Resources. Well-funded organizations can implement practices that may be beyond the reach of your program. Scarce funding does not necessarily mean you cannot move ahead, but you may need to identify new funding sources or explore cost-saving relationships with universities or other organizations. (See Chapter 6 for more on circumventing costs.) Also consider whether your staff has the time and expertise to implement best practices.

How Does Your Program Compare?

As you consider implementing change, first look closely at the recommended best practice. Consider whether the recommendation is appropriate for your program. As noted, not all recommendations will be desirable for your particular client base, system of care, or resources. Map out each recommendation that fits your program and consider it carefully. Include a description of what the recommendation means or examples of how it would work in clinical practice. As you work through the implementation process, you will add detail, identify challenges, and outline possible solutions. Ultimately, this process will help you make informed decisions. You might list each recommended component of an EBP. Exhibit 2-1 illustrates how closely a hypothetical program follows best practices for a family-based intensive outpatient treatment program.

By looking closely at best practices, you gain a sense of how your program compares. Perhaps some practices are in accordance with recommended best practices (e.g., teaching family members about substance use disorders) but other areas are not (e.g., providing child care).

How Do TAU Outcomes Compare With EBP Outcomes?

Before investing resources in changing practices, you should consider whether the proposed changes have the potential for better outcomes. If, for example, a new intervention demonstrates a 1-year abstinence rate of 20 percent, and TAU at your organization demonstrates a 1-year abstinence rate of 20 percent, changing current practices is unlikely to improve results. If, however, your 1-year abstinence rate is 10 percent, then your program may improve by implementing the new intervention.

A vital part of the preplanning stage is to identify your measurable TAU outcomes and compare them with outcomes of EBPs. These comparisons help determine whether to implement the new approach. Your program outcomes are the baseline measures for comparing outcomes for the changes you implement. (See Chapter 5 for more on baseline measures.) Exhibit 2-2 shows a sample of the measures and data sources for determining outcomes.

Is Your Program Ready for Change?

Evaluating readiness to change requires objectively examining the factors that help and impede change, strategizing ways to build on strengths, and addressing challenges. Depending on the circumstances and scope of change, this examination can assume many forms and degrees of intensity. In some cases, this appraisal can be made by an

Exhibit 2-1 Identifying EBPs Missing From a Hypothetical Program's Family-Based Services

Recommended Family-Based Services*	EBP Core Components	Hypothetical Program
Include family members in the intake session	Invite clients to bring family members to intake	No
	Conduct family interviews	No
	Encourage family participation	Minimal
	Ask family members to complete a brief family assessment	No
	If a family member makes contact, invite him/her to initial intake	No
Provide culturally relevant programs and education	Provide interpreters	No
	Make education resources available in languages spoken by clients and their families	No
	Allow the client to define "family" to include extended family and people who are not biologically related	Yes
	Incorporate cultural understandings of substance abuse, treatment, and recovery	Varies
Use client-initiated engagement efforts	Include family participation in treatment plan	Varies
	With client permission, contact family and offer invitation to participate	No
	Encourage client to invite family to participate	Varies
Offer incentives	Offer incentives for family participation in sessions and for completing assignments	No
	Provide refreshments	Yes (family day)
	Provide transportation	No
	Provide child care	No
Plan events (e.g., picnics, dinners) for families	Schedule family days on weekends or holidays	Yes (1 day)
	Combine with educational sessions (e.g., recovery support groups, family services, elements of substance use disorders)	Yes
Use community reinforcement training interventions	Teach family members about substance use disorders	Yes (2-hour session on family day)
	Reinforce that they are not the cause or the cure	Yes (see above)
	Communicate in nonjudgmental ways	Yes (see above)
	Encourage them to identify and pursue their own interests	No
	Encourage drinking of nonalcoholic beverages during social occasions	No
	Manage dangerous situations	No
	Discuss treatment with the family members who abuse substances	No
Create a family-friendly environment	Provide flexible program hours	No
	Accommodate families in large offices or meeting rooms	Yes, but may require more space
	Provide safe toys for children	No
	Train front-office staff to encourage family members	No
	Create a recordkeeping system that provides easy access to family-related information for each client	No

*Source: Adapted from Center for Substance Abuse Treatment, 2006.

Exhibit 2-2 Comparing EBPs With a Hypothetical Program's Practices

Best Practice			Hypothetical Program		
Outcome	**Measure**	**Rate**	**Outcome**	**Measure**	**Rate**
Psychosocial functioning baseline	Independent followup of 75% of all treatment completers using self-reports through a standardized tool	58% demonstrate improvement in at least one domain	Psychosocial functioning baseline	Not measured	N/A
Retention at 30 days	Client records	66%	Retention at 14 days	Client records	42%
Retention at 90 days	Client records	50%	Treatment completion (90-day program)	Client records	22%
Abstinence at 30 days	Random urine drug screens of all clients enrolled	43%	Abstinence at 30 days	Self-reports (not systematically recorded)	N/A
Abstinence at 60 days	Random urine drug screens of all clients enrolled	37%	Abstinence at 60 days	Self-reports (not systematically recorded)	N/A
Abstinence at 90 days	Random urine drug screens of all clients enrolled	22%	Abstinence at 90 days	Self-reports (not systematically recorded)	N/A
Abstinence at 1 year	Independent followup of at least 75% of all treatment completers using self-reports	20%	Abstinence at 1 year	Self-reports of treatment completers contacted by their counselor	Usually less than 40% of completers

informal group (such as the planning team or another team charged with assessing the program's culture). In other cases, more formal assessments or surveys may require an outside consultant.

The literature is rich in information about readiness to change, and several tools help organizations assess it (Knudsen & Roman, 2004; Lehman, Greener, & Simpson, 2002; Schuh & Leviton, 2006). Based on a survey of 500 staff members and more than 100 treatment units, Lehman and colleagues (2002) identified important factors in assessing organizational functioning and readiness for change: motivation and personality attributes of program leaders and staff, institutional resources, and organizational climate. Factors identified in the literature are described below.

Environmental stability. Organizations with consistent management and a basic structure can more readily adopt best practices (Lehman et al., 2002). Causes for organizational instability may need to be addressed before any change can take place. High staff turnover, for example, may require changes in management.

Organizational maturity. Schuh and Leviton (2006) suggest that organizations go through stages of organizational capacity, with more mature agencies more likely to implement EBPs with fidelity. An organization's ability to adopt practices depends on

which stage it is in. Five features define an organization's maturity:

- Governance—legal status (e.g., nonprofit), core documents (e.g., mission statement), oversight board, and so forth
- Financial resources—ability to generate funds, sustainability, diversity of funding sources, and the like
- Organizational development—degree of structure, role differentiation, skills of administrative staff, and so on
- Internal operations—administrative functions, operations, leadership, financial systems, management information systems, and so forth
- Core services—staff skill in providing key services.

Nonprofit agencies tend to develop core services first and underemphasize administrative infrastructures and board development and functioning. When the services offered are more evolved than the structures that support them, dysfunction ensues (Schuh & Leviton, 2006). Part of your planning process may be to examine your organization and consider whether you have an infrastructure adequate to support your core services. Do you have enough administrative support, financial tracking systems, an evolved and involved board? Change efforts present the opportunity to strengthen existing infrastructures and align them with the change efforts.

Policies, procedures, and protocols. What policies are related to the possible changes? For example, if you are considering integrating family-based treatment, which policies might affect your decision? Do you have policies that discourage contact with family members? What procedures might affect the decision to move forward? If your standard procedure is to refer people in need of family therapy to another agency, what implications will that have for integrating treatment? For example, incorporating a family component may require process changes so that staff members trained in performing family assessments conduct intakes.

Organizational fit. Phillips and Allred (2006) examined the administrators' decision process for implementing best practices. They found that service providers considered not only empirical evidence but also the practical merits and how the interventions fit with current practices and systems. Philosophical factors may cause a particular intervention to fit better than another. For instance, a program using 12-Step facilitation approaches may be leery of pharmacological interventions. These differences do not mean a new intervention should not be implemented. However, staff may need to be prepared for a change. Research suggests that clinicians are more likely to adopt treatments when they understand the evidence base and the potential to improve client outcomes.

Adequate resources. Financial resources are required to implement most changes. Organizations struggling financially are less likely to devote resources necessary for change (Lehman et al., 2002). Although many changes may prove profitable in the long run, change can be costly. It may involve additional training, staff time dedicated to planning and implementation, technological enhancements, or the expansion of space. Consider all possible costs, including but not limited to consultant costs, trainers, time for training, new staff hires, and administrative costs. Weigh the estimated costs against the potential for improved outcomes for clients, improved efficiencies, and associated cost reductions. To make up for any shortfalls in costs, consider all potential funding opportunities, including Federal, State, and private grants and matching funds. (For more on funding, see Chapter 6.)

Capacity. Substance abuse treatment organizations often have a limited capacity. An inpatient treatment center may have 32 beds, with the capacity for 10 more with modest renovations. An outpatient facility may be able to treat 100 clients at any given time.

The Innovative Organization

Research suggests that certain types of organizations may be more adaptable to change than others. Organizations with fewer resources are less likely to implement best practices (Rosenheck & Seibyl, 2005). More subtle characteristics also predict success. Knudsen and Roman (2004) use the term "absorptive capacity" to refer to the organization's "ability ... to access and effectively use information" (p. 51). In general, the organization's engagement with the substance abuse treatment field, the number of staff members with advanced degrees, and the degree to which innovation is valued positively affect the organization's ability to implement change. For more on factors that help or impede the adoption of EBPs, see Chapter 3.

Capacity refers to the maximum resources available for operation. It includes:

- Beds or treatment slots
- Available office space
- Hours of operation
- Computer equipment and access
- Educational/training resources
- Available financial resources
- Personnel.

Consider whether the best practices can be accommodated with existing resources. In the hypothetical scenario, including a family component requires additional space to accommodate family sessions, safe spaces for children, staff to watch children if needed, and changes in scheduling, among other things. Insufficient resources do not necessarily mean that the change cannot be implemented. It means that creative thinking may be needed to adapt the practice for your facility. For example, if additional space is unavailable at your site, a community partner may be able to accommodate family sessions or days.

Motivation. External pressures to adopt best practices can positively affect an organization's ability to implement change, as can the perceived needs for change (Simpson, 2002). The greater the external or internal pressure for change, the more likely for change to occur (Lehman et al., 2002).

External engagement. Based on data from the National Treatment Center Study, Knudsen and Roman (2004) suggest that *environmental scanning* (seeking external sources of information [e.g., the availability of EBPs; communication with other, similar organizations] to inform internal decisionmaking) or the use of such resources as professional development seminars and publications is an effective means to positively affect innovation. Likewise, *professional growth* is a predictor of readiness to change. Organizations that place a low value on professional growth or that offer few opportunities for it are associated with low readiness for change (Lehman et al., 2002).

Staff attributes. The percentage of master's-level counselors is positively related to innovation adoptions. The percentage of certified/licensed counselors and counselors in recovery appears to have an indirect positive influence on the acceptance of innovative practices (Knudsen & Roman, 2004). Efficacy is positively related to change. Staff members with low confidence in their skill negatively influence readiness for change.

The abilities, training, background, and workload of your staff will affect your decision. If the recommended best practice requires multiple master's-level staff members, is it feasible to make the necessary hires? How much time will be involved in training new staff? While contemplating change, it is important to assess staff competencies in the areas of targeted change:

- What specialized trainings do staff members have?
- What certifications do staff members hold?
- Do staff members have experience working with special populations? If so, which ones?

- Will the changes require hiring or recruitment?
- How much training of supervisors and staff will the proposed change require?
- Will the changes affect supervisory burden?

Work culture. The work culture can have a strong influence on an organization's adaptability. Staff cohesion, degree of clinical autonomy, communication styles, and level of stress affect an organization's readiness to change (Lehman et al., 2002; Simpson, 2002). Organizations that encourage growth, open communication, and teamwork are likely to be adaptable to change. Troubled organizations may need to address underlying problems before a change can be successful.

Staff needs. To be effective, substance abuse treatment organizations must give frontline staff members the resources and support they need to perform their jobs well. This support can range from adequate time to complete their work, to adequate pay to support their families, to time off to recharge, to resources (e.g., computer equipment, administrative support, procedures that simplify rather than complicate). Potential information sources include the following:

- **Exit interviews**. Conduct an exit interview with all staff members who resign, and track the results. If burnout is a common cause for departure, consider ways to lessen the workload, give extra time off, or promote self-care. If low wages are a factor, evaluate the competitiveness of your salaries and benefits.
- **Employee surveys.** Provide a means for employees to comment on the organization, management, and administration. Solicit suggestions for change.
- **Employer reviews.** Conduct 360-degree reviews. These reviews provide an ongoing mechanism for staff members to note what they need to do their jobs well.
- **Mechanisms for communication.** Provide regular forums in which staff members can identify problems and express their needs.

Administration/management. If staff turnover is high and morale is low, management may be part of the problem. Supervisors may lack skills for effective management. Administrators may be unprepared to make executive decisions and provide leadership or vision. A self-assessment can identify changes that may improve retention and the overall functioning of the organization. It may be useful to revisit (or create) job descriptions, skill sets, and knowledge requirements for all leadership positions. Does the leadership have the desired skills, experience, and knowledge? If not, how can you bring leaders up to speed?

The self-evaluation should not be limited to individual qualifications and performance. You should also look at management structures:

Is Your Organization Troubled?

In some cases, the work culture may be so troubled that even the status quo is difficult to maintain. Hawkins (2004) noted several characteristics of troubled organizations:

- High level of negativity and passivity
- Dominance by one or two groups
- Poor leadership
- Ineffective problemsolving skills
- Mistaking silence for support
- Strangled communication flow
- Volatile emotions (surface anger)
- Difficulty accepting changes
- Multiple win/lose situations
- High absenteeism rate
- Tendency to blame others or perceive self as victim
- Reputation for "eating their young"
- Recruitment or retention difficulty.

If your organization is troubled, you need to build a healthier work culture before change will be possible.

- What are the lines of authority?
- Are there checks and balances in place?
- Do mid-level managers have authority to address problems as they arise?
- Is there adequate communication between administrators and managers?
- What is the workload for leadership positions? Can some responsibilities be delegated to nonmanagerial staff?

In substance abuse treatment, it is common for counselors to assume leadership positions with little or no training in effective management. Technical Assistance Publication 21-A: *Competencies for Substance Abuse Treatment Clinical Supervisors* (Center for Substance Abuse Treatment, 2007) identifies core skill sets required for clinical supervisors. The Substance Abuse and Mental Health Services Administration's Addiction Technology and Transfer Center (http://www.nattc.org/index.html) offers useful resources to administrators and supervisors.

If your organization is not ready for change, consider what you can do to improve its ability to implement change. Before you can implement EBPs, you may need an organizational intervention. Organizational interventions require systematic attention to redefine goals and priorities and improve the organization's ability to adapt to change (Simpson, 2002).

To prepare your organization for change, list the factors that work for and against change and realistically assess what you can do to improve readiness. Consider whether measures to improve readiness can be done simultaneously with efforts to implement best practices or whether a fundamental change in the organizational culture is needed before EBPs can be implemented. You may need to build infrastructures, formalize processes, and establish specialized job descriptions.

Client needs. In most organizations, consumer needs drive the demand. Businesses change to stay competitive. D'Aunno (2006) points out, however, that clients in substance abuse treatment are not well positioned to demand the best care. This makes it even more important to use treatment proven to be effective. EBPs have produced better outcomes in certain populations, but a particular practice must match clients' needs. When identifying what practices and programs will work best with your clients, consider the following:

- Substances of abuse (e.g., alcohol, methamphetamine, multiple drugs)
- Co-occurring mental and medical disorders
- Gender
- Age
- Race/ethnicity
- Language capacity
- Spiritual/religious beliefs
- Income
- Insurance
- Employment status
- Legal constraints
- Parental status
- Family members
- Sexual orientation
- Mode of entry into treatment
  - Self-referred
  - Court ordered
  - Referrals from mental health practitioners
  - Referrals from primary care and other allied health and human service practitioners.

Consider past, current, and potential client characteristics. You can review internal records, check records from the U.S. Census for your community, and investigate other information sources to determine the demographics of your client base. Perhaps your treatment center is in a region that

is 40-percent African American yet only 8 percent of clients completing treatment are African American. A goal for your program may be to implement practices with demonstrated effectiveness for African-American clients. At this stage, you may want to consider what is known about client characteristics from the published literature. For example, a high percentage of people who abuse alcohol have a mood disorder (Karno & Longabaugh, 2003). To be effective, your program may need to have treatments and systems to address co-occurring depression.

In addition to compiling information about your clients, you may wish to identify potential client stakeholders. These could include current or past clients, members of advocacy groups, or representatives from self-help groups. These individuals not only provide useful qualitative information but also increase buy-in from your consumer base.

Finally, brief surveys of clients, former clients, or community partners may provide additional insights. Americans with Disabilities Act-compliant Web surveys are available at nominal cost. For a list of companies offering Web survey services, go to the American Evaluation Association Web site surveys page at http://www.eval.org/Resources/surveylinks.asp.

Community partners. Relationships with other providers, organizations, individuals, or agencies can be vital in initiating and maintaining change. Your organization may have relationships with providers to prescribe and monitor medication, provide more intensive psychiatric services or family therapy, or help with occupational or housing needs. Other organizations with which you can partner include:

- Social/welfare organizations
- Physicians, dentists, and other medical professionals
- Employment agencies
- Housing agencies.

For each relationship, describe its degree of formality. Is it a contractual relationship or an informal one? Are there key individuals with whom your organization does business? Is there a memorandum of understanding? If so, is it fully operational?

It is useful to map different types of services available in your service community. Perhaps another agency or organization provides services you need to implement a particular EBP. Service mapping provides a means to avoid duplication and identify possible partners and needs. If, for example, you are adding a component to treat people with fetal alcohol spectrum disorders (FASD), you could start by identifying the treatment needs of such individuals and identifying organizations or agencies in the community that can meet those needs. Perhaps you could link with an agency that offers vocational training and a community-based health center with physicians trained in treating the health consequences of FASD. By mapping services, you can identify both the needs your program will meet and how they fit into the service delivery system in your area.

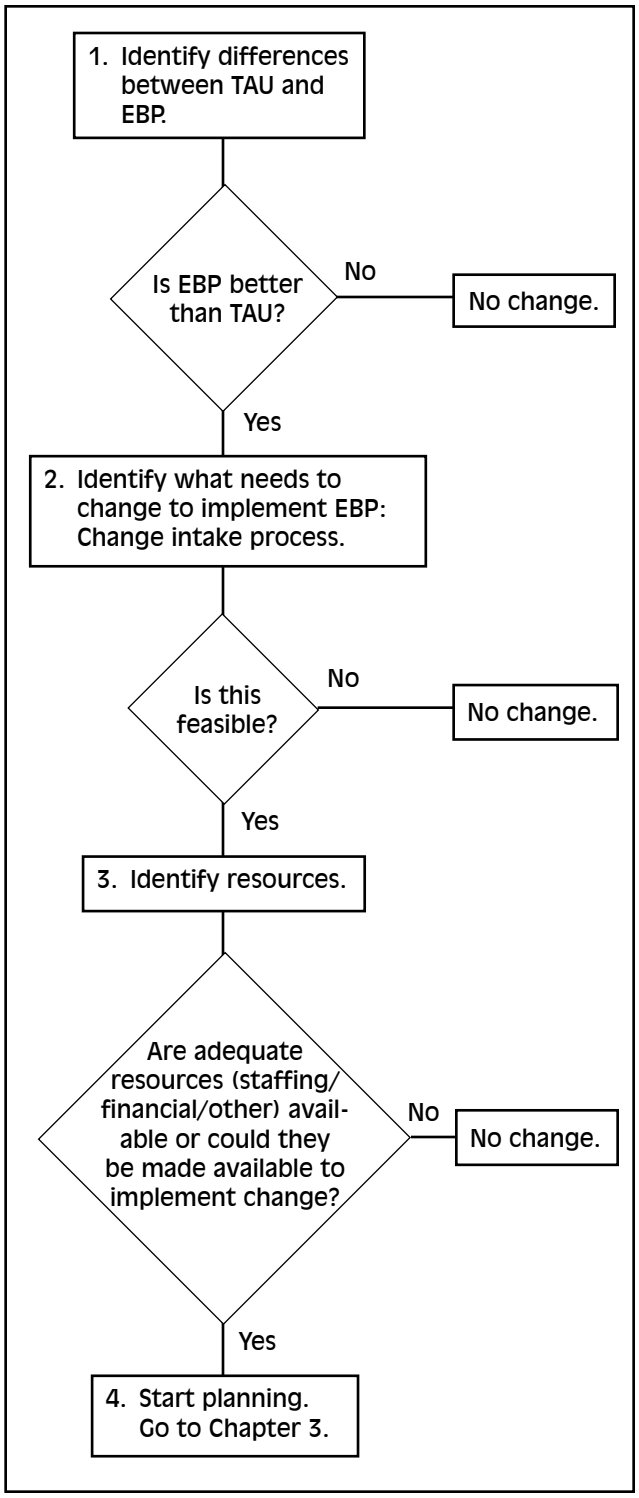
A Note on Fidelity

Whether you want to implement comprehensive programmatic change or add a specific intervention to your program, the goal should be to replicate the best practices and programs as closely as possible. Nonetheless, strict adherence to EBPs may not be feasible. Whether you choose to implement a "near best practice" when an exact match is impossible should be determined on a case-by-case basis. Be wary, however, of drifting from the goal. Based on a review of the literature, Fixsen and colleagues (2005) recommend that the practice first be attempted with fidelity before innovation is made. Generally, adaptations made *after* a program is implemented with fidelity are more successful than those made *before* the organization has fully implemented the best practice. If it is not feasible to implement EBPs with any degree of fidelity, you will have to decide whether to move forward. In some cases, you may elect to describe incremental steps that are acceptable interim measures.

Is Change Realistically Feasible?

Once you have determined where you are and where you would like to be, it is time to assess what will be involved in implementing best practices. Based on your assessment of current practices, determine what would need to change to get from *A* (TAU) to *B* (EBP).

Exhibit 2-3 Sample Change Decision Tree



Consider carefully what will be needed at each step before you commit to a course of action. Evaluate the likelihood of accomplishing each step. If, for example, the proposed change calls for the addition of at least two staff members and your program is operating at a deficit, it may not be feasible to move forward. Before abandoning the effort, however, creatively consider options. Remember, at this stage you are deciding only *whether* to move forward, not necessarily *how* to move forward.

Look closely at the recommendations. Break them down into small elements, and consider the potential for each:

- Is the recommendation consistent with community norms and values?
- Is it relevant to the client population?
- Is it feasible given political realities?
- Can financial resources be accessed?
- Are resources available in the community (e.g., referral, support services)?

You may decide to pursue all, some, or none of the EBPs. Some practices may be impossible to implement, at least at the present. For example, the research may indicate that a five-session HIV risk-reduction program produces better client outcomes than the standard one-session program. Limited availability of financial and personnel resources may make a five-session program implausible. You may consider offering three sessions instead.

Exhibit 2-3 is a sample decision tree of the process of deciding to move forward with implementing change. The choice is not as clear as *yes* or *no*. It may be yes for some components and no for others. Some aspects may require attention before moving forward.

Chapter 3—Planning

Hypothetical Scenario

Change is in the air at the small outpatient substance abuse treatment program for which you have served as executive director for the past year. You have reviewed evidence and decided to move forward with a plan to include in your program a component to treat depression. Counseling staff members have vocally opposed the plan, reminding you frequently of the last failed attempt to change practices. Their concern is that evidence-based practices (EBPs) are developed by researchers with very little understanding of real-world clients. What can you do to gain the buy-in needed to implement the plan?

The work you completed for preplanning will set the stage for the next step: Planning. You have made the decision to move forward, collected preliminary data, identified specific needs that may be met by implementing change, and are now prepared to map out your plan. This chapter highlights a logical, step-by-step approach to planning the implementation, although your change process may not necessarily follow these steps.

Who Should Be at the Planning Table? Selecting the Change Team

Assembling a planning team is one of the most important steps you will take in the journey toward implementing best practices. The team should be selected based on skills, knowledge, and social networks (Sirkin, Keenan, & Jackson, 2005). If your plan requires financial planning, the person charged with the operating budget should be involved. If the changes will affect the way case managers do their jobs, you should include case managers who can tell you which services they provide and what changes will be needed. If the change has implications for your relationships with outside providers or agencies, the team should include people who interact with representatives from these organizations. You might consult staff on advice for who should be on the team.

Your team should include stakeholders—the people with a vested interest in the outcome of your efforts. Stakeholders may include board members, counseling staff, administrative staff, or representatives from advocacy groups. Consumer involvement may be particularly important—or even required—for some funding streams. Consumer involvement adds pressure on staff members who may be opposed to change. Moreover, research suggests that effective interventions must be acceptable to clients or potential clients (Gotham, 2004).

The change team serves a strategic purpose. Carefully selected team members can ameliorate political fallout. The team should not consist solely of people who are likely to support the initiative. Naysayers bring valid perspectives; they insert reality into the discussion and identify potential pitfalls. Moreover, people are less likely to experience change as stressful, more likely to support change, and more likely to work toward it when they are involved in the change process (Johnson, Brems, Mills, Neal, & Houlihan, 2006). Including people on the change team

Successful Implementation: It's Not Just a Matter of Chance

Despite the obvious differences in goals, products, and clientele, Fortune 500 companies can provide models for efficiency, profitability, quality, and change management. One model for organizational change—DICE—posits four key factors for a successful change initiative:

- **Duration.** It is not how long the change process is expected to take but the time between reviews and milestones that matters. The most effective milestones focus on big-picture items—accomplishments and completed action items—rather than day-to-day functions. Formal reviews should be distinct from maintenance meetings where the project team assesses whether the change has the desired effect.
- **Integrity.** The success of the implementation project depends largely on the abilities, cohesiveness, and dedication of the planning group.
- **Commitment.** To be effective, change must have the backing of top-level administrators and the people who will be affected by the changes.
- **Effort.** Whatever the change, if the level of effort is too great or the existing workload too demanding, the implementation is less likely to be successful. Ideally, a change initiative should not change any one person's workload more than 10 percent.

SOURCE: Sirkin et al., 2005.

is a critical way to establish buy-in up front. The members of this planning team can serve as "ambassadors" of the change to their respective constituencies during the implementation phase (see Chapter 4).

You can always add members as the process evolves. As your plan takes shape, you may need the input from people not represented. As you encounter potential conflicts, a solution may be to include critics on the team.

Once the team is identified, establish how it will function:

- Establish clear lines of communication and a communication plan (e.g., Web portals, listservs, regular meetings)
- Identify a point of contact for external stakeholders
- Appoint a lead—the person who will drive efforts forward
- Clearly define lines of authority—identify to whom the team reports (e.g., board of directors, executive director).

Where *Exactly* Do You Want To Go? Defining Your Destination

Before making a specific plan, you should clearly identify what you hope to accomplish. If, for example, you are planning to implement EBPs, your goal may be to obtain outcomes comparable with those established for similar programs using the same practices. Fidelity is important. If you want outcomes comparable with those noted in Treatment Improvement Protocols (TIPs), you need to institute comparable practices.

Successful plans have clear goals and established measures for success (milestones). The goal is the desired destination; the plan is the route (EBP implemented with fidelity) you will use to reach your destination. When considering your destination, determine ahead of time how you will know when you have reached it. What variables can be measured? If you are implementing a specific intervention such as motivational interviewing (MI), how will you measure success? Examples of measurable outcomes include the following:

- **Outcome:** Staff competency (e.g., ability to conduct MI)
  Measures: Observations, taped work samples, certifications, self-reports
- **Outcome:** Improved client outcomes
  Measures: Improved client retention rates, higher abstinence rates
- **Outcome:** Increased net revenues (from increased patient fees or new/expanded contracts with funders)
  Measures: Financial reports.

It may not be possible to achieve all desired outcomes. By prioritizing outcomes, you can

focus on accomplishing the most important ones first. Once you have prioritized the outcomes, decide how you will measure success. What is the baseline for each expected outcome? What is the goal? Include specific details about each change, the justification for each change, a list of affected stakeholders, the expected outcomes, and indicators to evaluate the effects of the change. Exhibit 3-1 gives an example of how to measure outcomes for one component. This information should be tracked for each component.

Are You Ready for the Trip? Revisiting the Organizational Assessment

Once you have reached the planning stage, you have already decided that your organization is ready to implement change. It is important to bear in mind, however, that part of your change plan may require interventions to prepare the organization for change. However effective a practice may be and however committed individuals may be to implementing change, not all organizations are amenable to implementing EBPs. If, for example, your organization's culture does not encourage innovation, part of your planning process may be to change that culture.

Revisit the factors you considered in the preplanning stage (Chapter 2), and include in your plan steps for addressing problems. Looking at the hypothetical scenario at the beginning of this chapter, you might improve the staff's receptivity to change by promoting professional growth. Consider sending staff to conferences, distributing TIPs for review and discussion, circulating relevant journal articles, or setting aside space for a library. These activities foster an atmosphere that values innovation and embraces EBPs.

For each potential problem, note steps you can take to address it. If you observed that your organization lacks adequate administrative infrastructure, include steps in your plan to remedy this: hire an administrative assistant to assist in day-to-day operations, implement a financial software reporting system, or differentiate staff responsibilities.

What Are the Change Targets? Setting the Stage

Change targets do not have to be extensive. You may want to start with a small pilot project first. This can be accomplished by implementing an EBP on a small subset of your clients first or by implementing one or two components of a program.

Building on your preplanning work, you can now identify the change targets—areas, programs, structures, or functions that need to be addressed to make change possible. Several possibilities are highlighted below, but there may be many others. The more forethought you put into this phase, the better prepared you will be to implement change and the smoother the implementation is likely to be. Exhibit 3-2 presents an example of how you track changes needed to implement an EBP.

Exhibit 3-1 Sample Measure and Indicators

Measure	Justification	Expected Outcomes	Baseline Measures	Indicators
Include family in initial intake	Families • Provide information • Help engage loved ones • Help formulate a treatment plan	• Improved retention rates • Increased abstinence rates • Improved psycho-social functioning	• Retention rates as of [date] • Drug/alcohol use as of [date] • Employment rates as of [date]	• Improved retention rates (measured weekly) • Improved abstinence rates at 3, 6, 9, and 12 months • Improved employment rates at 6 and 12 months

Exhibit 3-2 Change Tracking Form

Domain	Component	Change Needed? Y/N
Administration and oversight	Mission statement	
	Oversight board	
	Supervisory staff competencies	
Work culture	Flexibility	
	Support	
	Growth opportunities	
	Infrastructure	
Policies and procedures	Intake	
	Screening and assessment	
	Treatment placement	
	Treatment planning	
	Service recording	
	Discharge planning	
	Continuity of care	
	Incentives	
Staff	Staff skills and competencies	
	Recruitment	
	Training	
	Time to attend trainings	
	Caseload size/workload	
	Productivity	
	Reflective supervision, mentoring, or coaching	
	Specialized counselor performance appraisal	
	Evaluation of service effectiveness and quality assurance	
	Strategies to avoid burnout	
Capacity	Client capacity (e.g., number of beds in inpatient treatment centers)	
	Meeting rooms (e.g., for screening, family therapy)	
	Audiovisual technology (e.g., for training)	
	Vehicles	
Information technology	Computers/Internet access	
	Client tracking	
	Information sharing	
	Recordkeeping	
	Capability to record data needed for outcomes	
	Ability to generate and analyze outcome data	
	Personnel	
	Staff skills competencies	

Exhibit 3-2 Change Tracking Form (continued)

Domain	Component	Change Needed? Y/N
Evaluation	Resources for evaluation component and recordkeeping	
	Evaluation expertise	
	Additional measures	
	Followup	
	Incentives	
Community partnerships	Memoranda of understanding	
	Contracts/subcontracts	
	Informal understandings	
	Communication protocols	
	Referrals	

Administration and oversight. Your plans may require changes at an administrative level. Perhaps your mission statement needs to be updated. If, for example, you are including programs for families, you may wish to revise your mission statement to reflect the family focus. Determine whether changes need board approval.

Staff training. Most change plans require that staff be trained in new policies, procedures, or treatments. Plans for training should be specific and include answers to the following questions:

- Are there internal staff members proficient in the EBP?
- Who will conduct the training?
- Do we need to hire an experienced consultant?
- Do we have the funds to pay for training?
- What is the duration/frequency of the training?
- How will staff time be made available for training?
- What are the training goals?
- How will outcomes be measured?
- How will training be reinforced?
- How/when will new staff be trained?
- Are there curricula for training in the EBP?
- Do supervisory staff members have the skill to provide training, feedback, and monitoring?

Substance abuse treatment organizations sometimes consider training in a new intervention to be the final objective. But the literature increasingly demonstrates that training staff is not enough. Learning a new skill or intervention requires practice and reinforcement. Implementation rates improve when staff members are given regular feedback and reinforcement (Andrzejewski, Kirby, Morral, & Iguchi, 2001).

Roadblocks. Anticipating difficulties can smooth implementation. By identifying factors related to organizational readiness to change, you have already begun anticipating roadblocks. Scrutinize the organizational factors that may impede progress. Think carefully through your goals and action items. Where are you most likely to encounter problems? They could be internal (staff resistance, lack of training) or external (legal, regulatory issues, confidentiality issues).

Substance abuse treatment centers are bound by requirements of external funding organizations or regulators that may inadvertently erect the following roadblocks:

- **Licensure.** Is specific training or licensure required to conduct the proposed intervention? If so, what additional training/certification is needed for the clinician and program?
- **Accreditation.** Does the proposed change have implications for your accreditation? For example, if you add a component that is likely to attract more clients, will your treatment center still meet required staff–client ratios?
- **Health, fire, or safety requirements.** Your health or safety inspector may require certain safety features. Do the changes have any effect on building regulations? For example, if you plan to offer child care, do you need additional safety measures or a special inspection?
- **Coding and verification requirements.** Funding sources may require that you record data in a certain way, using specified instruments. Coding and verification requirements can have implications for the types of treatment you provide and the credentials of the staff members who provide specific interventions. Consider whether the suggested changes have any implications for coding. Will you bill to new codes? Are there associated requirements? Are the people slated to perform the intervention (e.g., intake) properly credentialed to do so?
- **Confidentiality**. If you have an evaluation component, how will you collect information and follow up while meeting confidentiality requirements? If you are seeking to expand treatment to include families, what are the implications for client confidentiality? Adding new partners or changing relationships with existing ones can have implications for information sharing.

Funding requirements. The terms of your grant or award may include requirements that will affect the change plan. Familiarize yourself with the terms to ensure compliance.

Financial considerations. If you are considering adding new components, are there adequate resources? Will the interventions qualify for reimbursement, and if so, under what codes? Are there other possible funding sources or ways to share costs with community partners?

Personnel. How will you address internal resistance to change? McGovern and colleagues (2004) found that clinicians are much more likely to adopt EBPs if the relevance of the intervention is made clear to them. Therefore, include a plan to demonstrate the relevance of the proposed intervention or program and how it can improve client outcomes. Beyond that, ensure that clinicians have adequate time for training. Koch and colleagues (1998) examined the literature and identified several strategies to address staff resistance:

- **Recognize staff concerns.** Staff members have legitimate perspectives and fears. By valuing their expertise, you can reduce their resistance. Common fears and ways to allay them include
  - *Less time for treatment.* Paperwork and other implementation activities take time away from staff members' primary concern—helping people. Continually remind staff how the efforts will ultimately help them better serve their clients.
  - *Outcomes will be used against staff.* Some staff members may think that if their outcomes do not improve, the lack of improvement will be used against them in reviews. Emphasize that the evaluation outcomes will be used to constructively improve practices, not to identify poor performers.
  - *Violation of consumer confidentiality.* Involve staff in identifying safeguards to protect confidentiality.
  - *Lack of value.* Many staff members will have had experiences in which

they were required to take extra steps or change practices without being told the outcomes, either positive or negative. Results should be reported to staff promptly. Data collection efforts should be delayed until an accurate and timely system is in place to generate reports for staff.

- **Educate and discuss.** The change and how it will improve clients' lives must be clear to staff. Allow for open discussions of the proposed change. Consider staff feedback in planning and implementation.
- **Obtain management support.** Visible support from decisionmakers is crucial. Change efforts can easily fall by the wayside without management support.
- **Walk the walk.** If you are implementing new practices, you should demonstrate them. All members of the change team are mentors and should act accordingly.
- **Start small.** In some programs, it may be best to start with a pilot project or to pilot test before final implementation. These results can be used to inform the implementation plan.
- **Start with volunteers.** Volunteers should understand that the effort will require time away from other responsibilities.
- **Provide incentives.** Base performance on adherence to best practices. Offer bonuses or rewards for those who partake in the change plan or obtain desired outcomes.
- **Reduce burden on staff.** Wherever possible, choose the path that imposes the smallest burden on staff. In designing a new intake form, for example, you may be able to eliminate collecting information that will not be measured or is not otherwise required or useful. Remember the practical applications of what you implement, and seek staff members' expertise on how the changes are likely to affect them.

Risk Management in EBPs

Panzano and Roth (2006) evaluated the decisionmaking process of 78 projects involving decisions to adopt 1 of 4 evidence-based mental health practices. They found that the propensity to adopt a best practice depended not so much on the inherent risk-taking traits of the decisionmakers, but rather on the *perceived* risks of adopting the practice. Implementation was negatively related to the perceived risk, positively related to the expected capacity to manage risk, and positively related to an organization's past propensity to take risks.

- **Provide timely and useful feedback.** When evaluation results are available, share them with staff.
- **Use the results of evaluation to improve services or to show how services have improved.** Most staff members are motivated to help people. If a new intervention is working, share that. If it is not, explain where improvements are needed.
- **Monitor for signs of staff resistance.** Well-laid plans have gone awry because of staff resistance or sabotage, not always manifested in the form of open reluctance. There could be quiet refusal to perform new functions or follow new procedures. Do not assume that no news is good news. Monitor activities to ensure compliance; if it is lacking, find out why. Encourage dialog so that staff members can voice their concerns openly.

Lessons Learned

- **It's not just about the intervention.** Changing services and practices requires more than intervention-specific knowledge. Service providers may need to learn information management technologies, assessment tools, client tracking, and so forth.
- **It's not just about evidence.** Technologies are adopted into systems and organizations. Evidence of outcomes must be balanced with political and financial realities.

SOURCE: Phillips & Allred, 2006.

- **Solicit feedback at regular intervals.** Get feedback on the change plan. Be prepared to listen, reflect, and adjust the plan.

Cost. Cost can be prohibitive, especially for substance abuse treatment facilities operating at a deficit. As you work through your plan, identify ways to cut costs. Could you use volunteers for certain functions? Could you partner with other agencies, organizations, or research institutions? What are the potential benefits versus the costs? Could other components be cut to accommodate changes?

What Is Your Route? Mapping the Implementation Plan

You have already done a lot of the work. Formalizing the implementation plan is now a matter of assembling the pieces, establishing timelines, and identifying milestones.

Review the work you have done so far. You have prioritized expected outcomes, assessed your organization's readiness for change, identified change targets, and noted potential roadblocks. Now is the time to strategize:

- If your organizational self-assessment has identified issues that will negatively influence change, determine what can be done at each level to improve readiness for change.
- Identify ways to maximize the positive elements. For example, in staff meetings highlight new efficiencies that free staff members to take advantage of professional growth.
- For each change target, identify specific strategies to accomplish your goals and designate people charged with carrying them out. If, for example, you need to modify the mission statement to address the commitment to serving families, specify steps for drafting a mission statement and submitting it to the board for approval.
- Determine a timeline for change. Set measurable milestones, such as hiring a new intake staff member or completing training in a certain intervention. Be sure to build in components to measure success.
- Assign responsibilities for implementing the specific strategies. Identify people to oversee specific areas. Clearly state who will monitor progress.
- Establish a communication plan (e.g., weekly meetings, message board).
- If training is required, determine training format, schedule, and attendees. Specify expected outcomes for training and a plan to measure success. For example, suppose you decide to increase your staff members' proficiency with MI to improve client retention. You will want to measure the degree to which staff MI skills have increased with the training and any changes in client retention.
- Build in an evaluation component. What are your baseline measures? When, how, and by whom will data be collected? How will they be stored and analyzed?
- Make fidelity measures core to your plan. How will you measure the degree to which implemented practices match best practices? Who will monitor the practices? How and when will you determine whether modifications are required?
- Identify a plan to sustain newly implemented best practices.
- Make sure your action plan is multitiered and addresses multiple layers (e.g., administrative—time for oversight, reporting mechanisms for external stakeholders).
- Identify resources needed, including funding, personnel, administrative support, technology, and consultants (e.g., evaluators, trainers).

Now it's time to implement your plan!

Chapter 4—Implementation

Hypothetical Scenario

As the administrator for an intensive outpatient treatment facility, you recently launched a change initiative to include occupational training as a treatment component. You lined up supporters and formed a change team. The initial enthusiasm has waned somewhat, as your staff complains of the extra work involved and questions why the change was necessary in the first place. What can you do to motivate staff and address complaints before they grow into problems?

You have developed a plan, set action items, identified potential roadblocks, established timelines, and determined communication strategies. Members of your implementation team know their responsibilities, deadlines, and milestones. Now it is time to put the pieces in motion.

Are You There Yet? What To Expect Along the Way

Change is stressful, even in the best circumstances. For substance abuse treatment clinicians who deal with tense situations every day, the added stress of changes that affect their jobs can be detrimental. By offering staff members opportunities to engage in the change process, to join the dialog, and to offer their expertise, you stand not only to gain valuable insights, but also to minimize stress. In a study of the relationship between stress and change in substance abuse treatment and mental health agencies, Johnson and colleagues (2006) found that staff members' level of self-reported stress during change processes declined as their perceived control and input into the process increased.

As you install the change plan, it may seem awkward at first. Expect protests, confusion, and disharmony. This initial stage is temporary. As Fixsen and colleagues (2005) note,

> Compelling forces of fear of change, inertia, and investment in the status quo combine with the inherently difficult and complex work of implementing something new. And, all of this occurs at a time when the program is struggling to begin and when confidence in the decision to adopt the program is being tested. (p. 16)

Simple strategies can help along the way. Some are noted below.

Make realistic goals. Bars that are set too high can negatively affect morale and set up lose/lose situations. Make sure milestones are realistic. For example, instead of striving for an 80-percent completion rate of a newly implemented intake form, set the bar at 20 percent, then 40 percent, and so forth. Small successes motivate continued success.

Celebrate baby steps. Make accomplishments public. Send congratulatory e-mails. Make announcements at staff meetings. Invite staff for a celebratory cake. It may also be effective to provide case studies, highlighting the human aspect of the new practice or program. For example, tell the staff about a thank-you note from a patient who was helped by the new family counseling component you're implementing.

Strategies for an Effective Implementation

Relevant. The change must have obvious application. As you introduce your change plan, make sure you explain how the innovation fits with your mission and goals and clients' needs.

Timely. Make sure you explain why change is needed now.

Clear. Use plain language in explaining the change and the change process. Avoid using elaborate conceptual models or other visual aids that require a legend or advanced degree to understand.

Credible. Cite sources. Circulate Treatment Improvement Protocols (TIPs). Show evidence that the new practice or program works.

Multifaceted. Your change plan involves multiple systems and people. Allow for different styles, speeds, and ways of learning. Create multiple venues for learning, messages for different stakeholder groups, and communication formats.

Continuous. Change is a long-term process requiring continual reinforcement. Acknowledge accomplishments, however small. Make your message clear and consistent.

Bidirectional. Allow for regular communication between your implementation team and the people it affects.

SOURCE: Addiction Technology Transfer Center, 2004.

Keep your eye on the prize. Continually remind program staff and other stakeholders of why you are changing practices. Provide reminders of how the changes will improve lives. Stay in contact with all stakeholders and staff. Provide updates and reassurances. Create an open dialog. Allow staff members to voice concerns openly.

Evaluate and reevaluate. Measure your progress and make modifications as needed. Adhere to your data collection and analysis plan. Observe preliminary results, and modify practices as needed. Working out the bugs, streamlining new procedures, and making modifications to better your organization are typical of any change process.

Monitor progress. Hold people accountable for deadlines and milestones. Schedule regular meetings to assess progress and troubleshoot challenges. Do not assume that all is going according to plan or that no news is good news. Success often includes making modifications to the strategy until the criterion for success is met.

Stay faithful to fidelity. The point of change efforts is to replicate best practices as closely as possible. Clear, consistent guidance may avoid drifting from the program you want to implement.

Factor in personalities. Just as clients in substance abuse treatment do not respond equally to different treatment approaches, staff members are likely to need different kinds of interventions to convince them to change. Wyszewianski and Green (2000) outline four basic types of counselors and propose strategies for convincing them to change practices:

- **Seekers** are engaged in the field. They read journals, subscribe to listservs, and access electronic repositories of information. They readily adopt a new practice when research supports its use. Seekers are likely to embrace changes when they critically evaluate the evidence themselves. For this group, distributing original research findings, outcomes, or other data will likely convince them of the need for change.
- **Receptive clinicians** are likely to change practices when information comes from credible sources. Unlike seekers, they rely on expert opinions that are based on scientific findings. This group will use TIPs or other consensus documents. It may be important to remove obstacles to implementing new practices and procedures and offer continued support.

- **Traditionalists** rely mostly on authoritative sources for deciding to change practices. However, they focus less on evidence and more on experience, skill, and the authority of the people advocating change. Traditionalists are likely to accept recommendations from sources they consider clinically valid (e.g., people with clinical experience). To win traditionalists' support for the change plan, it is important to remove obstacles and offer supportive mechanisms. Traditionalists are likely to respond to rewards, penalties, and real-time reinforcement.
- **Pragmatists** want the bottom line. They are unlikely to be receptive to practices that disrupt treatment or otherwise interfere with treatment as usual. For pragmatists, removing obstacles and creating a smooth transition are crucial. They are likely to require strong incentives to change (e.g., performance review based on incorporation of change) and strong incentives to overcome barriers.

How Do You Navigate Roadblocks?

Change plans can fail at the implementation stage often because of unforeseen factors. Some factors may mean an end to the change plan. Funding may be cut, eliminating financial resources. Policies that mandated the change may be revoked. Other unforeseen events may require adjustments. Research may determine that a new treatment approach is more effective than the proposed approach. If a key staff member resigns, who can fill his or her role? If support from key stakeholders is withdrawn, what can be done to regain their support? This section highlights problems that sometimes occur during the change process and suggests possible solutions.

The organizational memory. As most administrators or managers know, one of the biggest challenges in changing course is past experiences with attempts to change. Veteran staff members may recall details of the disaster that befell the organization when person *X* attempted to change *Y*. Staff members who "remember when" are voicing legitimate fears. History can repeat itself, but it does not have to. Ask the staff members who recall previous events to share their insights. What went wrong the last time? What can be done differently? In a way this is much like doing relapse prevention with patients, encouraging them to learn from past efforts. Encourage a climate of active participation and shared decisionmaking.

Low participation/interest. Perhaps you are creating a new program and the interest or response is not what you expected. You have made family counseling available, but only a few clients have used it. Or perhaps staff members have not engaged in planned trainings. When participation is not what it should be, the first step is to figure out *why*. Are clients unaware of the services? Are counselors not offering them? Are sessions at inconvenient times?

Inadequate resources. A frequent challenge in implementing change plans is a lack of human and financial resources. If you have done your homework, you have already identified the necessary resources and found ways to make them available. But unforeseen circumstances occur. Perhaps you have underestimated the time needed for the implementation team to tend to the change process. You may need to adjust timelines to allow for a slower pace or supply rewards for the extra work required.

Role confusion. As you embark on new processes and programs, standard operating procedures are no longer standard. Routines are disrupted. The work no longer flows. As people struggle to find their way through the change, it is important to check in frequently. For example, perhaps you charged someone to administer a new assessment tool but failed to specify how the activity should be billed or who should enter the data in the system or how the results will affect

treatment planning. Regular meetings will identify and remedy planning oversights.

Resistance. A certain amount of resistance to change is to be expected. Change disrupts everyday life. It pushes people out of their comfort zones and requires them to adapt to practices, learn new skills, and live with uncertainty. Resistance can generally be confronted by encouraging open discussions of the change process and addressing concerns directly.

You're (Almost) There!

Full operation has occurred when the programs and practices are completely integrated, when the "changes" are now standard operating procedures, and when you have reached your goals. Once you have implemented your plan, you are almost there. The evaluation component (Chapter 5) will help you identify where your program is working and where it is not. Midcourse adjustments are likely to be necessary.

Chapter 5—Evaluation

Hypothetical Scenario

You are a clinical supervisor in a small inpatient treatment center for women. Recently, you applied for a grant that would enable children younger than age 10 to reside at the treatment facility with their mothers. Grant administrators have informed you that your award is contingent on establishing a plan to evaluate the evidence-based practices (EBPs) that you will use. At a minimum, your evaluation must demonstrate outcomes in abstinence at specified intervals. In addition, children must be evaluated based on predetermined developmental measures and psychosocial functioning. Data at 1 year posttreatment are required for at least 60 percent of participants.

It is common for funding and regulatory agencies to require substance abuse treatment providers to demonstrate results. Even without such an imperative, evaluation is key to any implementation effort. Without it, there is no way of knowing the effect of the changes or how closely you are following EBPs (fidelity). Evaluation is a built-in navigation system. It will alert you when you are off course and offer reassuring evidence when you are on target. It gives you "numbers to sell" to funding agencies, boards of directors, community partners, and skeptical staff members. Finally, evaluation results can provide the underpinning for sustainability (see Chapter 6).

This chapter is only a starting point for planning the evaluation. Excellent guides to program evaluation are available online. Appendix C provides a list of additional resources.

Before You Begin

Evaluations of new programs or practices serve two purposes: (1) to determine how closely your new programs and practices match best practices and (2) to measure the effect of the change on one or more elements of your program: clients, staff, processes, procedures, costs, or other factors. Most substance abuse treatment organizations operate on limited budgets, and defining a clear reason for the change is important to contain costs and focus resources on the most important factors. Your evaluation may be to measure:

- How closely the program or practice is being implemented as planned
- How closely the program or practice matches best practices or programs
- Whether you are meeting your objectives for change
- The degree to which outcomes compare with treatment as usual (TAU) (before implementation) and/or the outcomes of similar organizations (e.g., other inpatient programs for mothers with young children)
- The effect of the intervention on predetermined measures (e.g., client outcomes, abstinence)
- The costs of a program or practice
- The efficiency of the program or practice

- The effectiveness of specific implementation strategies (e.g., training, mentoring).

Other factors are likely to influence the purpose and scope of your evaluation. As noted in the hypothetical scenario at the beginning of this chapter, funding sources often require an evaluation component. Factors to consider in deciding the purpose of your evaluation are noted below:

- **Cost.** Determine how you will pay for the evaluation. Do you have funds set aside for evaluation? Will additional funds be available if needed? Is there a set-aside in current funding streams or grant opportunities for the evaluation component?
- **Existing information.** Identify ready sources of data. Tapping existing information may cut costs. Identify the data you routinely collect (e.g., admission and discharge interviews, family interviews), and consider whether existing forms and data entry or storage processes will be useful in the evaluation effort. Are there data in other reports you routinely submit (e.g., annual reports to a funding or accreditation body) that will be useful in your evaluation?
- **Funding, licensure, or accreditation requirements.** Funding, licensure, and accreditation agencies may dictate the parameters of the evaluation (e.g., the use of an outside evaluator, specific instruments at specified intervals). Be specific when noting requirements for data collection, analysis, and reporting.
- **Expertise.** Consider staff members' experience or expertise (e.g., statistical evaluation, information technology, focus groups, data collection, coding, analysis). Look to community partners, boards of directors, and your volunteer base for skills that may prove valuable.
- **Management information system (MIS).** Identify program data that are routinely collected by a statewide MIS or a managed care company-based MIS. This effort will ensure that data collection is not duplicated. It may be possible to develop or enhance a program-level MIS that supplies data required by third-party payers and governmental bodies to collect change-specific information. If your organization does not have the resources to develop a sophisticated system, you should be able to automate collecting at least a minimum amount of client information through commercially available software.
- **Resources.** Identify resources available for the evaluation. Do staff members with evaluation experience have time available? Are people available to perform quality checks and data collection? Do you have computer equipment that you can use to store data? Do you have statistical software packages?
- **Past experience.** Note whether your organization has conducted evaluations in the past. If so, were they successful? What were the lessons learned? What was the cost? Can components of past evaluations be used in the current evaluation? Can you use data from past evaluations for comparison?

Select the Evaluation Team

Deciding whom to include on the evaluation is a practical and strategic decision. At a practical level, you will want to include staff members with research and evaluation skills. You will also want staff members, clinical supervisors, and other personnel with an understanding of (1) how the program works, (2) the change you are implementing, (3) the types of information that will be useful, (4) the ways in which the evaluation can be easily integrated into the current program, and (5) how the results may be used for future program improvement.

Your choices should be strategic. By incorporating input from stakeholders, you enhance the credibility of the evaluation and make the process transparent. Taking the hypothetical

scenario at the beginning of this chapter as an example, you might consider consulting:

- The project officer or representative of the funding agency
- Representatives from the State child welfare department
- Counseling and supervisory staff members
- Experts in child welfare
- Former clients and their family members
- Members of the board of directors
- Community representatives
- Representatives from associations
- Representatives from school systems or daycare facilities
- Representatives from housing authorities
- Representatives from the court system
- Maternal/child health groups.

For most organizations, evaluation team members should be limited to those with a vital interest. Input from too many stakeholders may slow the evaluation by trying to address everyone's interest, but input from an appropriate few will build credibility where you need it most.

Identify the Evaluator

Whereas the evaluation itself will be a team effort involving many stakeholders and staff members, someone should oversee the effort. You may decide to hire an outside evaluator, such as an independent consultant, a research institute, a research university, or a nonprofit or professional research firm. You may ask other programs about their experiences with evaluators and the associated costs (Hosley, 2005). Even if you select an external evaluator, you may need in-house expertise for an ongoing evaluation.

Guidelines for a Successful Evaluation

Invest in planning. As precisely as possible, identify what you would like to discover, and use this information to guide your evaluation.

Integrate the evaluation into the program. Program managers often view evaluation as something "tacked on" to please funders or regulatory agencies. The evaluation should be integrated into the change plan from the very beginning, and the evaluation results should continually support the process.

Participate in the evaluation to show program staff that it is important. An evaluation needs the support and active participation of the program administrator. Even if an outside evaluator is hired to conduct the evaluation, the administrator should be a full partner in the evaluation process.

Involve as many program staff members as much as possible and as early as possible. Staff members will have questions and issues that the evaluation can address and can contribute their expertise to ensure that the evaluation questions, design, and methodology are appropriate for the program's participants. Early involvement of staff members will increase their willingness to participate in data collection and other evaluation-related tasks.

Be realistic about the burden on you and your staff. Evaluations take time and work. Even if your evaluation calls for an outside evaluator to do most of the data collection and analysis, it takes time for the evaluator to access records, administer questionnaires, or conduct interviews. Agencies and evaluators often underestimate how much additional effort this involves.

Be aware of the ethical and cultural issues. When you evaluate a program that provides services, always consider your responsibilities to the clients. Evaluation instruments and methods of data collection should be culturally sensitive.

SOURCE: Administration for Children and Families, 2003.

If you decide to hire an evaluator, keep your team involved to ensure that the evaluator understands the goals of your program and your evaluation. You must inform the evaluator of any requirements for data collection specified by funding sources and identify potential data sources.

For programs with in-house expertise, performing the evaluation without outside help may cut costs. Be wary, however, because the person charged with your evaluation should have relevant, recent expertise. A caveat: it could be a serious strategic mistake to use internal resources (or find the cheapest external evaluator) to minimize costs. That approach may leave an agency with a poorly executed, useless evaluation. Another option is to select a combination approach in which you hire an evaluator to create the design, verify data integrity, and perform statistical analysis while your staff collects and enters data. Exhibit 5-1 summarizes the pros and cons of each approach.

Hire an Evaluator

If you decide to hire an evaluator, your choice can make the difference between a solid evaluation that impresses funding agencies and a costly evaluation that calls your program into question. *The Program Manager's Guide to Evaluation* (Administration for Children and Families, 2003) provides six steps for selecting an evaluator.

Step 1. Draft a job description. This should list the services or products to be provided by the evaluator. It should describe the evaluation activities to be performed and the timelines for completing them.

Step 2. Identify sources for evaluators. Potential sources include the following:

- **Other organizations.** Other organizations may have experiences with evaluators. Ask them relevant questions. Was the work completed on time and on budget? Did the evaluator collaborate with staff? Did he or she produce a credible report? Did the evaluator attend staff and board meetings as needed?
- **Evaluation divisions of State or local agencies.** Some evaluation divisions offer their services at no cost.

Exhibit 5-1 Pros and Cons of Evaluation Approaches

Approach	Pros	Cons
External evaluators	• May see more clearly how the program functions, what can be improved, and barriers to change • Inspire faith in funders for outcomes identified by impartial third parties • Have technical expertise to design and conduct evaluation	• Generally are more expensive than internal or combined evaluation • May lead to conflicts if perceived negatively • May lack an understanding of the nuances of the program
Internal evaluators	• Generally are less expensive • Promote maximum involvement and participation of program staff and contribute to building staff expertise for future evaluation efforts • Allow for close monitoring and immediate adjustments	• Can be taxing on staff • May lack sufficient knowledge of evaluation design, data collection, and analysis • May not be viewed as objective by funders and others
Combinations	• Provide cost efficiency (may maximize the benefit while minimizing cost)	• Can be inefficient if communication and cooperation are not sound

SOURCE: Adapted from the Corporation for National and Community Service, n.d.

Sample Ad

Professional Evaluator Wanted

Seasoned evaluator sought for a residential substance abuse treatment program for women. The evaluator will:

- Develop an evaluation plan based on grant and program requirements
- Select standardized instruments (if available)
- Train project staff
- Design and administer surveys
- Design data collection instruments
- Develop a database
- Code, enter, and clean data
- Conduct interviews and focus groups
- Provide regular progress reports
- Attend project staff meetings and other administrative meetings
- Write an evaluation report
- Present findings at local and national meetings and conferences.

Candidates should have expertise in relevant qualitative and quantitative data analysis tools (e.g., SPSS). Familiarity with confidentiality regulations is required. Candidates must have expertise in culturally appropriate tools. Also required is experience with substance abuse treatment program evaluations and Federal grantee reporting requirements.

- **Local colleges and universities.** Specific departments or university-based research centers are possible sources.
- **Technical assistance providers.** Some Federal grant programs include a national or local technical assistance provider. If your agency is participating in this kind of grant program, help in identifying and selecting an evaluator is an appropriate technical assistance request.
- **Research institutes and consulting firms.** Many experienced evaluators are part of research institutes and consulting firms. They are sometimes listed in the Yellow Pages under "Research" or "Marketing Research." Your State human services department may have a list of firms that have bid on recent contracts for evaluations of State programs.
- **National advocacy groups and local foundations.** Some groups have the staff and resources to conduct (or help conduct) evaluations. Individuals from these groups usually have a substantive understanding of substance abuse treatment systems and a clear sense of the issues that will be important.
- **Professional associations**. Examples include the American Evaluation Association, American Sociological Association, and the Society for Research on Child Development.

Step 3. Advertise and solicit applications. Potential sources include the following:

- The local newspaper
- Job boards or newspapers of local colleges or universities
- Agency or association newsletters or Web sites
- Local and national meetings
- Professional journals
- Listservs.

Advertise as widely as your budget allows, using multiple advertising sources and allowing as much time as possible between posting the position and reviewing applications.

Step 4. Select an applicant. In reviewing applicants, you should include the following considerations:

- Experience conducting similar evaluations at comparable costs
- Familiarity with your funding or regulatory agency's reporting requirements (e.g., Government Performance and Results Act)
- Experience working with substance abuse treatment programs
- Experience evaluating programs that work with minority or other special populations
- The type of evaluation plan proposed
- The candidate's report-writing competence as demonstrated by samples of recent written evaluations.

After you have narrowed your selection to two or three candidates, you are ready to determine whether you and the evaluator are compatible. As you do with other job applicants, you must check references from other programs that worked with the candidate.

Step 5. Negotiate costs. It is common for an evaluator to propose a higher cost than you had planned. In this case, your choices are to look for a cheaper evaluator, identify other funding sources, or negotiate with the evaluator. In the last case, you may persuade the evaluator to donate a portion of the costs as in-kind services or to give you a prorated cost. Some universities can lower costs by engaging graduate students to conduct some evaluation activities under the direction of a professor. Alternatively, a researcher may be willing to contribute his or her services in exchange for data about participants and programs. If you choose this option, be sure to adhere to all State and Federal confidentiality requirements. (Go to the Substance Abuse and Mental Health Services Administration's Web site for information on 42 Code of Federal Regulations and Health Insurance Portability and Accountability Act requirements [http://www.hipaa.samhsa.gov].)

> Many program managers and staff believe that it is unethical to use program or agency financial resources for an evaluation, because available funds should be spent on serving participants. However, it is more accurate to view money spent on evaluation as an investment in your program and in your participants, rather than as a diversion of funds available for participants. Evaluation is essential if you want to know whether your program is benefiting participants.
> —*Administration for Children and Families, 2003*

Step 6. Create a contract. A contract spells out terms, prevents confusion, and protects your organization should your evaluator fail to live up to his or her responsibilities. Your contract should specify the following:

- **Ownership.** Specify that the agency owns and controls the data, and note the procedures required for releasing information to external sources.
- **Responsibilities for evaluation tasks.** Specify who is responsible for specific evaluation activities. Be sure that the individuals specified are qualified or will be sufficiently trained. For example, if you hire a firm to conduct the evaluation, specify the level of staff required for certain activities. Junior staff members should not design the evaluation, but they might conduct interviews or focus groups.
- **Expectations.** Spell out how your organization expects to be involved in the evaluation and, conversely, how the evaluators will be involved in your program. Specify whether the evaluators are expected to attend board or staff meetings. Indicate that you expect to be consulted on decisions about data collection instruments and who will perform specific evaluation tasks. Spell out the level of contact between the evaluator and the program.
- **Deadlines.** Make the timeline part of the contract. Specify milestones and deliverables.
- **Reports.** Document the reports you expect, when, and in what format. If

When Problems Arise

- **Original design is inadequate.** The evaluation may outgrow its plan. In some cases staff can pick up the work. If not, discuss add-ons to the existing contract. Sometimes, a new contract may be warranted.
- **Evaluator departs or terminates the contract.** You will likely need to hire a new evaluator.
- **Evaluator fails to meet contract obligations.** If attempts to negotiate a solution are unsuccessful, public agencies should turn the case over to their procurement office. Private agencies should seek legal counsel.
- **Evaluator lacks expertise in specific areas.** Focus groups or interviews with community members may ensure that evaluation questions and activities are appropriate for communities served.
- **You question findings.** If the evaluator's conclusions are not what you expected, consult with the evaluator to ensure that the instruments used were appropriate and implemented properly. However, remember that the point of an evaluation is to obtain objective measures. It may be simply that your program or practices are not working as expected. Obtain specific information. For what groups are the interventions working? For what groups are they not working?

there is a final report, be specific about the expected scope and content and the process for reviewing drafts.

- **Publications.** Prevent difficulties later by establishing the process for determining authorship for any publications based on evaluation results. Outline procedures (e.g., who will write, who will contribute, who must approve). Be sure to incorporate any grant requirements.

Estimating Cost

For most substance abuse treatment programs, cost is a primary concern. In *The Program Manager's Guide to Evaluation* (Administration for Children and Families, 2003), the authors equate evaluation to building a house:

> If you spend a small amount of money, you can build the foundation for the house. Additional money will be required to frame the house and still more money will be needed to put on the roof. To finish the inside of the house so that it is inhabitable will require even more money.

General guidelines for cost are as follows:

- **Minimal cost evaluations.** For little money, you can obtain basic data on the number of clients being served, services being provided, and demographic information about the people you serve. In some cases, you can acquire information on client satisfaction with services or staff's satisfaction with training. Generally, minimal spending will not show you how successful your implementation plan was in terms of fidelity measures or outcomes.
- **Moderate cost evaluations.** A modest increase in the evaluation budget will enable you to assess changes in client outcomes. Depending on resources or availability of control groups (including historical control groups), you can ascribe changes in outcome specifically to an intervention. You can collect indepth information about aspects of program intervention through interviews or focus groups.
- **Highest cost evaluations.** If you have sufficient resources, you can evaluate long-term outcomes—such as abstinence at 2 years or children's psychosocial functioning at 5 years after the treatment episode. The expenses are associated with tracking clients after they complete the program to get an adequate response rate (more than 75 percent) to make conclusions from followup data credible.

Despite the expense, long-term outcome information can reveal whether initial outcomes are maintained over time.

Although it is generally true that as you increase your budget you gain more information, indiscriminately collecting data can be a waste of resources. Carefully consider each piece of information you plan to collect. What does it tell you? Is this information helpful for your organization's mission? Decide what you need to know per funding requirements, accreditation, and so forth and what information is not essential now but may be useful in the future (e.g., information that might help with fundraising). Your plan will start with items that satisfy the first requirement and will add items to meet the second requirement as resources allow.

Strategies for Trimming Evaluation Costs

- Prioritize evaluation questions. Distinguish between essential and optional items.
- Search for inexpensive ways to gather information (e.g., as added items at points at which information is already gathered).
- Share costs with other agencies/organizations.
- Use staff or volunteers whenever possible.

SOURCE: Hosley, 2005.

Planning the Evaluation

Whether you are doing your evaluation with an internal or external evaluator, planning the evaluation is vital. Careful planning can prevent future problems, such as discovering that you have not collected data consistently or realizing that you missed an opportunity to collect important information. Every evaluation is unique to the particular program and system in which it operates. It is critical to collect only the data you need for the evaluation—such as how closely your program adheres to best practices (fidelity) or how best practices are improving client outcomes. The assessment burden (i.e., the number of instruments and questions you ask of participants) has a great influence on the cost of the evaluation and, perhaps more important, the willingness of participants to cooperate. Be parsimonious in data collection.

Step 1. Selecting the Type of Evaluation

There are two basic types of evaluations: process evaluations and outcome evaluations.

Process evaluations demonstrate how a program functions, how different parts relate to one another, and how well the pieces fit together. This information determines whether a program's overall functioning has improved as a result of the changes. Process evaluations can elucidate unquestioned practices, such as who makes decisions and how new staff members are trained. Types of process evaluations are explained below:

- **Fidelity evaluations** measure how closely the intervention or component matches EBPs. A fidelity evaluation of motivational interviewing (MI), for example, could include observation of counseling sessions. The observer could record how closely the clinician followed best practices.
- **Cost-benefit evaluations** provide information on the relative costs and benefits of a particular implementation. Cost-benefit analysis can include measures of overall costs (e.g., the administrative burden of a particular program or intervention), or it can provide information on costs saved by reducing recidivism through a deterrent program. The Drug Abuse Treatment Cost Analysis Program (DATCAP) is a collection instrument and interview guide for use in a variety of settings. DATCAP can be used for economic evaluations of addiction treatment through the sharing of proprietary instruments, working papers, and published research. Resources are available at http://www.DATCAP.com.
- **Program evaluations** are generally broader than outcome evaluations (see below) or fidelity evaluations. Program evaluations attempt to appraise the

whole program—how well does the program adhere to its mission? How well does it address the needs of consumers? Information for a program evaluation can be gleaned from other types of evaluation, such as outcomes evaluation or cost-benefit evaluation.

Outcome evaluations provide information on the effect the changes have on the individual, program, or community. This type of evaluation is tailored to specific factors identified for change (e.g., increase client retention). It provides information about the program's or intervention's success compared with TAU. Outcome evaluations measure short-term change (improved retention in treatment) or long-term change (decreased criminal activity).

Step 2. Deciding What To Measure and How To Measure It

A first step in your evaluation is to decide what, exactly, you want to measure. What are the goals of the evaluation? Are you interested in outcomes, such as retention rates and abstinence rates? Do you want to know how closely your program follows best practices? Evaluations can measure the following:

- Client satisfaction
- Outcomes of specific interventions
- Effectiveness of training in achieving desired outcomes (e.g., skill enhancement, staff retention, staff satisfaction)
- Degree to which the program or practice matches EBPs
- Program efficiency
- Costs of program or intervention.

For every piece of information, you should identify how you will measure outcomes. Exhibit 5-2 gives examples of measures for the program described in the hypothetical scenario at the beginning of the chapter. For most substance abuse treatment organizations, costs will be a primary concern. Data that are independent of patient self-reports increase the costs of the evaluation. Generally, self-report measures are acceptable as long as data are collected in the manner that ensures their reliability and validity (e.g., independent followup interviews).

Exhibit 5-2 Sample Evaluation Measures

Outcome	Measure	Inpatient (0–6 months)	Outpatient (7–12 months)
Abstinence	Substance-free urine sample	Random urine drug testing	Random urine drug testing
Housing	Stable housing defined as lease, ownership, or indefinite residence with family member/friend in drug-free accommodation	N/A	Followup visit Confirmation through lease, title, or letter from family/friend
Employment	3 months of employment for at least 30 hours per week	Self-reports at intake	Confirmation with employer or pay stubs Self-reports of days worked, type of work, and net income
Criminal justice involvement	Arrests with charges to new crimes Probation/parole violations	Criminal record at intake	Self-reports and court, probation, or parole officer reports
Child psychosocial functioning	Assessment at intake	Periodic assessments Staff, family, and teacher observations	Periodic assessments Staff, family, and teacher observations

Step 3. Setting the Baseline

Most types of evaluations require a baseline for comparison. Baseline measures provide a snapshot of conditions and outcomes of TAU. Data may be collected on a range of factors:

- Outcomes
  - Urine drug test results
  - Psychosocial functioning as measured from either self-reports or third-party reports (e.g., family members, probation officers)
  - Days abstinent
  - Retention rates
  - Psychosocial functioning (e.g., employment, satisfaction scales)
  - Recidivism (arrests, incarceration)
- Client demographics (e.g., gender, race, ethnicity)
- Numbers treated
- Duration of treatment
- Costs of treatment
- Referrals
- Number of counseling sessions
- Types of interventions
- Client–counselor ratios.

Your current data collection processes may not capture enough data to establish a baseline. For example, if the EBP measures abstinence at 90 days through random urine drug screens, you may not have comparable data. Perhaps you rely on self-reports. Or perhaps you do not track this information. To establish a baseline, you must implement random urine drug testing and record those results in a systematic, retrievable manner *before* you make changes to your treatment program. Otherwise, you will not know with certainty how well the changes are working. Exhibit 5-3 compares the advantages and disadvantages of different methods for collecting data.

Step 4. Selecting Data Collection Points

As you develop your evaluation plan, consider appropriate points at which to collect data. These points could be at intake and at specified times before and after intake. Data collection points are also time intervals after a specific event, such as a training episode or an employee evaluation. In some cases, funders may require that data be collected at specified points as illustrated in the hypothetical scenario at the start of the chapter. For example, you may be required to record outcomes at specified intervals. Or you may want to replicate the treatment guidelines for the new EBP you are implementing to better compare outcomes.

Step 5. Measuring Fidelity

Although best practices cannot always be replicated in the real world, measuring fidelity is vital to the evaluation. Without it, you have no way of knowing how closely you are following best practices or whether changes in outcomes are attributable to the new programs or practices or to other factors.

In a review of fidelity measures, Mowbray and colleagues (2003) provide an overview of fidelity criteria in mental health, education, and other human services and outline the steps involved in establishing fidelity criteria:

- **Identify key components of the intervention or program.** These elements, strategies, or processes define the best practice. For example, the best practice for a family-focused intervention might include 5 sessions of family therapy, at least 2 sessions of individual therapy for each family member, and 10 followup family sessions. Key components would be each type of session (family and individual), sessions during and after treatment, and the number of each.

Exhibit 5-3 Comparison of Data Collection Methods

Method	Advantages	Disadvantages	Examples
Questionnaires, surveys	Can be collected anonymously Are inexpensive Provide broad reach	Can bias client's responses Provide no followup May require sampling expert	Questionnaires on client/family/staff experiences Staff perceptions of needs/problems/attitudes Client satisfaction surveys Surveys of community partners and community perceptions of program
Interviews	Provide depth of information Can engage/educate clients/stakeholders	Are time consuming Are difficult to analyze Are costly Allow for interviewer bias Are questionable unless standardized, validated tools are used	Posttreatment interview Staff interviews to assess perceptions Interviews with partner groups
Documentation reviews	Provide comprehensive and historical information Can be conducted without interruption of processes Evaluate information available Can be unbiased	Are time consuming May record incomplete information Require clear parameters Can limit scope and quality of what has been recorded	Chart reviews Review of intake information
Observational studies	Provide real-time information Are flexible	Are difficult to interpret Can have observer bias May alter behaviors in presence of observer Can be expensive	Observational evaluation of counseling techniques
Focus groups	Allow for guided discussion Can be easy way to gather information/impressions Can quickly gather breadth of information	Are difficult to analyze Require experienced facilitator Are logistically challenging Allow for peer influence	Focus groups of patients Focus groups of stakeholders to identify perception/experience
Case studies	Are in depth Illustrate success/problems/limitations Support the power of personal narrative	Are time consuming Are subjective Offer few data for analysis	Case records

SOURCES: Centers for Disease Control and Prevention, 2005; McNamara, 2007; W. K. Kellogg Foundation, 1998.

> Don't worry about what type of evaluation you need or are doing—worry about what you need to know to make the program decisions you need to make, and worry about how you can accurately collect and understand that information.
>
> *—McNamara, 2007*

- **Define measurable indicators for each component.** In some cases, the indicator will be easy to define. A treatment session occurred or did not occur. In other cases, the indicator will not be so clear-cut. For specific techniques (e.g., MI), the indicators may not be obvious and may require subjective observation.
- **Collect the data measuring the indicators.** Data collection for fidelity measures might include the number of sessions a client attends or the amount of time spent in treatment sessions.
- **Examine the reliability and validity of the fidelity criteria.** To be worthwhile, fidelity measures should consistently and accurately measure indicators. Mowbray and colleagues (2003) identify common measures for assessing the validity and reliability of the fidelity criteria. For example, observations of a counselor's use of a particular technique might yield two very different interpretations, suggesting that the evaluation criteria need to be more objective (inter-test reliability).

Collecting Data

Your evaluation will be only as good as your data. Without clear, consistent data collection procedures and thorough quality checks, the evaluation will be useless. Questions to consider when deciding how data will be collected include the following:

- Who will collect the data? Are staff members responsible? If so, are they trained in data collection techniques? Do they have adequate time?
- Will data collection use validated, reliable tools (strongly recommended when available) or a tool of your own invention (making outcomes less comparable with the EBP)?
- How will you ensure that data are collected consistently and in formats that minimize errors?
- Will data be compiled from outside sources (e.g., the courts)? If so, are the data collection points compatible with measures collected internally (e.g., at the same intervals, using the same methods)?
- How will data be stored? Will backup systems ensure data are not lost? Is the system secure? Does it conform to confidentiality requirements?
- Who is responsible for quality assurance? Have you developed a system to verify that data are collected, recorded, and stored appropriately? How often will quality assurance checks be performed?

Analyzing Data

Data analysis is the examination of the information gathered. It can be as simple as calculating percentages based on answers to questions or as complex as identifying relationships between events or outcomes. There are two basic types of analysis:

- **Quantitative data analysis.** Gives measurements as percentages, significance, or probabilities. It assigns numbers to information, quantifying results. Quantitative data can be derived from surveys, demographics on client outcomes, or costs. Generally, performing quantitative data analysis requires a background in statistical analysis.
- **Qualitative data analysis.** Provides more contextual information and can be a valuable tool in explaining why elements work or do not. It can help you understand how closely your program follows EBPs. For example, if you have

adopted MI, results of observations and interviews could demonstrate where counselors are falling short. Qualitative data analysis can describe processes, highlight key relationships, and give the overall picture in which the program exists or the practices occur. Qualitative data can be derived from interviews, open-ended surveys, focus groups, or observations.

Regardless of type of data analysis, important considerations include the following:

- How will the data be analyzed (e.g., statistical method)?
- Who will analyze the data? Are they qualified to do so?
- What measures have you taken to minimize bias? For example, if you ask clinicians to rate their clients' functioning, are standardized criteria used by all clinicians?

Results that are not what you had hoped are not necessarily a sign of a failed implementation effort. They mean only that you may need to revise your strategy. Are you adhering to best practices? Are counselors consistent in how they deliver services? Are the parts of the plan working together? For areas that fall short, use your implementation team to identify problems and possible solutions. Perhaps trainings are insufficient or counselors need more feedback on their performance.

Reporting

Evaluation results should be shared openly and often and with consideration of the audience (W. K. Kellogg Foundation, 1998). Highlight positive effects, but make sure your results are presented in a credible way for your audience. For the implementation team, you should show how the evaluation results compare with the goals and implementation plan. Demonstrate where you are meeting targets and where you are falling behind. Communicate findings to all staff members, accentuating the positive effects and soliciting feedback on why results may not be what you had hoped. For funding and accreditation agencies, your results must include discussion of the methodology and limitations and the names of professional evaluators. Note any corrective actions taken as a result of the evaluation and processes you have implemented to ensure the validity of the results.

Ultimately, the evaluation will serve as a cornerstone to justify the changes to staff, funders, and stakeholders. If you have conducted a credible evaluation with demonstrated outcomes, you are well on your way to the next chapter—sustainability.

Chapter 6—Sustainability

Hypothetical Scenario 1

You have implemented your change plans, and the results are good. Client retention 6 months after implementation has improved 20 percent! You celebrate your success and congratulate staff, only to discover that staff members are unhappy with the changes. More clients are staying in treatment, and new admissions have not decreased. Overburdened by the increased client load, some staff members ask to return to the way things were before the changes. Your plan, although successful, also achieved unintended consequences. What to do now?

Change efforts—no matter how effective—are not likely to survive without a plan to sustain them. By carefully developing the implementation plan and evaluating new programs and practices, you are well on your way to implementing long-term change. However, full implementation—the point at which best practices or programs become "practice as usual"—can take as long as 2 to 4 years (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Even then, best practices are not self-maintaining. Changes in staffing, treatment priorities, reimbursement systems, and funding or accrediting requirements require an ongoing effort to ensure practices are in line with research.

Sustainability Phases

Sustainability can be understood as a long-term process involving three overlapping phases (Jerald, 2005):

- Maintenance—the immediate aftermath of the implementation
- Extension—survival after the change has proved successful
- Adaptation—long-term survival.

Jerald (2005) notes that, although these phases apply to discrete periods, the strategies to ensure sustainability should be instigated as soon as the change efforts begin. This chapter suggests ways to nurture the changes for each stage and suggests strategies for long-term financial survival.

Maintenance Phase

Change plans—however successful—often have unanticipated consequences. No amount of planning can foresee how changes in one area will affect other program components. Strategies for monitoring your progress and making necessary adjustments are noted below.

Provide reinforcement. The literature on organizational change consistently demonstrates the importance of consistent and clear reinforcement of the new practices (Dansereau & Dees, 2002; Fixsen et al., 2005; Silversin & Kornacki, 2003; Torrey et al., 2002). Reinforcement can come in many forms: continual reminders in staff meetings, evaluations that reward implementations, ongoing training and coaching, or supervisory oversight. Dansereau and Dees

(2002) evaluated training programs for implementing cognitive mapping. They found that the key to successful and sustained implementation is to focus less on the "rules" of the intervention and more on providing specialized feedback. They recommend practice sessions to help counselors integrate intellectual understanding with the actual performance of the intervention and ongoing coaching that provides one-on-one feedback. In practice, such reinforcement can be challenging to fit into an already-taxed work schedule. If these practice sessions are implemented, the schedules for the individuals involved should be reduced to accommodate the added burden.

Monitor fidelity. Over time, some practitioners retreat to old patterns and behaviors, making it important to continually monitor how closely the programs and practices follow best practices. In their review of the literature, Fixsen and colleagues (2005) found that positive outcomes are more likely to continue when fidelity is high. The distinction needs to be made, however, between "drift" and "reinvention" (sometimes referred to as innovation). Drift refers to the tendency to move away from best practices as time goes on. The pull of treatment as usual (TAU) may cause clinicians to return to familiar treatment approaches. Programs may retreat from the practices that have proved to be effective. Conversely, reinvention refers to positive adaptations that improve outcomes or that make evidence-based practices (EBPs) possible. For example, a substance abuse treatment agency may find that recommended daily counseling sessions are too costly to sustain but that comparable outcomes are acquired through sessions held three times a week.

Monitor outcomes. As the change effort unfolds, do not wait for the final evaluation to examine the results. Although the full benefit of the changes may take time, preliminary results can identify areas in need of change or attention.

Look out for unintended consequences. As noted in hypothetical scenario 1, change sometimes has unintended consequences. A new policy may have repercussions you had not considered. For example, you may have a new policy requiring drug testing, but you did not establish processes for collecting and processing samples. Or perhaps you have added a family component but find that staff members are overburdened with the emotional repercussions from their clients.

Monitor how change has affected revenues and expenses. Have you improved your outcomes slightly while increasing your costs significantly without a commensurate increase in revenues from your new or improved services? Keep your eye on the bottom line. New funding revenues may be needed, or you may need to scale back your program. (See Where's the Money? on page 49.)

Train new staff. Not all new staff will enter your program with the same understanding of best practices. Include training in best practices at orientation, and explain why you adhere to best practices.

Hypothetical Scenario 2

You are the director of a program that provides residential treatment for mothers and their children. Two years ago, you started a groundbreaking program that included treatment for co-occurring disorders with specialized attention to trauma, parenting classes, and other components tailored to the population you serve. The program was considered one of the best in the country—a model program that others sought to replicate. Staff is now familiar with the interventions and practices and executes them routinely. Surprisingly, however, the gains you made in years 1 and 2 hold steady in year 3 and drop dramatically in year 4. What happened?

As you explore the causes, you note that since your program first began, staff turnover has been high. New staff members have not been trained and coached on the interventions to the same degree. Moreover, since your program began, the number of clients abusing several drugs has increased and several clients have begun abusing methamphetamine. Funding cuts have forced you to reduce treatment to a maximum of 3 months. A community-based nonprofit that you had partnered with to help program graduates find jobs has closed. The only occupational services provided now are through the overtaxed county employment office. What to do now?

Extension Phase

Treatment Improvement Protocols (TIPs) describe best practices at a particular time. As new research becomes available, substance abuse patterns shift, client demographics change, funding streams expand and contract, and best practices can become outdated. Without specific, ongoing mechanisms to ensure long-term survival, today's EBPs may not be considered best practices in the future. To stay up to date, your program must implement mechanisms such as the following to ensure that program components remain current:

- Continue to monitor outcomes and other consequences of the implementation, and make adjustments as they are indicated.
- Be prepared to make changes. Reconvene your implementation team if major changes are indicated, and begin the planning process anew.
- Develop staff skills. Recruit staff with experience in the best practice or program. Continue to include best practices in new staff orientation, and provide ongoing training for all staff members. Initiate a mentoring program that allows less experienced staff members to benefit from seasoned counselors. Incorporate best practices into employee reviews, and provide rewards for adherence.
- Stay abreast of developments and research. As new TIPs are issued, review their recommendations. Be prepared to revise and update as research suggests improved practices.
- Keep your finger on the pulse of your client base. Identify changes in client demographics, and anticipate needs in the communities you serve.

Hypothetical Scenario 3

Once considered a model program, your organization now faces the possibility of closing its doors. Practices that worked well 10 years ago are not working as well now. Your clientele is getting younger; the number of female clients is increasing; and many clients abuse methamphetamine. TAU no longer works—potential clients are looking for programs that offer specialized programs, that treat co-occurring mental disorders, and that offer extended continuing care. What went wrong?

Adaptation Phase

The adaptation phase is more than the survival of the best practices; it is the long-term survival of the organization itself. Unless you have a clear sense of your organization's values, mission, and goals, your organization can easily flounder in the face of changes and challenges. This section suggests steps you can take to build an organization that thrives.

> Sustaining success over the long term requires a fierce, very intentional kind of "opportunism." That isn't just a platitude: The research on organizational change has confirmed again and again that the organizations most successful at sustaining improvement over long periods of time learn to enact new, "next generation" improvements even as they work to maintain practices that are already working.
>
> *—Jerald, 2005*

Create a vision. Sustaining change for the long run requires a clear vision of where your organization is headed beyond the implementation stage. Define your goals for the long term. Rewrite your mission statement to promote the use of EBPs. Understand the niche that your program fills. Consider gaps in current delivery systems, and develop ideas for how your program might position itself to bridge them.

Garner support. Publicize your implementation of best practices and improved outcomes in every source available to you (e.g., organization newsletter, Web site, local media, presentations at conferences, local/national associations, advocacy groups). Develop relationships with universities and other research institutions. Stay active in professional associations, and make your presence known to advocacy groups.

Encourage advocacy. Cultivate relationships with people who support your program and are in positions to speak for you. Torrey and colleagues (2002) suggest maintaining long-term involvement with clients and their families. These consumers often have a personal interest in ensuring that the best possible care is available. The authors also suggest that fostering relationships with advocacy organizations, universities, and professional organizations may provide valuable reinforcement to programs.

Stay adaptable. Programs that work now may be less effective in the future. Set up a system for periodic review of current practices and exploration of new programs and practices. Be prepared to change course as improved treatment options become available.

Monitor trends. Stay abreast of trends in the field. Subscribe to journals, attend conferences, and encourage staff members to stay current in their field. Be familiar with trends in your community, and be prepared to address changing demographics of abuse.

Hypothetical Scenario 4

You have completed an evaluation of a program to integrate treatment for co-occurring mental disorders into your long-term outpatient substance abuse treatment program. The results are positive. At 1 year, clients show higher rates of employment, improved psychosocial functioning, higher abstinence rates, and fewer arrests compared with TAU. Despite the promising outcomes, the grant that funds the additional components runs out in 6 months, and you cannot reapply. If funding sources are not identified, you will be forced to dismantle services. What to do now?

Where's the Money?

The best-laid plans require money. Even with a thoughtful vision, precise change plans, and a commitment to organizational change, your best thinking is not likely to take you far without a plan for sustained financial support.

Long-range financial planning is an imprecise exercise. Funding sources can be unpredictable, changing frequently. The same logic that applies to effective personal financial planning applies here. Diversify funding sources. Overreliance on one funding stream can be disastrous when the funding ends.

Perhaps the new or improved service can be self-sustaining through increased revenue (e.g., an increased fee for the service or additional patients attracted because of the change). Positive outcomes achieved under one funding stream can be used to acquire additional funding. By providing services with proven effectiveness, you will be better positioned to compete for other funding sources.

Draft a detailed account of all elements of the new program or practice and the resources (personnel, equipment, space, etc.) needed to sustain all aspects of your program, including ongoing evaluation. Include in your equation

Cost-Cutting Strategies

- **Solicit in-kind support.** Solicit nonmonetary contributions for goods and services you would otherwise purchase (e.g., donations of computer equipment, plumbing services from local businesses).
- **Share resources/staff.** Consider sharing resources with other organizations in your community (e.g., staff, vehicles, computer equipment, combined trainings).
- **Hand the services off to another organization or agency.** Keep program components running by allowing another organization to assume responsibility for them.
- **Tap into personnel resources that are shared or in training.** Recruit people in other organizations who can be shared at low or no cost (e.g., clerical staff). Take advantage of volunteers, internships, and college work-study programs.
- **Develop a fee-for-service structure.** Consider requiring clients to pay for services. Sliding-fee scales impose minimal burdens on those with limited resources while providing a steady (if limited) financial stream.
- **Budget efficiently.** Examine your current budget. Are funds used efficiently? Do they fit with your organization's priorities? Are there programs or services that do not demonstrate good outcomes? Is there duplication in services?

SOURCE: Robert Wood Johnson Foundation, n.d.

Exhibit 6-1 Sample Budget Forecast

Expenditures	Year 1	Year 2	Year 3	Year 4	Year 5
Computer equipment	$2,500	$500	$500	$500	$1,200
Space/insurance	$12,000	$12,500	$13,000	$13,500	$14,000
Vehicles	$12,000	$1,000	$1,000	$1,000	$1,000
Staff	$289,000	$312,000	$325,000	$350,000	$375,000
Training	$10,000	$8,000	$5,000	$5,000	$5,000
Evaluator	$12,000	$6,000	$6,000	$6,000	$6,000
Total costs	**$337,500**	**$340,000**	**$350,500**	**$376,000**	**$402,200**

Income	Year 1	Year 2	Year 3	Year 4	Year 5
Federal funds	$250,000	$250,000	$250,000	0	0
State grant funds	$50,000	$50,000	$50,000	$50,000	$50,000
Potential matching funds	$125,000	$125,000	$125,000	0	0
Fees for service	$40,000	$40,000	$40,000	$40,000	$40,000
Total funds	**$465,000**	**$465,000**	**$465,000**	**$90,000**	**$90,000**
Surplus/Deficit	***+$127,500***	***+$125,000***	***+$114,500***	***-$286,000***	***-$312,200***

the costs of monitoring, mentoring, and training. Consider your overall budget, your projected revenues, and the total expected expenditures (see Exhibit 6-1).

Think creatively when considering possible financial resources. Funding can come from traditional sources (grants, Federal support), as well as from unexpected places (third parties, planned giving arrangements). Venues for financial inflow are noted below:

- Federal grants
- State legislature appropriations or grants
- City council/government appropriations or grants
- County appropriations or grants
- Client fees
- Third-party funding (organizations or businesses with a track record of supporting substance abuse treatment or with a vested interest in treatment)
- Fundraisers
- Endowments or planned giving.

Appendix A—Bibliography

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Appendix B—Implementation Theory Resources

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Appendix C—Evaluation Resources

American Evaluation Association
http://www.eval.org

Centers for Disease Control and Prevention
http://www.cdc.gov/eval

Community Tool Box, University of Kansas
http://ctb.ku.edu

Georgetown University Center for Child and Human Development
http://gucchd.georgetown.edu

Harvard Family Research Project
http://www.gse.harvard.edu/hfrp

Innovation Network
http://innonet.org

Network for the Improvement of Addiction Treatment
https://www.niatx.net/Home/Home.aspx?CategorySelected=HOME

Robert Wood Johnson Foundation Community Toolbox
http://www.rwjf.org/grantees/howtotools/communitytoolbox.jsp

Sierra Health Foundation
http://www.sierrahealth.org

University of Wisconsin Cooperative Extension

- Evaluation Resources
  http://www.uwex.edu/ces/pdande
- Logic Model Course
  http://www1.uwex.edu/ces/lmcourse

W. K. Kellogg Foundation
http://www.wkkf.org

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Appendix E—Acknowledgments

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Other Technical Assistance Publications (TAPs) include:

TAP 1 *Approaches in the Treatment of Adolescents with Emotional and Substance Abuse Problems* **PHD580**
TAP 2 *Medicaid Financing for Mental Health and Substance Abuse Services for Children and Adolescents* **PHD581**
TAP 3 *Need, Demand, and Problem Assessment for Substance Abuse Services* **PHD582**
TAP 4 *Coordination of Alcohol, Drug Abuse, and Mental Health Services* **PHD583**
TAP 5 *Self-Run, Self-Supported Houses for More Effective Recovery from Alcohol and Drug Addiction* **PHD584**
TAP 6 *Empowering Families, Helping Adolescents: Family-Centered Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems* **BKD81**
TAP 7 *Treatment of Opiate Addiction With Methadone: A Counselor Manual* **BKD151**
TAP 8 *Relapse Prevention and the Substance-Abusing Criminal Offender* **BKD121**
TAP 9 *Funding Resource Guide for Substance Abuse Programs* **BKD152**
TAP 10 *Rural Issues in Alcohol and Other Drug Abuse Treatment* **PHD662**
TAP 11 *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* **PHD663**
TAP 12 *Approval and Monitoring of Narcotic Treatment Programs: A Guide on the Roles of Federal and State Agencies* **PHD666**
TAP 13 *Confidentiality of Patient Records for Alcohol and Other Drug Treatment* **BKD156**
TAP 14 *Siting Drug and Alcohol Treatment Programs: Legal Challenges to the NIMBY Syndrome* **BKD175**
TAP 15 *Forecasting the Cost of Chemical Dependency Treatment Under Managed Care: The Washington State Study* **BKD176**
TAP 16 *Purchasing Managed Care Services for Alcohol and Other Drug Abuse Treatment: Essential Elements and Policy Issues* **BKD167**
TAP 17 *Treating Alcohol and Other Drug Abusers in Rural and Frontier Areas* **BKD174**
TAP 18 *Checklist for Monitoring Alcohol and Other Drug Confidentiality Compliance* **PHD722**
TAP 19 *Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders* **PHD723**
TAP 20 *Bringing Excellence to Substance Abuse Services in Rural and Frontier America* **BKD220**
TAP 21 *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* **(SMA) 08-4171**
TAP 21-A *Competencies for Substance Abuse Treatment Clinical Supervisors* **(SMA) 08-4243**
TAP 22 *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* **BKD252**
TAP 23 *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices* **(SMA) 08-3929**
TAP 24 *Welfare Reform and Substance Abuse Treatment Confidentiality: General Guidance for Reconciling Need to Know and Privacy* **BKD336**
TAP 25 *The Impact of Substance Abuse Treatment on Employment Outcomes Among AFDC Clients in Washington State* **BKD367**
TAP 26 *Identifying Substance Abuse Among TANF-Eligible Families* **BKD410**
TAP 27 *Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services With Child Welfare* **BKD436**
TAP 28 *The National Rural Alcohol and Drug Abuse Network Awards for Excellence 2004, Submitted and Award-Winning Papers* **BKD552**
TAP 29 *Integrating State Administrative Records To Manage Substance Abuse Treatment System Performance* **(SMA) 09-4268**
TAP 30 *Buprenorphine: A Guide for Nurses* **(SMA) 09-4376** (available mid-2009)
TAP 31 *Implementing Change in Substance Abuse Treatment Programs* **(SMA) 09-4377**

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