IMPLEMENTATION TOOLKIT

For guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

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Suggested reference

Acknowledgements

Conflicts of interest

Contents

Glossary

The following terms are used throughout this document and are defined here for ease of reference.

Alcohol and/or other drug (AOD) use disorders	The presence of an AOD use disorder as defined by the DSM-5, including the use of alcohol; benzodiazepines; cannabis; methamphetamines, cocaine, and other stimulants; hallucinogens; heroin and other opioids; inhalants, and tobacco.
AOD organisational leaders	People responsible for overseeing the delivery of care or services within an AOD treatment setting.
AOD treatment settings	Specialised care or services that are specifically designed for the treatment of problematic AOD use and include, but are not limited to, facilities providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies (e.g., methadone, buprenorphine or buprenorphine/naloxone for opiate dependence), and outpatient counselling services. These services may be in the government, non-government or private sector.
AOD workers	All those who work in AOD treatment settings in a clinical capacity. This includes, but is not limited to, nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, peer workers and other AOD workers.
Co-occurring conditions	The co-occurrence of one or more AOD use disorders with one or more mental health conditions.
Evidence-based practice	An approach to healthcare decision making that involves integrating the best available research evidence with clinical expertise, client preferences and values, and characteristics of the treatment setting.
Evidence-to-practice gap	The difference between what research evidence recommends and what is routinely applied in care delivery across treatment settings as part of usual, day-to-day care.
The Guidelines	The *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (3rd edition)*.
Guidelines recommendations	A collection of evidence-based practices recommended in the Guidelines for the identification, management and treatment of co-occurring conditions in AOD treatment settings.
Implementation indicator	Measures used to determine the degree to which evidence-based practices are routinely applied in care delivery across treatment settings.

Implementation project	A time-limited activity undertaken by organisations that aims to increase the uptake of evidence-based practice by completing a series of implementation steps, including: i) implementation planning; ii) identifying current evidence-to-practice gaps; ii) identifying barriers to implementation; iii) choosing implementation strategies and tools and iv) implementing and evaluating change.
Implementation status	The degree to which evidence-based practices are routinely applied in care delivery across treatment settings.
Implementation strategy	A method or technique used by AOD organisations to increase the uptake of evidence-based practices.
Implementation tool	A specific instrument designed to help individual AOD staff complete a specific task.
Implementation toolkit	A compilation of guidance, strategies or tools that are flexible, adaptable, and action-oriented, designed to help organisations translate research evidence into clinical practice within their treatment setting.
Implementation work plan	A detailed timeline of deliverables needed to achieve the aims of an implementation project.
Mental health conditions	Refers to those with a diagnosable mental disorder as well as those who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder.
Mental disorders	Refers to the presence of a mental disorder (other than AOD use disorders) as defined by the DSM-5.

About the Guidelines Implementation Toolkit

What is an implementation toolkit?

Implementation toolkits are a compilation of guidance, strategies or tools that are flexible, adaptable, and action-oriented, designed to help organisations translate research evidence into clinical practice[2]. Implementation toolkits can assist organisations to better understand the unique 'black box' of <u>how</u> to implement research evidence into practice in their treatment setting (**Figure 1**)[3].

Figure 1. The 'black box' of implementing research into practice

What are the existing evidence-to-practice gaps?
What are the barriers to implementation?
How should change be implemented?

Research evidence → The 'black box' of implementation → Evidence based practice
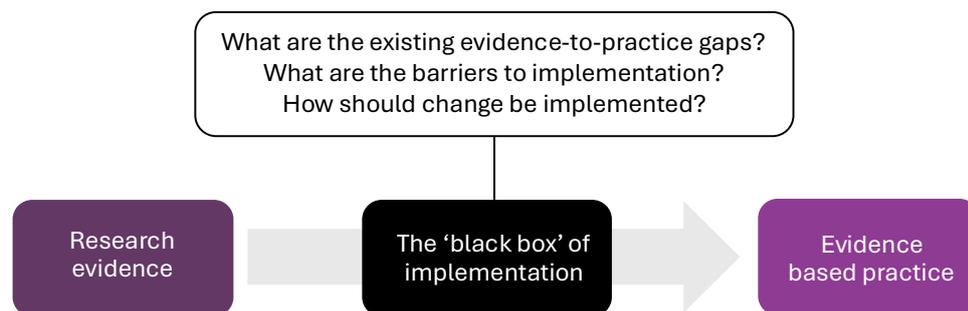
Toolkit aims

It is estimated that close to one-in-two clients of alcohol and other drug (AOD) treatment settings meet criteria for at least one co-occurring mental disorder[4]. Funded by the Australian Government Department of Health and Aged Care and published in 2022, the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (3rd edition)* ('the Guidelines', **Figure 2**) aim to build the capacity of the Australian AOD workforce to identify, manage and treat these commonly co-occurring conditions. This implementation toolkit ('the Toolkit') aims to support AOD organisational leaders translate the Guidelines into practice. By organisational leaders, we mean people responsible for overseeing the delivery of care or services within an AOD treatment setting. More specifically, the Toolkit aims to assist organisational leaders to identify and address the following:

Figure 2. The Guidelines on co-occurring conditions

1. evidence-to-practice gaps in relation to Guidelines recommendations;

2. barriers to the implementation of Guidelines recommendations;

3. implementation strategies and tools to address identified barriers; and

4. processes for implementing and evaluating change.

As this Toolkit has been designed to accompany the Guidelines, it is assumed that those who use this Toolkit will be familiar with their contents.

Who is the Toolkit designed for?

The Toolkit has been developed for people working within AOD treatment settings who have the capacity to influence change, such as organisational leaders, service managers, clinic directors, quality assurance and improvement officers. For guidance and training on how to implement Guidelines recommendations as part of AOD workers' individual practice, please visit the Comorbidity Guidelines website (comorbidityguidelines.org.au).

Toolkit development process

This Toolkit was developed by researchers at the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney, in consultation with AOD organisational leaders and workers, people with lived experience of receiving care for AOD use, and their loved ones. The development of this Toolkit was informed by the best available evidence and best-practice guidance on the development of implementation toolkits[11, 12], and involved:

i)   a systematic review of the contents and effectiveness of existing toolkits[1];

ii)   an implementation needs assessment with multiple stakeholder groups, including AOD organisational leaders and workers, people with lived experience of receiving care for AOD use, and their loved ones; and

iii)   usability testing and refinement of the draft toolkit.

Further information on the development of the Toolkit is available from the Matilda Centre.

How to use this Toolkit

This Toolkit guides organisational leaders through a **five-step implementation process** for putting Guidelines recommendations into practice. **Steps 1-4** inform the development and evaluation of an implementation work plan described in **Step 5**. Each step is accompanied by: i) guidance on how to complete the step; ii) an example of the step being completed in practice; and iii) implementation tools. This Toolkit, like others, is designed to be flexible and adaptable to individual AOD treatment settings. As such, the steps outlined in this Toolkit do not need to be carried out in a rigid or prescriptive way, and use of the accompanying Tools is optional. Rather, organisational leaders can use their experience, judgement and expertise to apply the Toolkit within their local context.

There are two broad implementation approaches for using the Toolkit (**Figure 3**). The **step-by-step** approach involves working through each step of the Toolkit from start to finish. This approach may be suitable for organisational leaders seeking step-by-step guidance on how to develop an implementation project for Guidelines recommendations. The **pick-n-mix** approach involves using specific guidance or tools from the Toolkit based on the needs of your organisation. This approach may be suitable for organisational leaders seeking guidance or tools to assist with an existing internal implementation or quality improvement project.

Figure 3. Approaches to using Toolkit

Step-by-step approach

Work through each step of the Toolkit from start to finish.

1	Implementation planning
2	Identify current evidence-to-practice gaps
3	Identify barriers to implementation
4	Choose implementation strategies and tools
5	Implement and evaluate change

Pick-n-mix approach

Use specific guidance or tools from the Toolkit based on the needs of your organisation.

Step 1. Implementation planning

1.1 Familiarise yourself with the Guidelines

Before starting the implementation process, it is expected that organisational leaders would be familiar with the Guidelines and its accompanying resources. A **quick guide** is available as a primer or refresher resource.

In a nutshell, the Guidelines aim to provide AOD workers with evidence-based information and resources to assist with the identification, management and treatment of co-occurring AOD and mental health conditions.

Evidence-based practice is an approach to healthcare decision making which aims to integrate the best available research evidence (e.g., the Guidelines) with clinical expertise, client preferences and values, and characteristics of the AOD treatment setting (**Figure 4**)[5].

In AOD treatment settings, the Guidelines outline 17 evidence-based recommendations for implementation across four service delivery areas. These include: i) intake and assessment; ii) treatment planning; iii) approaches to care; and iv) exit planning (**Figure 5**). These 17 recommendations have not been listed specifically in the Guidelines, rather they are woven throughout.

When an organisation has implemented Guidelines recommendations, it means that recommendations are **routinely applied in care delivery across treatment settings.** As such, clients can expect to experience these practices as part of their usual, day-to-day care.

Figure 4. Evidence-based practice
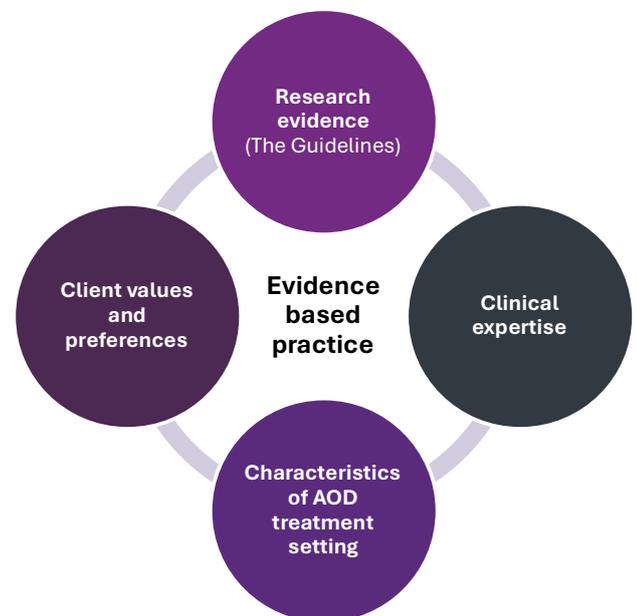
Figure 5. Guidelines recommendations

Intake and assessment

1 Include clients with co-occurring mental health conditions

2 Screen and assess for co-occurring mental health conditions

3 Screen and assess for risk (suicide, self-harm, domestic and family violence)

Treatment planning

4 Work collaboratively with clients to plan treatment

5 Take co-occurring mental health conditions into account when planning treatment

6 Use a holistic health care approach

7 Tailor approaches to care for specific population groups

8 Use a coordinated care approach

9 Involve peers in treatment or service delivery

10 Involve loved ones or carers in treatment or service delivery

Reassess and monitor response to treatment

Approaches to care

11 Use a trauma-informed care approach

12 Engage clients in treatment by building a strong therapeutic relationship

13 Take a non-judgemental approach to treatment

14 Take a non-confrontational approach to treatment

15 Feel confident that treatment will be beneficial for clients

16 Have realistic expectations for treatment

Exit planning

17 Ensure continuity of care

| Implementation planning | Identify current gaps | Identify barriers to implementation | Choose implementation strategies | Implement and evaluate change |

1.2 Choose which recommendations to implement

AOD treatment settings may have already implemented at least some of the Guidelines recommendations across different areas of service delivery[1].

While some AOD organisations may choose to include *all* Guidelines recommendations as part of a long-term implementation project, others may want to prioritise *specific* recommendations as part of a short-term project. There are many reasons for prioritising the implementation of specific Guidelines recommendations, including:

- organisational leaders, workers or clients perceive that specific recommendations are not routinely implemented, and that implementing these recommendations will improve the quality of care and client outcomes;

- internal quality improvement or accreditation processes have identified that specific recommendations are not routinely implemented; or

- external groups or requirements (e.g., funders, regulators or service standards) have identified that some or all recommendations are a priority to implement.

When choosing which Guidelines recommendations to implement, consider[6, 7]:

- What evidence do you have that the recommendations are not currently implemented in your treatment setting (e.g., do intake policies or client files show that screening for mental health conditions is not routine)?

- Are the recommendations considered a priority for your organisation (as identified by organisational leaders, workers and clients)?

- Do you have the support, resources and decision-making authority to implement the recommendations (Who will be involved? What resources will you need?)

- Are there any current or future organisational changes that could impact the successful implementation of these recommendations (systems, funding, reporting or staffing)?

1.3 Implementation project planning

Once you have selected the Guidelines recommendations you want to implement, the next steps are to[6, 7]:

1. choose your team;

2. define the aims and scope for your project; and

3. consider your timeline.

Choose your team

If you are implementing multiple recommendations across several treatment settings or programs, consider choosing different team leaders with appropriate expertise who oversee the delivery of care across each of these treatment settings or programs. Ideally, the aim and scope of your project should be developed in consultation with your team.

Define aims and set scope

Aims are the overall goals of the project.

Scope involves specifying which areas of service delivery fall within or outside the project (e.g., whether only specific treatment settings or programs will be included).

It is worth noting that your aims and scope may change slightly based on what you discover in **Steps 2-4** (identifying evidence-to-practice gaps, identifying barriers and choosing implementation strategies) and in developing your work plan as part of **Step 5**.
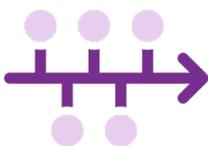
Consider project timeline

It is also important to consider how the number of Guidelines recommendations you choose to focus on will influence your project timeline. **Figure 6** shows example timelines for a small and large project. While timelines in each AOD treatment setting will vary depending on available resources, it is worth considering how feasible your aims and scope are by estimating your timeline during the implementation planning stage.

Figure 6. Choosing Guidelines recommendations: example project timeline

Small implementation project (6 months total)

Implementing one Guidelines recommendation

2 weeks	2 weeks	1 month	1 month	3 months
Implementation planning	Identify current gaps	Identify barriers to implementation	Choose implementation strategies	Implement and evaluate change
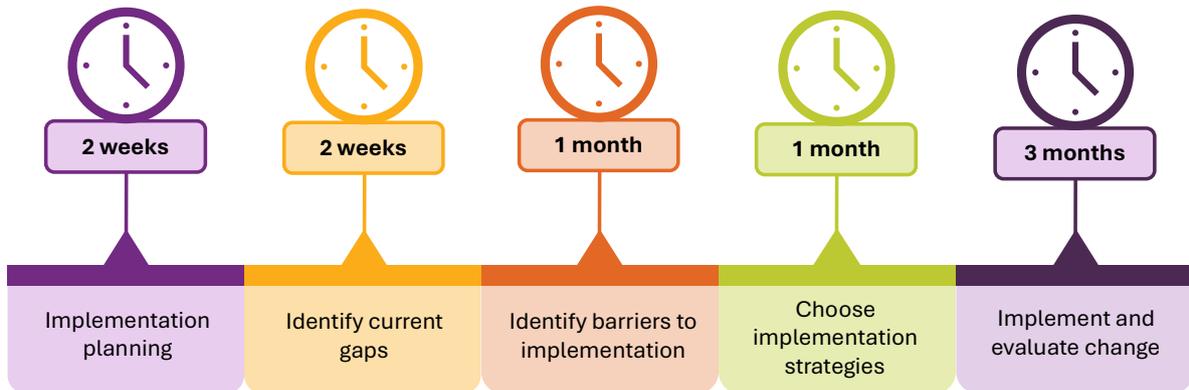
Large implementation project (2 years total)

Implementing most or all Guidelines recommendations

1 month	2 months	2 months	2 months	1.5 years
Implementation planning	Identify current gaps	Identify barriers to implementation	Choose implementation strategies	Implement and evaluate change
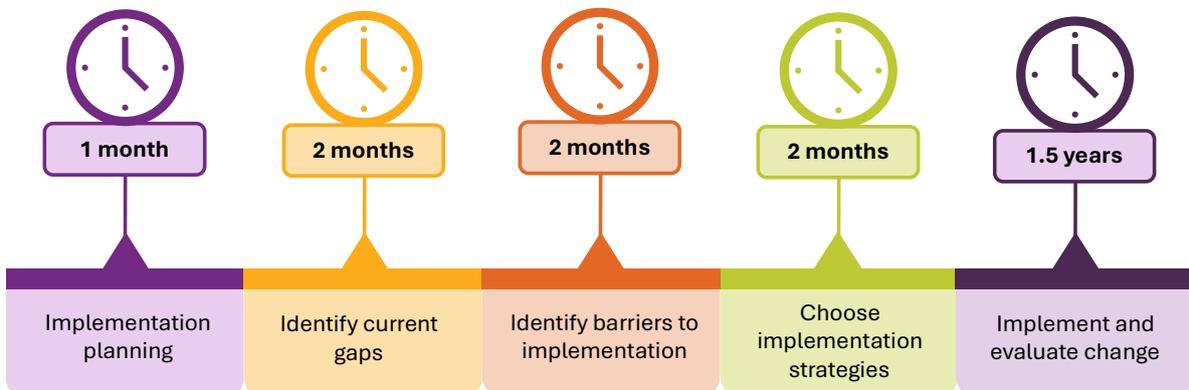
1.4 Implementation planning: Example

Table 1 provides an example of implementation planning for a small project. In this project, the team have chosen to implement Guidelines recommendation #17 (*Ensure continuity of care*). **Table 1** is available as a template as part of our **work plan tool.**

Table 1. Example of implementation planning in practice

Guidelines recommendations to implement	Implementation team	Aims and scope
Ensure continuity of care	**Project manager:** Service manager **Project leads:** • Counselling team leader • Nursing unit manager	**Aim:** Increase organisational capacity for ensuring continuity of care **Scope:** In scope: • Residential rehabilitation program • Clinical staff Out of scope: • Community-based programs • Administrative staff • Cleaning and other service maintenance staff

1.5 Implementation planning: Tools

Implementing the Guidelines on co-occurring conditions: Quick guide

Familiarise yourself with the Guidelines, accompanying resources and the implementation process with our **three-page quick guide**. The quick guide may also be helpful to share with service staff when socialising the idea of undertaking an implementation project.

Step 2. Identify current evidence-to-practice gaps

What is an evidence-to-practice gap?

In most AOD treatment settings, the degree to which Guidelines recommendations are routinely applied exists along a continuum from rarely, to routinely occurring in practice[1]. Implementation status refers to the degree to which Guidelines recommendations *routinely* occur within this continuum. When recommendations are not implemented or variably implemented, there is an evidence-to-practice gap (**Figure 7**).

Figure 7. The implementation status continuum

How can AOD organisations identify evidence-to-practice gaps?

Determining the implementation status and gaps within an AOD treatment setting will depend on which Guidelines recommendations are being implemented.

> **For each Guidelines recommendation, consider[8-10]:**
>
> - Recommendation: Which Guidelines recommendation are you implementing?
>
> - Implementation indicators: What will show you that the recommendation is being implemented in practice?
>
> - Methods: How will you look for implementation indicators?
>
> - Where are the gaps? Where within care or service delivery are the gaps (areas for improvement)? Where is the recommendation being done well (areas to maintain)?
>
> - Implementation status: Overall, would you say the recommendation is not implemented, variably implemented, or implemented?

2.1 Choose implementation indicators

Implementation indicators are measures that can be used to determine the implementation status of Guidelines recommendations across three key levels within an AOD organisation[8, 9].

Structural indicators determine whether organisational processes or resources are in place to support the delivery of Guidelines recommendations (e.g., whether there is an organisational process for exit planning throughout care).

Process indicators determine whether Guidelines recommendations are happening routinely as part of day-to-day care (e.g., the degree to which staff and clients perceive that exit planning is incorporated into care).

Outcome indicators determine the impact Guidelines recommendations have on clinical outcomes (e.g., treatment completion rates, clients engaging with external services as part of exit planning).

There are numerous implementation indicators for the 17 Guidelines recommendations, and most AOD treatment settings will already routinely capture some indicators as part of quality improvement, reporting or accreditation. Depending on how many Guidelines recommendations are being implemented and which indicators are already being captured, it is at the discretion of organisational leaders and their team which indicators are most suitable to determine implementation status. See **Table 2** for examples of indicators for the Guidelines recommendation #17 (*Ensure continuity of care*).

2.2 Choose how to look for implementation indicators

At this stage, the method chosen to identify implementation indicators is also important to ensure that the data collected will be valid and reliable. Methods of identifying indicators can be talk-based (e.g., interviews or roundtable discussions), text-based (e.g., surveys, client file audits) or a combination of both (e.g., an organisational audit). The method chosen by the implementation team will depend on: i) the support and resources available within the AOD treatment setting (e.g., time, funding, availability of AOD workers and clients); ii) the suitability of the method (e.g., talk-based methods may be preferred by some clients), and iii) the type of data the implementation team will be collecting. See **Table 2** for examples of methods of looking for indicators.

When choosing implementation indicators and methods, consider:

- **If you are implementing multiple Guidelines recommendations**, indicators are likely to be suitable for multiple recommendations, but in specific ways. For example, organisational policies can be an implementation indicator for Guidelines recommendations #11 (*Use a trauma-informed approach to care*) and #17 (*Ensure continuity of care*) if both trauma-informed care and exit planning policies are present in these policies.

- **When choosing how to look for indicators**, consider using a combination of talk-based and text-based methods to allow people to expand on their perspectives. It is possible that written questions in surveys may be misunderstood, or that searching for indicators in text-based sources (e.g., client files) will not capture *why* data is missing.

- **Implementation teams are advised to consult with multiple stakeholder groups**, as perspectives may differ between groups (e.g., organisational leaders, frontline workers, clients and loved ones). Capturing different perspectives will help to ensure that current gaps are accurately identified.

- **The methods used to collect indicators** may influence how comfortable people are discussing certain areas of service delivery. For example, AOD workers may not want to acknowledge that they are not confident in their skills if they are being consulted as part of a roundtable with organisational leaders. Similarly, clients or loved ones may be uncomfortable discussing their perceptions of care if they feel it will impact their relationship with care providers. Consider consulting workers separately from organisational leaders, or using methods that protect confidentiality (e.g., anonymous online survey). For example, the **Guidelines evidence-to-practice gap surveys and scoring guide** can be used to explore implementation perspectives for multiple Guidelines recommendations across different stakeholder groups.

For additional tools to assist with choosing implementation indicators and methods, see **Additional Resources: Step 2**.

Table 2. Example of implementation indicators and methods

Guidelines recommendation: Ensure continuity of care	
Indicators *What will show you that the Guidelines recommendation is being implemented in practice?*	**Data source (where) and methods (how)** *Where and how will you look for indicators?*
Structural indicators	
• The organisation's model of care incorporates exit planning at key points during treatment. • There are policies and procedures to ensure that exit planning is incorporated into treatment. • A majority (>70%) of workers have training in case management. • There is an aftercare program or relationships with external services to facilitate continuity of care.	• **Data source:** Organisational policies and procedures (text-based). • **Methods:** Organisational audits, checklists or rating scales (text-based).
• The organisation has an exit plan template available for AOD workers to use with clients.	• **Data source:** Client files (text-based). • **Methods:** Client file audit, checklists or rating scales (text-based).

• Stakeholders perceive that organisational support and resources are available to implement exit planning (e.g., time, funding, availability of internal workers or external services).	• **Data source:** Stakeholder perceptions of care (text or talk-based, depending on method used).
	• **Methods:**
	    ○ Questionnaires or surveys (text-based).
	    ○ Interviews, roundtable discussions, focus groups, yarning circles or working groups (talk-based).

Table 2. Example of implementation indicators and methods (continued)

Guidelines recommendation: Ensure continuity of care	
Indicators *What will show you that the Guidelines recommendation is being implemented in practice?*	**Data source (where) and methods (how)** *Where and how will you look for indicators?*
Process indicators	
• A majority (>70%) of client files indicate exit plans are being completed and used (e.g., presence of referrals).	• **Data source:** Client files (text-based). • **Methods:** Client file audit, checklists or rating scales (text-based).

• Stakeholders perceive that exit planning is routinely incorporated into treatment planning.
• Stakeholders perceive that upon exiting treatment, exit planning ensures continuity of care.
	• **Data source:** Stakeholder perceptions of care (text or talk-based, depending on method used).
	• **Methods:**
	  ○ Questionnaires or surveys (text-based).
	  ○ Interviews, roundtable discussions, focus groups, yarning circles or working groups (talk-based).

Outcome indicators	
• Client-reported outcome measures (e.g., AOD use, mental health symptom severity, quality of life, treatment completion rates) improve when exit planning is completed.	• **Data source:** Client files (text-based). • **Methods:** Client file audit, checklists or rating scales (text-based).

• Stakeholders perceive that exit planning improves client outcomes (e.g., AOD use, mental health symptom severity, quality of life, treatment completion rates).	• **Data source:** Stakeholder perceptions of care (text or talk-based, depending on method used).
	• **Methods:**
	  ○ Questionnaires or surveys (text-based).
	  ○ Interviews, roundtable discussions, focus groups, yarning circles or working groups (talk-based).

2.3 Identify where the gaps are within service delivery

For each Guidelines recommendation, data from indicators will likely show that gaps exist within specific areas of service delivery (i.e., areas to improve). On the other hand, data will also show areas of service delivery where the recommendation is being done well (i.e., areas to maintain). By identifying these areas, the team can then address the gaps as part of **Steps 3-5** (identifying barriers, implementation strategies and developing a work plan), while also ensuring areas of service delivery that are being done well are maintained. This will be discussed further in **Steps 3-5**.

2.4 Determine implementation status

Once gaps have been identified, the team can determine the overall implementation status of each Guidelines recommendation. Depending on the indicators being used, there may already be a clear cut-off for what counts as **not implemented** (e.g., an audit score that indicates whether a particular service standard has been met). If not, the team can collectively decide the implementation status of each Guidelines recommendation, keeping in mind that **implemented** means the recommendation is *routinely applied* in care delivery across treatment settings, and clients can expect to experience the recommendation as part of their usual, day-to-day care.

2.5 Prioritise which gaps to include in your work plan

If you are implementing several Guidelines recommendations, there will likely be multiple gaps across different areas of service delivery, and you may need to prioritise what to include in your work plan.

> **When choosing which gaps to address, consider**[6, 7]:
>
> - Which gaps are most relevant to the aims and scope of your implementation project?
> - Which gaps are a priority for your organisation (organisational leaders, workers and clients)?
> - Which gaps do you have the internal or external resources to address (time, staffing, funding, or organisational support)?
> - Do the aims and scope of your project need to change based on any gaps you have identified?

2.6 Identifying current gaps: Example

Table 3 continues the example project from **Step 1**. As part of **Step 2**, the team have identified current gaps for Guidelines recommendation #17 (*Ensure continuity of care*). Note that the team did not use all the indicators from **Table 2**, but instead chose the indicators most suitable for their treatment setting. **Table 3** is available as a template as part of our **work plan tool.**

Table 3. Example of identifying current gaps

Guidelines recommendation: Ensure continuity of care				
Indicators *What will show you that the Guidelines recommendation is implemented in practice?*	**Data source and methods** *Where and how will you look for indicators?*	**Gaps to address** *What areas need to be improved?*	**Areas to maintain** *What is working well?*	**Implementation status**
Structural indicators • There are relationships with external services to facilitate continuity of care. • There are policies and procedures to ensure that exit planning is incorporated into treatment.	• **Data source:** Organisational policies and procedures • **Method:** Checklist for indicators developed by team	**Gap 1: Lack of relationships with external services.** There are few external services (particularly mental health services) available to refer clients to, especially when the client lives outside the catchment area.	✓ There are policies and procedures to ensure that exit planning is incorporated into treatment.	**Variably implemented**
Process indicators • A majority (>70%) of client files indicate exit plans are being completed and used in practice (e.g., presence of referrals).	• **Data source:** Client files • **Method:** Client file audit	**Gap 2: Lack of referrals to external services.** A minority (<20%) of client files indicate exit plans are being used in practice, particularly for ongoing mental health needs.	✓ A majority (>70%) of client files have completed exit plans.	

Table 3. Example of identifying gaps in practice (continued)

Guidelines recommendation: Ensure continuity of care				
Indicators *What will show you that the Guidelines recommendation is implemented in practice?*	**Data source and methods** *Where and how will you look for indicators?*	**Gaps to address** *What needs to be improved?*	**Areas to maintain** *What is working well?*	**Implementation status**

Process indicators
• Stakeholders perceive that clinical staff have the knowledge and skills needed to implement exit planning.
• Stakeholders perceive that exit planning is routinely incorporated into treatment planning.
 	
Outcome indicators
• Stakeholders perceive that exit planning improves client outcomes.
	• **Data source:** Stakeholder perceptions of care
	• **Methods:**
	  ○ Online survey (Clinical staff and clients)
	  ○ 3 x focus groups (Clinical staff, clients, family members/loved ones)
		Gap 3: Lack of confidence in skills. Clinical staff and clients perceive that workers lack skills required to use case management knowledge in practice.
		
		Gap 4: Views of family members/loved ones not routinely sought during exit planning. Family members/loved ones perceive that they are variably given an opportunity to be involved in exit planning.
			✓ Clinical staff perceive that they have the case management knowledge required for exit planning.
			✓ Both clinical staff and clients perceive that when exit planning is implemented, it improves client outcomes.
				See above

2.7 Identifying current gaps: Tools

Guidelines evidence-to-practice gap surveys and scoring guide

Our **Guidelines evidence-to-practice gap survey and scoring guide** is an example of an implementation indicator that explores implementation perceptions for multiple Guidelines recommendations across different stakeholder groups.

Step 3. Identify barriers to implementation

What are implementation barriers?

Once the implementation team have decided on which gaps to prioritise, the next step is to understand *why* these gaps exist. This involves identifying barriers to implementation. There are many frameworks and models for defining barriers to implementation, with barriers typically occurring across different levels. For example, barriers to implementing Guidelines recommendations may occur at the level of the health system, AOD sector, organisation or workforce, as well as the Guidelines themselves (**Figure 8**)[1, 11, 12]. Organisational leaders may have limited capacity to implement change for barriers at certain levels, such as the AOD sector or health system-level (e.g., attitudes of external service providers toward AOD use) or Guidelines-level (e.g., some workers finding the Guidelines too detailed). The focus for organisational leaders is to:

- **Implement change** for barriers you <u>can</u> change.

- **Manage the impact** of barriers you <u>cannot</u> change.

Figure 8. Perceived barriers to the implementation of Guidelines recommendations[1]

AOD sector and health system-level barriers

External connections or communications

Attitudes toward AOD use

Service availability and suitability

Sector-wide funding

Organisation-level barriers

Support and culture

Internal connections or communications

Internal staffing

Workforce-level barriers

Knowledge   Skills

Attitudes about guidelines

Internal funding

Guidelines-level barriers
Complexity and format, lack of adaptability for specific settings or clients

Recognising organisational strengths

While barriers to implementation can be challenging, they are not insurmountable. Addressing barriers is also key to implementing Guidelines recommendations and improving outcomes for clients with co-occurring conditions. Each team will face a unique set of barriers, but they will also have a unique set of organisational strengths[13]. These strengths (also referred to as 'facilitators', or 'enablers' to implementation) will be useful when choosing implementation strategies and tools as part of **Step 4**.

> **For each Guidelines recommendation, consider:**
>
> • <u>Defining barriers:</u> How will your team identify barriers and come to a shared understanding of how they contribute to gaps?
>
> • <u>Methods</u>: How will you look for barriers?

3.1 Choose how to define barriers

There are two main approaches to defining barriers to implementation: brainstorming and using an existing framework. These approaches are outlined below.

Brainstorming

Brainstorming allows an open and collaborative approach to identifying barriers across stakeholder groups[6, 7]. Brainstorming may be especially helpful if you can consult several groups of stakeholders across multiple brainstorming sessions. Following these sessions, the implementation team can synthesise what was discussed to develop a shared understanding of: i) names and definitions for barriers; ii) the degree to which these barriers are contributing to gaps; and iii) which barriers the team can address (i.e., implement change vs manage impact).
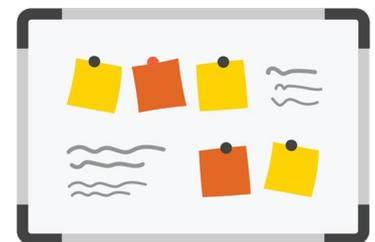
Brainstorming sessions can be aided by the use of implementation tools such as process mapping, the '5 whys', affinity diagrams, or cause and effect diagrams[6, 7]. For additional tools to assist with brainstorming, see **Additional resources: Step 3**.

Use an existing implementation framework

Frameworks that list and define barriers to implementation are called determinant frameworks[11]. The **Guidelines implementation barriers rating tool** is one such framework that can help teams define and rate the impact of barriers across four levels of the implementation process[1].

Using a framework to define barriers may be helpful if members of your team are exploring barriers independently (i.e., across multiple treatment settings, or one-on-one with stakeholders). The framework ensures everyone has a shared understanding of what barriers you are looking for, and what these barriers mean.

3.2 Choose how to look for barriers

Identifying barriers requires methods that are suitable for exploring *why* Guidelines recommendations are not being implemented from the perspective of stakeholders. As such, some text-based data sources and methods used in **Step 2** (e.g., client files, client file audits) are not suitable for exploring barriers. Instead, methods for identifying stakeholder perceptions of care are more appropriate for this step. As with **Step 2**, it is recommended that the team use a combination of text-based methods that protect confidentiality (e.g., questionnaires or surveys) and talk-based methods that allow people to expand on their perspectives (e.g., interviews or focus groups). As in **Step 2**, consulting multiple stakeholder groups (e.g., organisational leaders, frontline workers, clients and loved ones) is essential to capturing different perspectives and ensuring that barriers are accurately identified.

3.3 Prioritise which barriers to focus on

The implementation team may find that barriers vary across different Guidelines recommendations, gaps, and levels of the implementation process (i.e., health system, AOD sector, organisation level). As with gaps, it may not be feasible to address all barriers, and you may need to prioritise what to include in your work plan.

When choosing which barriers to focus on, consider:

- Which barriers are most relevant to the aims and scope of your project?

- Do the aims or scope of your project need to change based on the barriers you've found?

  - For example: In **Table 4**, the team discovered that for **Gap 3**, clients and family members/loved ones perceived a lack of communication between clinical and administrative staff. Initially, administrative staff were out of scope, which may now need to change.

- Which barriers do you have capacity to change (do you have the internal or external resources you need such as time, staffing, funding, or organisational support?)

- Are there barriers you can change that will address multiple gaps?

  - For example: In **Table 4**, the team discovered that the same barriers were contributing to **Gaps 1 & 2**. They also found that internal communication was contributing to multiple gaps, but in specific ways that can be targeted in **Step 4**.

- Are there some gaps that exist simply because something hasn't previously been recognised?

  - For example: In **Table 4**, the team identified that for **Gap 4**, family members' views were not routinely sought during their loved ones' exit planning. During consultation with staff, there was a lack of clarity about whether to routinely ask clients about involving family members, and whether there were existing organisational policies and procedures in place for this.

3.4 Identifying barriers to implementation: Example

Table 4 continues the example project from **Steps 1-2**, which focuses on implementing Guidelines recommendation #17 (*Ensure continuity of care*). **Table 4** is available as a template as part of our **work plan tool.**

Table 4. Example of identifying barriers to implementation

Guidelines recommendation: Ensure continuity of care Implementation status: Variably implemented			
Gaps to address *What needs to be improved?*	**How will you define barriers?**	**Methods** *How will you look for barriers?*	**What are the barriers and how can they be addressed?** *What can you implement change for?* *What will you need to manage the impact of?*
Gap 1: Lack of relationships with external services. There are few external services (particularly mental health services) available to refer clients to, especially when the client lives outside the catchment area. **Gap 2: Lack of referrals to external services.** A minority (<20%) of client files indicate exit plans are being used in practice, particularly for ongoing mental health needs.	Implementation team will use Guidelines implementation barriers rating tool.	• Online survey (clinical staff). • 1 x roundtable discussion with clinical staff. • One-to-one interviews with clients and family members/loved ones.	**Implement change** • *Lack of internal communication.* Clients and family members/loved ones perceive a lack of communication between clinical staff and external services accessed prior to entering AOD treatment (e.g., previous psychologists, counsellors or GPs), despite the client sharing this information as part of exit planning. **Manage impact** • *Lack of external mental health services.* All groups perceive a lack of external mental health services to collaborate with, and that the organisation has limited ability to maintain relationships with services outside the organisation's catchment area.

Table 4. Example of identifying barriers to implementation (continued)

Guidelines recommendation: Ensure continuity of care Implementation status: Variably implemented			
Gaps to address *What needs to be improved?*	**How will you define barriers?**	**Methods** *How will you look for barriers?*	**What are the barriers and how can they be addressed?** *What can you implement change for?* *What will you need to manage the impact of?*
Gap 3: Lack of confidence in skills. Clinical staff and clients perceive that workers lack skills required to use case management knowledge in practice.	*See above*	*See above*	**Implement change** • *Lack of skills.* Clinical staff do not feel confident in how to advocate for clients as part of case management, particularly when external services express stigma toward the client and/or themselves as an AOD worker. • *Lack of internal communication.* Clients and family members/loved ones perceive a lack of communication about exit planning between clinical staff and administrative staff (i.e., referrals are sent, but administrative staff are not made aware, or do not have access to information needed to action referrals when external services make contact). **Manage impact** • *External attitudes about AOD use.* Clinical staff perceive some external services will not accept referrals due to stigma about AOD use.
Gap 4: Views of family members/loved ones not routinely sought during exit planning. Family members/loved ones perceive that they are variably given an opportunity to be involved in exit planning.			**Implement change** • *Lack of internal communication.* Clinical staff perceive organisational policies and procedures are unclear about whether they should routinely ask clients about involving family members/loved ones. • *Lack of knowledge.* Increase staff knowledge and awareness of how to involve family members/loved ones with clients' consent while also maintaining confidentiality.

3.5 Identifying barriers to implementation: tools

Guidelines implementation barriers rating tool

If you need help defining barriers to implementation and assessing their impact, you can use the **Guidelines implementation barriers rating tool** to rate the impact of 18 different barriers across four levels of the implementation process.

Step 4. Choose implementation strategies and tools
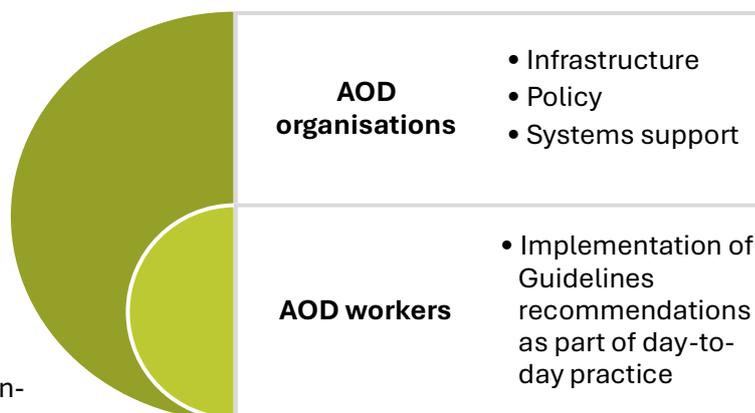
What are implementation strategies and tools?

The next step in the implementation process is to identify combinations of **implementation strategies** *(how will you do it?)* and **tools** *(what will you do it with?)* to address gaps and barriers. There is no one right way to choose implementation strategies or tools for your work plan. Each AOD treatment setting will have a unique combination of support, resources and organisational strengths. So, it is at the discretion of the team which strategies and tools will be the most suitable and feasible.

- **Implementation strategy** is a method or technique to increase the uptake of evidence-based practices (e.g., professional development, redesigning service workflow)[14].

- **Implementation tool** is an instrument designed to increase the delivery of evidence-based practice (e.g., a training program, clinical reminders on case files)[2] .

How can AOD organisations choose implementation strategies and tools?

There is limited research about which implementation strategies and tools work best in AOD treatment settings. Reviews have shown that most AOD treatment settings use strategies or tools that address workforce-level barriers (e.g., workforce training to address lack of knowledge or skills), rather than organisation-level barriers (e.g., a lack of infrastructure, policy,

Figure 9. The importance of organisational support

| AOD organisations | • Infrastructure
• Policy
• Systems support |
| AOD workers | • Implementation of Guidelines recommendations as part of day-to-day practice |

or systems support, **Figure 9**)[15, 16]. Implementation approaches that only address workforce-level barriers may have limited long-term impact if organisation-level barriers prevent workers from using what they have learned in training [16].

For each Guidelines recommendation, accompanying gaps and barriers, consider:

- How will you choose implementation strategies and tools?

- What are your organisational strengths for the Guidelines recommendation? (How can these strengths be used to address gaps and barriers?)

- What implementation strategies and tools will be used in your work plan? (Which are most suitable and feasible for your project and AOD treatment setting?)

4.1 Choose how to define implementation strategies and tools

As with barriers, there are two main approaches to defining implementation strategies and tools: brainstorming and using an existing implementation framework or resource. These approaches are described below.

Brainstorming

As with barriers, teams may want to take an open and collaborative approach to identifying implementation strategies or tools through brainstorming. At this stage of brainstorming, sessions can be aided by using quality improvement tools such as multi and weighted voting to decide which implementation strategies or tools will address gaps and barriers. These tools are discussed further below as part of mapping[6, 7].
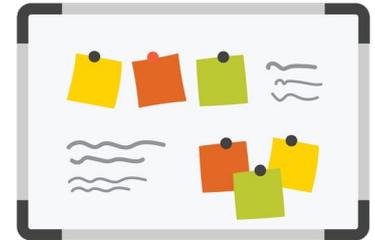
Use an existing implementation framework or resource

Many existing frameworks or resources are available for mapping implementation strategies or tools to barriers within health care organisations[17]. However, frameworks are often broad in their definitions of implementation strategies, and tools are not specific to AOD organisations[18, 19]. The **Guidelines implementation strategies rating tool** suggests strategies for barriers to implementing Guidelines recommendations[1]. For more resources from Australian AOD peak bodies, see **Additional resources: Step 4**.

4.2 Identify organisational strengths

Organisational strengths may have emerged when identifying gaps in **Step 2,** i.e., areas of service delivery that are working well. These areas may indicate unique organisational strengths (also referred to as 'facilitators', or 'enablers' of implementation) that can offset barriers[13]. For example, in **Table 3** the team discovered a key strength in their existing policies and procedures, which ensured exit planning was being incorporated into treatment, and exit plans included in a majority (>70%) of client files. In **Table 5**, the team decided to build on this strength, and use the same policies and systems that had supported exit planning to redesign workflow as one of their implementation strategies.

4.3 Map implementation strategies and tools to barriers

When choosing implementation strategies or tools, it is common for gaps and barriers to be grouped together with implementation strategies or tools. This process is called 'mapping', and allows the team to add their thoughts about different approaches (**Figure 10**)[6, 7].

Figure 10. Example of implementation mapping

Gaps 1 & 2
Lack of relationships with external services

Lack of referrals to external services

Barriers: implement change
Lack of internal communication
Clinical staff not maintaining client's existing relationships with external services during treatment

What if client doesn't know / provider info incorrect in file?

Strategy: Redesign workflow
Tool: Update exit plan template, design 'Continuity of care' agreement to send to external services after intake

When to action referrals? Ask services RE wait list times?

Barriers: manage impact
Lack of external mental health services
Particularly when client based outside catchment area

Any online psych services?

Strategy: Outreach to external services
Tool: HealthPathways directory and healthdirect service finder

Or possible to get psych registrar, start internal aftercare w. telehealth counselling?

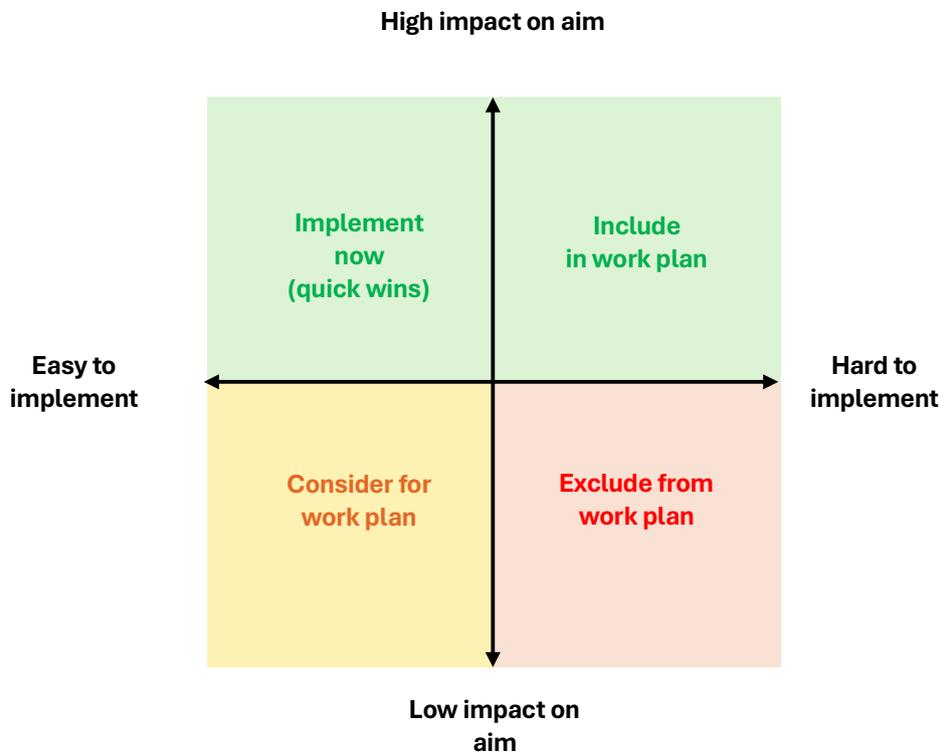## 4.4 Prioritise which implementation strategies or tools to include in work plan

At the end of the mapping stage, the team will have a list of implementation strategies and tools, which will become deliverables for the work plan in **Step 5**. It may not be feasible to include all implementation strategies and tools in the work plan, depending on the aims and scope of the implementation project as well as organisational resources and support. Outlined below are two main approaches for prioritising what to include.

Categorise implementation strategies and accompanying tools

Teams can number and categorise their implementation strategies and accompanying tools, based on: i) impact on project aim; and ii) ease of implementation[6] (**Figure 11**). Ideas that will have a high impact on the aim and are easy to implement (quick wins) may be appropriate to delegate outside of the project. Project deliverables should focus on ideas that require planning to implement but are impactful for the project aim (i.e., top right quadrant of **Figure 11**)[6].

Figure 11. Prioritising strategies and tools for work plan

High impact on aim

Implement now (quick wins)	**Include in work plan**
Consider for work plan	**Exclude from work plan**

Easy to implement ← → **Hard to implement**

Low impact on aim

Multi-voting

Another approach to prioritising ideas is multi-voting. This approach involves allocating a certain number of votes proportionate to i) the number of team members voting and ii) the number of implementation strategies and tools available to vote on. Over a series of voting rounds, the team comes to a consensus about which strategies and tools are a priority for the project. For examples of tools to assist with multi-voting, see **Additional resources: Step 4**.

4.5 Choosing implementation strategies and tools: Example

Table 5 continues the example project from **Steps 1-3**, which focuses on the implementation of Guidelines recommendation #17 (*Ensure continuity of care*). **Table 5** is available as a template as part of our **work plan tool.**

Table 5. Example of choosing implementation strategies and tools

Guidelines recommendation: Ensure continuity of care **Implementation status:** Variably implemented				
Gaps to address	**What are the barriers?**	**How will you choose implementation strategies and tools?**	**What are your organisational strengths?** *How can these be used to address gaps and barriers?*	**What implementation strategies and tools will you use in your work plan?**
Gap 1: Lack of relationships with external services. There are few external services (particularly mental health services) available to refer clients to, especially when the client lives outside the catchment area. **Gap 2: Lack of referrals to external services.** A minority (<20%) of client files indicate exit plans are being used in practice, particularly for ongoing mental health needs.	**Implement change** • *Lack of internal communication*. Clients and family members/loved ones perceive a lack of communication between clinical staff and external services accessed prior to entering AOD treatment (e.g., previous psychologists, counsellors or GPs), despite the client sharing this information as part of exit planning. **Manage impact** • *Lack of external mental health services*. All groups perceive a lack of external mental health services to collaborate with, and that the organisation has limited ability to maintain relationships with services outside organisation's catchment area.	2 x brainstorming sessions: • *First session:* brainstorm, map strategies and tools. • *Second session:* use multi-voting to decide final strategies and tools to use in work plan.	✓ Organisational support already in place (i.e., exit planning policy, exit planning template incorporated into treatment planning, being completed).	**Implement change** • **Strategy: Redesign workflow** *Tool: Update exit plan template to include 'Continuity of care agreement' to send to external services client has relationship with. Send after intake.* **Manage impact** • **Strategy: Outreach to external services** *Tool: HealthPathways directory and healthdirect service finder.*

Table 5. Example of choosing implementation strategies and tools (continued)

Guidelines recommendation: Ensure continuity of care
Implementation status: Variably implemented

Gaps to address	What are the barriers?	How will you choose implementation strategies and tools?	What are your organisational strengths? *How can these be used to address gaps and barriers?*	What implementation strategies and tools will you use in your work plan?
Gap 3: Lack of confidence in skills. Clinical staff and clients perceive that workers lack skills required to use case management knowledge in practice.	**Implement change** • *Lack of skills.* Clinical staff do not feel confident in how to advocate for clients as part of case management, particularly when external services express stigma toward the client and/or themselves as an AOD worker. • *Lack of internal communication.* Increase staff awareness of how to involve family members/loved ones with clients' consent while also maintaining confidentiality. **Manage impact** • *External attitudes about AOD use.* Clinical staff perceive some external services will not accept referrals due to stigma about AOD use.	*See above*	✓ Clinical staff have good knowledge of exit planning, information in client files is well written and easy to share with administrative staff	**Implement change** • **Strategy: Professional development** *Tool: Monthly supervision sessions for clinical staff, focusing on how to advocate as part of case management.* • **Strategy: Redesign workflow** *Tool: Design and implement exit planning procedure for administrative staff.* **Manage impact** • See strategy for Gaps 1-2 (outreach to external services).

Table 5. Example of choosing implementation strategies and tools (continued)

Guidelines recommendation: Ensure continuity of care Implementation status: Variably implemented				
Gaps to address	**What are the barriers?**	**How will you choose implementation strategies and tools?**	**What are your organisational strengths?** *How can these be used to address gaps and barriers?*	**What implementation strategies and tools will you use in your work plan?**
Gap 4: Views of family members/loved ones not routinely sought during exit planning. Family members/loved ones perceive that they are variably given an opportunity to be involved in exit planning.	**Implement change** • *Lack of internal communication*. Clinical staff perceive organisational policies and procedures are unclear about whether they should routinely ask clients about involving family members/loved ones. • *Lack of knowledge*. Increase staff knowledge and awareness of how to involve family members/loved ones with clients' consent while also maintaining confidentiality.	*See above*	✓ Organisational support already in place (i.e., exit planning policy, exit planning template incorporated into treatment planning, being completed). ✓ Both clinical staff and clients are motivated to implement exit planning, as they perceive it improves client outcomes.	**Implement change** • **Strategy: Redesign workflow** *Tool: Update Exit Planning Policy and exit plan template to include section on how and when to involve family members/loved ones in exit planning while also managing confidentiality.* • **Strategy: Conduct ongoing training** *Tool: Hold training session with current staff, focusing on implementing updated policy into practice. Add training session as part of onboarding for new staff.*

4.6 Choosing implementation strategies: Tools

Guidelines implementation strategy rating tool

If you need help identifying which implementation strategies might be most suitable and feasible for your treatment setting, you can use the **Guidelines implementation strategy rating tool.**

Step 5. Implement and evaluate change

The final step, **Step 5** is to develop, implement and evaluate a work plan using everything the team has discovered as part of **Steps 1-4**[20]. At this point in the implementation process, organisational leaders will have finalised the aims, scope and team for the project, including which Guidelines recommendations will be implemented.

Additionally, for each Guidelines recommendation, the team have finalised:

- o Current evidence-to-practice gaps that will be addressed as part of the work plan.

- o Barriers that are contributing to current gaps, with clear distinction for which of the barriers the work plan will be implementing change, and which barriers the work plan will be managing the impact of.

- o Implementation strategies and tools to target gaps and barriers, which will now become deliverables for your work plan.

5.1 Develop work plan

For each combination of implementation strategies and tools, consider the following:

- **What are the deliverables** (how will you put your implementation strategies and tools into practice?) Deliverables should be S.M.A.R.T[6, 7]:

  - o **S**pecific: What exactly are you trying to achieve?

  - o **M**easurable: How and when will you know you've achieved it?

  - o **A**ttainable: Is it possible to achieve it?

  - o **R**elevant: Is it a priority to achieve it?

  - o **T**imely: When do you want to achieve it?

- **Monitoring data** (how will you know the deliverable is complete?)

  - o Similar to identifying gaps for Guidelines recommendations, your work plan will need indicators that show the degree to which your deliverables are being implemented[20].

- **Person or team member responsible** (who will do it?)

- **Timeframe** (when does it need to be done by?)

5.2 Carry out and revise work plan as needed

During this stage, the team will put into practice the deliverables outlined in the work plan. The team may choose to reflect on and refine the work plan regularly as it is being delivered, or at key milestones during the delivery process. This process of iterating the workplan will depend on the support and resources available within the AOD treatment setting.

When carrying out and revising your work plan, consider the following[6, 7, 20]:

- What changes do you see in your monitoring data?
- What is working well? What is not working well? Why?
- Does anything need to change?

Once the work plan is complete, the team may also choose to do a follow-up analysis. Here, the team may use the same indicators from **Step 2** to analyse the implementation status for each Guidelines recommendation in the work plan. Doing so will allow the team to determine the impact the work plan has had on the gaps identified in **Step 2**.

5.3 Sustain and scale improvements

Depending on the outcomes of the work plan, the team may also choose to:

- **Sustain any improvements that the work plan** has had on the implementation status of Guidelines recommendations (what deliverables worked? Do they need to be done on an ongoing basis?)
- **Scale the work plan across other areas of service delivery** that were not in scope as part of your original project (would this work plan be suitable for these areas? Who should be consulted?)

5.4 Implement and evaluate change: Example

Table 6 shows the project work plan from **Steps 1-4**, which focuses on the implementation of Guidelines recommendation #17 (*Ensure continuity of care*). **Table 6** is available as a template as part of our **work plan tool.**

Table 6. Example of a work plan

Aim	Increase organisational capacity for ensuring continuity of care		Implementation team	**Project manager:** Service manager **Project leads:** • Counselling team leader (clinical staff) • Nursing unit manager (clinical nursing staff) • Operations manager (administrative staff)
Scope	**In scope:** • Residential rehabilitation program • Clinical and administrative staff	**Out of scope:** • Community-based programs • Cleaning and other service maintenance staff		

Guidelines recommendation and implementation status	Gaps to address *Which gaps will the deliverables address?*	Deliverables *How will you put your implementation strategies and tools into practice?*	Monitoring data *How will you know the deliverable is complete?*	Person responsible *Who will do it?*	Timeframe *When does it need to be done by?*
Ensure continuity of care Implementation status: *Variably implemented*	**Gap 1: Lack of relationships with external services.** There are few external services (particularly mental health services) available to refer clients to, especially when the client lives outside the catchment area. **Gap 2: Lack of referrals to external services.** A minority (<20%) of client files indicate exit plans are being used in practice, particularly for ongoing mental health needs.	**1. Update exit plan template with *Continuity of care agreement*.** **1a.** Draft *Continuity of care agreement* and update exit plan template. **1b.** Pilot agreement with counselling and nursing staff. **1c.** Finalise *Continuity of care agreement* and updated exit plan template. **1d.** Incorporate *Continuity of care agreement* and updated exit plan into *Exit planning procedure (Administrative staff)*.	**1a.** Draft *Continuity of care agreement* and updated exit plan template complete. **1b.** Feedback session with counselling nursing staff complete, feedback documented. **1c.** *Continuity of care agreement* and exit plan template updated in client file systems and being used by clinical staff. **1d.** *Continuity of care agreement* and updated exit plan incorporated into *Exit planning procedure* for administrative staff.	**1a, 1b & 1c.** Counselling team leader and nursing unit manager. **1d.** Service manager and Operations manager.	3 months

Table 6. Example of work plan (continued)

Guidelines recommendation and implementation status	Gaps to address *Which gaps will the deliverables address?*	Deliverables *How will you put your implementation strategies and tools into practice?*	Monitoring data *How will you know the deliverable is complete?*	Person responsible *Who will do it?*	Timeframe *When does it need to be done by?*
Ensure continuity of care Implementation status: *Variably implemented*	*See Gaps 1-2.*	**2. Outreach to external services, focusing on mental health services.** **2a.** Develop a list of external mental health services for outreach using HealthPathways directory and healthdirect service finder. **2b.** Conduct outreach visit to external mental health services to discuss developing and strengthening links between services. **2c.** In partnership with the mental health service, develop a Memorandum of Understanding (MOU) template for external mental health services. **2d.** At least one completed MOU with an external mental health service. *Note: it is anticipated this deliverable will also address Gap 3, as it will improve external referrals.*	**2a.** Completed list. **2b.** At least five outreach visits with external mental health services. **2c.** MOU template completed. **2d.** Completed MOU with external mental health service, successful referrals to service documented in client files.	**2.** Service manager	6 months

Table 6. Example of work plan (continued)

Guidelines recommendation and implementation status	Gaps to address *Which gaps will the deliverables address?*	Deliverables *How will you put your implementation strategies and tools into practice?*	Monitoring data *How will you know the deliverable is complete?*	Person responsible *Who will do it?*	Timeframe *When does it need to be done by?*
Ensure continuity of care Implementation status: *Variably implemented*	**Gap 3: Lack of confidence in skills.** Clinical staff and clients perceive that workers lack skills required to use case management knowledge in practice.	**3. Clinical supervision.** **3a.** Plan for monthly supervision sessions focusing on how to advocate as part of case management developed. **3b.** Counselling team leader and nursing unit manager to hold monthly sessions with clinical staff (counselling and nursing staff).	**3a.** Plan for supervision sessions completed. **3b.** Monthly supervision sessions held and attended by clinical staff, counselling team leader and nursing unit manager perceive case management skills are improving.	**3.** Counselling team leader and nursing unit manager.	6 months
		4. Design and implement *Exit planning procedure (Administrative staff)*. **4a.** Draft *Exit planning procedure (Administrative staff)*. **4b.** Ensure procedure works with current systems (i.e., administrative staff have access to the necessary client file information). **4c.** Pilot procedure with administrative staff. **4d.** Finalise *Exit planning procedure (Administrative staff)*, notify clinical staff of any changes to workflow.	**4a.** Draft *Continuity of care agreement* and updated exit plan template. **4b.** Feedback session with counselling nursing staff complete, feedback documented. **4c.** *Continuity of care agreement* and exit plan template updated in client file systems and being used by clinical staff. **4d.** *Continuity of care agreement* and updated exit plan incorporated into *Exit planning procedure* for administrative staff.	**4.** Service manager and Operations manager.	6 months

Table 6. Example of work plan (continued)

Guidelines recommendation and implementation status	Gaps to address *Which gaps will the deliverables address?*	Deliverables *How will you put your implementation strategies and tools into practice?*	Monitoring data *How will you know the deliverable is complete?*	Person responsible *Who will do it?*	Timeframe *When does it need to be done by?*
Ensure continuity of care Implementation status: *Variably implemented*	**Gap 4: Views of family members/loved ones not routinely sought during exit planning.** Family members/loved ones perceive that they are variably given an opportunity to be involved in exit planning.	**5. Update Exit Planning Policy and procedures to include involving family members/loved ones in exit planning.** *Note: this requires Deliverables 1 & 4 to be completed first.* **5a.** Draft additional section in Exit Planning Policy focusing on how and when to involve family members/loved ones in exit planning while also managing confidentiality. **5b.** Ensure updated Exit Planning Policy complies with current Risk Management Policy and Client Confidentiality Policy. **5c.** Update exit planning procedures and templates for both clinical and administrative staff to reflect policy change. **6. Conduct ongoing training for involving family members/loved ones in exit planning** **6a.** Hold training session with clinical and administrative staff focused on putting new policy into practice. **6b.** Action any staff feedback on updated policies and procedures. **6c.** Finalise training session content, add to onboarding for new staff.	**5a & 5b.** Exit Planning policy updated. **5c.** Exit planning procedures for both clinical and administrative staff updated. **6a.** Training session held and attended by clinical and administrative staff. **6b.** Feedback on updated policies and procedures documented and actioned. **6c.** Training session content finalised and added to onboarding.	**5a – 5c.** Service manager and Operations manager. **6a.** All team members. **6b.** Service manager and Operations manager. **6c.** Service manager.	7 months

5.5 Implement and evaluate change: tools

Implementation project and work plan template

If you need help developing your implementation project and work plan, you can use our **project and work plan template,** which includes templates for all example tables shown in Steps 1-5 of the Toolkit.

Additional resources

Step 2: Identifying evidence-to-practice gaps

- Agency for Clinical Innovation (2025). *Experiential evidence methods*. NSW Health. Available from: https://aci.health.nsw.gov.au/support-for-innovation/evidence/experiential/typology

- Insight (2016). *AOD client engagement toolkit*. Queensland Government. Available from: https://insight.qld.edu.au/toolkits/project-gauge/detail

Step 3: Identifying barriers to implementation

- Clinical Excellence Commission (2025). *Brainstorming*. NSW Government. Sydney, Australia. Available via: https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/brainstorming

- Clinical Excellence Commission (2025). *Affinity diagrams*. NSW Government. Sydney, Australia. Available via: https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/affinity-diagrams

- Clinical Excellence Commission (2025). *Cause and effect diagrams*. NSW Government. Sydney, Australia. Available via: https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/cause-and-effect-diagrams

- Agency for Clinical Innovation (2025). *Diagnostics mapping*. NSW Government. Sydney, Australian. Available via: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0010/486766/Diagnostics-Mapping.pdf

- Weiner BJ. (2023) *Prioritizing implementation barriers: a toolkit for designing and implementation initiative*. ImpSciMethods.org. Available via: https://www.impscimethods.org/toolkits/prioritizing-implementation-barriers-toolkit

Step 4: Choosing implementation strategies or tools

Multi-voting

- Clinical Excellence Commission (2025). *Multi and weighted voting*. NSW Government. Sydney, Australia. Available via: https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools/multi-and-weighted-voting

- Walk Training and Consulting (2017). *Multivoting* [Video]. YouTube. Available via: https://www.youtube.com/watch?v=E80xQ1CPnOI&ab_channel=WalkerTrainingandConsulting

Resources from Australian AOD peak bodies

- Australian Indigenous HealthInfoNet (2025). *Alcohol and Other Drugs Knowledge Centre*. Edith Cowan University. Sydney, Australia. Available via: https://aodknowledgecentre.ecu.edu.au/

- Alcohol and Drug Foundation (2025). *Resources for health professionals*. ADF. Sydney, Australia. Available via: https://adf.org.au/resources/health-professionals/

- Comorbidity Guidelines (2022). *Appendices*. The Matilda Centre for Research in Mental Health and Substance Use, the University of Sydney. Sydney, Australia. Available via: https://comorbidityguidelines.org.au/appendices

- Insight and Dovetail (2025). *Toolkits*. Queensland Health. Brisbane, Australia. Available via: https://insight.qld.edu.au/toolkits

- National Centre for Education and Training on Addiction (NCETA) (2025). *Resources*. Flinders University. Adelaide, Australia. Available via: https://nceta.flinders.edu.au/resources
- Network of Alcohol and other Drugs Agencies (NADA) (2025). *AOD resource finder*. NADA. Sydney, Australia. Available via: https://nada.org.au/resources/aod-resource-finder/

References

1. Madden E. Improving evidence-based practice for co-occurring alcohol and other drug and mental health conditions: the role of implementation toolkits: The University of Sydney; In preparation.

2. Agency for Healthcare Research and Quality. *AHRQ Publishing and Communications Guidelines, Section 6: Toolkit Guidance*. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2013.

3. Hoagwood K, Atkins M, Ialongo N. Unpacking the black box of implementation: the next generation for policy, research and practice. *Administration and policy in mental health* 2013;40(6):451-5.

4. Kingston REF, Marel C, Mills KL. A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. *Drug and Alcohol Review*. 2017;36(4):527-39.

5. Hoffmann T, Bennett S, Mar CD. *Evidence-based practice across the health professions (3rd edition)*. Chatswood, Australia: Elsevier Australia; 2016.

6. NSW Agency for Clinical Innovation. *Implementation Guide: Putting a model into practice*. 2015.

7. Langley G, Moen R, Nolan K, Nolan T, Norman C, Provost L. *The Improvement Guide (2nd edition)*. Clinical Excellence Commission, NSW Government; 2024.

8. Kitson A, Straus SE. The knowledge-to-action cycle: identifying the gaps. *Canadian Medical Association Journal*. 2010;182(2):E73-7.

9. Kilbourne AM, Beck K, Spaeth-Rublee B, Ramanuj P, O'Brien RW, Tomoyasu N, et al. Measuring and improving the quality of mental health care: a global perspective. *World Psychiatry*. 2018;17(1):30-8.

10. Weiner BJ, Lewis CC, Sherr K, Fahim C, Straus SE, Leeman J, et al. *Practical Implementation Science (1st edition)*. New York: Springer Publishing Company; 2022.

11. Nilsen P. Making sense of implementation theories, models and frameworks. *Implementation Science*. 2015;10(1):53.

12. Damschroder LJ, Reardon CM, Widerquist MAO, Lowery J. The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Science*. 2022;17(1):75.

13. Grol R, Grimshaw J. Evidence-based implementation of evidence-based medicine. *Joint Commission Journal on Quality Improvement*. 1999;25(10):503-13.

14. Proctor EK, Powell BJ, McMillen JC. Implementation strategies: recommendations for specifying and reporting. *Implementation Science*. 2013;8(1):139.

15. Louie E, Barrett EL, Baillie A, Haber P, Morley KC. A systematic review of evidence-based practice implementation in drug and alcohol settings: applying the consolidated framework for implementation research framework. *Implementation Science*. 2021;16(1):22.

16. Roche A, Nicholas R. Workforce development: An important paradigm shift for the alcohol and other drugs sector. *Drugs: Education, Prevention and Policy*. 2017;24(6):443-54.

17. Powell BJ, Waltz TJ, Chinman MJ, Damschroder LJ, Smith JL, Matthieu MM, et al. A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. *Implemention Science*. 2015;10:21.

18. Yakovchenko V, Chinman MJ, Lamorte C, Powell BJ, Waltz TJ, Merante M, et al. Refining Expert Recommendations for Implementing Change (ERIC) strategy surveys using cognitive interviews with frontline providers. *Implementation Science Communications*. 2023;4(1):42.

19. Ashcraft LE, Goodrich DE, Hero J, Phares A, Bachrach RL, Quinn DA, et al. A systematic review of experimentally tested implementation strategies across health and human service settings: evidence from 2010-2022. *Implementation Science*. 2024;19(1):43.

20. Hateley-Browne J, Hodge L, Polimeni M, Mildon R. *Implementation in action: a guide to implementing evidence-informed programs and practices*. Australian Institute of Family Studies, Australian Government; 2019.