EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Illness Management and Recovery

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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EVIDENCE-BASED PRACTICES

KIT

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Illness Management and Recovery

Evaluating Your Program

Evaluating Your Program shows quality assurance team members how to evaluate the effectiveness of your Illness Management and Recovery (IMR) program. It includes the following:

- A Readiness Assessment;
- The Illness Management and Recovery Fidelity Scale;
- The General Organizational Index; and
- Outcome measures that are specific to your program.

You will also find instructions for conducting assessments and tips on how to use the data to improve your program.

For references, see the booklet *The Evidence.*

This KIT is part of a series of Evidence-Based Practices KITs created by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

This booklet is part of the Illness Management and Recovery KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Illness Management and Recovery

What's in *Evaluating Your Program*

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Why Evaluate Your Illness Management and Recovery Program

Key stakeholders who are implementing Illness Management and Recovery programs may find themselves asking two questions:

- **Has IMR been implemented as planned?**
- **Has IMR resulted in the expected outcomes?**

Asking these two questions and using the answers to help improve your program are critical for ensuring the success of your IMR program.

To answer the first question, collect **process measures** (by using the IMR Fidelity Scale and General Organizational Index). Process measures capture how services are provided. To answer the second question, collect **outcome measures.** Outcome measures capture the results or achievements of your program.

As you prepare to implement IMR, we strongly recommend that you develop a quality assurance system using both process and outcome measures to monitor and improve the quality of the program from the startup phase and continuing through the life of the program.

Why you should collect process measures

Process measures give you an objective, structured way to determine if you are delivering services in the way that research has shown will result in desired outcomes. Process measures allow agencies to understand whether they are providing services that are faithful to the evidence-based model. Programs that adhere more closely to the evidence-based model are more effective than those that do not follow the model. Adhering to the model is called *fidelity*.

Collecting process measures is an excellent method to diagnose program weaknesses while helping to clarify program strengths. Once IMR programs reach high fidelity, ongoing monitoring allows you to test local innovations while ensuring that programs do not drift from the core principles of the evidence-based practice.

Process measures also give mental health authorities a comparative framework to evaluate the quality of IMR programs across the state. They allow mental health authorities to identify statewide trends and exceptions to those trends.

Why you should collect outcome measures

While process measures capture how services are provided, outcome measures capture the program's results. Every mental health service intervention has both immediate and long-term consumer goals. In addition, consumers have goals for themselves, which they hope to attain by receiving mental health services. These goals translate into outcomes and the outcomes translate into specific measures.

Research Has Shown That You Can Expect These Outcomes

- More knowledge about mental illnesses
- Fewer relapses
- Fewer rehospitalizations
- Reduced distress from symptoms
- More consistent use of medications

Consumer outcomes are the bottom line for mental health agencies, just as profit is in business. No successful businessperson would assume that the business was profitable just because employees work hard.

Why develop a quality assurance system

In the mental health system, you should develop a quality assurance system that collects not only process measures such as those on the IMR Fidelity Scale and General Organizational Index, but also outcome measures, such as those specified above, to show the effect that IMR has for consumers. Developing a quality assurance system will help you do the following:

- Diagnose your program's strengths and weaknesses;
- Formulate action plans for improving your program;
- Help consumers achieve their goals for recovery; and
- Deliver mental health services both efficiently and effectively.

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Conduct a Readiness Assessment

Let's assume that administrators and IMR leaders have read *Building Your Program.* Your new IMR team has completed *Training Frontline Staff.* How do you know if you are ready to begin providing IMR services to consumers?

The Readiness Assessment on the next page will help quality assurance team members, advisory group leaders, and IMR coordinators, directors, or leaders track the processes and administrative tasks required to develop an IMR program.

Answering these questions will help you generate an ongoing "to-do" list (or implementation plan) to guide your steps in implementing IMR. Your answers will also help you understand which components of IMR services are in place and what work still remains.

Readiness Assessment

Check any areas that you feel you do NOT completely understand.

- ❑ Which clinical teams and practitioners will provide IMR?
- ❑ Who will supervise IMR practitioners?
- ❑ Who will coordinate or direct the IMR program?
- ❑ What is the role of IMR director or coordinator, IMR leader, and practitioners?
- ❑ What is the size of the IMR practitioner caseload?
- ❑ What is the IMR supervisory structure (for example, how often does the IMR leader meet with practitioners and the director or coordinator.)?
- ❑ How will you supervise your IMR practitioners?
- ❑ What are the specific admission criteria for your program?
- ❑ How will you advertise IMR to consumers, families, and other staff?
- ❑ How will families or other supporters be involved in IMR?
- ❑ Will you provide IMR in an individual or group format?
- ❑ What will be the program policy and procedure for developing, documenting, and routinely assessing consumers' goals for IMR?
- ❑ What will be the program policy and procedure for completing the Strengths and Knowledge Inventory and IMR Progress Note?
- ❑ What will be the program policy and procedure for administering review questions at the end of IMR sessions?
- ❑ How will you select a location for your IMR sessions?
- ❑ How does the IMR team relate to advisory groups?
- ❑ How will you measure your program's fidelity to the IMR model?
- ❑ How does the system for collecting consumer outcome data work?

Note areas where you still are unclear or have questions. Arrange to speak to an IMR consultant or experienced IMR leader.

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Evaluating Your Program

Conduct a Process Assessment

In addition to conducting the Readiness Assessment, you should conduct your first process assessment before providing any IMR services. By doing so, you will determine whether your agency has core components of IMR in place. During the first 2 years of implementing IMR, plan to assess your IMR program every 6 months.

After your IMR program has matured and achieved high fidelity, you may choose to conduct assessments once a year. Agencies that have successfully implemented IMR indicate that you must continue to evaluate the process to ensure that you do not revert to previous practice patterns.

Once your program has achieved high fidelity to the evidence-based model, IMR staff may tailor the program to meet individual needs of the community. If you continue to use process assessments along with outcome monitoring, you will be able to understand the extent to which your changes result in your program's departure from model fidelity and whether the changes positively or negatively affect consumers.

How to use process measures

Two tools have been developed to monitor how IMR services are provided:

- The IMR Fidelity Scale; and
- General Organizational Index.

You may administer both tools at the same time.

The IMR Fidelity Scale has 13 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*). The items assess whether the IMR program is provided as the evidence-based model prescribes.

The General Organizational Index is a second set of process measures that have been developed. In contrast to fidelity scales, which are specific to each evidence-based practice, the General Organizational Index can be used when implementing any evidence-based practice. It measures agency-wide operating procedures that have been found to affect agencies' overall capacity to implement and sustain any evidence-based practice.

For the IMR Fidelity Scale and General Organizational Index, see *Appendixes B* and *D*. You can also print these forms from the CD-ROM in your KIT.

Who can conduct process assessments?

We recommend enlisting two assessors to conduct your process assessment. Data collected by two assessors simultaneously increase the likelihood that information will be reliable and valid.

Agencies that have successfully implemented IMR programs have taken different approaches to identify assessors. Some agencies train IMR Advisory Group members as assessors and rotate the responsibility of completing assessments. Others have preexisting quality assurance teams and simply designate members of the team to complete assessments of their IMR program. In other cases, the mental health authorities have designated staff to conduct assessments.

Assessments can be conducted either internally by an agency or program or externally by a review group. External review groups have a distinct advantage because they use assessors who are familiar with the IMR model but, at the same time, are independent. The goal is to select objective and competent assessors.

Although we recommend using external assessors, agencies can also use the fidelity scales to rate their own programs. The validity of these ratings (or any ratings, for that matter) depends on the following:

About the process measures that are included in the KIT

Quality assurance measures have been developed and are included in all Evidence-Based Practice KITs. The IMR Fidelity Scale was developed by a group of researchers at Indiana University-Purdue University Indianapolis and the developers of the KIT (Kim Mueser and Susan Gingerich). The standards used for establishing the anchors for the fully implemented ratings were determined through a variety of expert sources as well as through empirical research. The scale has undergone numerous drafts and review by many groups. Revisions were made based on feedback from a variety of sources during the 3-year pilot testing of the KIT materials.

The General Organizational Index, developed by Robert Drake and Charlie Rapp, is a newly developed scale. This scale has undergone multiple revisions based on feedback gathered during the 3-year pilot testing of the KIT materials.

- The knowledge of the person making the ratings;
- Access to accurate information pertaining to the ratings; and
- The objectivity of the ratings.

If you do conduct your assessment using internal staff, beware of potential biases of raters who are invested in seeing the program look good or who do not fully understand the IMR model. It is important that ratings be made objectively and that they be based on hard evidence.

Circumstances will dictate decisions in this area, but we encourage agencies to choose a review process that fosters objectivity in ratings, for example, by involving a practitioner who is not centrally involved in providing the service.

Only people who have experience and training in interviewing and data collection procedures (including chart reviews) should conduct assessments. In addition, assessors need to understand the nature and critical ingredients of IMR.

If your agency chooses to use a consultant or trainer to help implement your IMR program, involving that person in the assessment process will enhance the technical assistance you receive. Whichever approach you choose, we encourage you to make these decisions early in the planning process. For a checklist to help evaluate assessors' training and work performance, see *Appendix J*.

How to conduct process assessments

A number of activities take place before, during, and after a process assessment. In general, assessments include the following:

- Interviewing administrators, the IMR leader, IMR practitioners, consumers, and families;
- Observing IMR sessions (either live or videotaped);
- Conducting a chart review; and
- Reviewing IMR educational handouts.

Collecting information from multiple sources helps assessors more accurately capture how services are provided. A day-long site visit is the best way to learn this information. The following suggestions outline steps in the assessment process.

Before the process assessment

Prepare your assessment questions

A detailed protocol has been developed to help you understand each item on the IMR Fidelity Scale and General Organizational Index, the rationale for why it was included, guidelines for the types of information to collect, and instructions for completing your ratings. Use the protocols to help prepare the questions that you will ask during your assessment visit. For the IMR Fidelity Scale and General Organizational Index protocols, see *Appendixes C* and *E*.

While we expect that quality assurance teams will select which outcome measures meet your agency's needs, you should use the IMR Fidelity Scale and General Organizational Index in full. Collecting data for all the items on these scales will allow your agency to gain a comprehensive understanding of how closely your IMR services resemble the IMR model.

Create a timeline for the assessment

List all the necessary activities leading up to and during the visit and create a timeline for completing each task. Carefully coordinating efforts, particularly if you have multiple assessors, will help you complete your assessment in a timely fashion.

Establish a contact person

Have one key person in the IMR program arrange your visit and communicate beforehand the purpose and scope of your assessment to people who will participate in interviews. Typically, this contact person will be the IMR leader.

Exercise common courtesy and show respect for competing time demands by scheduling well in advance and making reminder calls to confirm interview dates and times.

Establish a shared understanding with the IMR team

The most successful assessments are those in which assessors and the IMR team share the goal to understand how the program is progressing according to evidence-based principles. If practitioners or administrators fear that they will lose funding or look bad if they don't score well, then the accuracy of the data may be compromised. The best agreement is one in which all parties are interested in learning the truth.

Indicate what you will need from respondents during your visit

In addition to the purpose of the assessment, briefly describe what information you need, whom you must speak with, and how long each interview or visit will take to complete. The visit will be most efficient if the IMR leader gathers beforehand as much of the following information as possible:

- Roster of IMR practitioners—(roles, full-time equivalents [FTEs]);
- Roster of IMR consumers for each employment specialist;
- Number of consumers in each IMR group;
- IMR group attendance sheets;
- Copy of the agency's IMR brochure;
- Copy of the IMR program mission statement;
- Copies of IMR curriculum and educational handouts;
- Total number of consumers that the IMR program served in the previous year; and
- Number of consumers who dropped out of the IMR program in the previous year.

Reassure the IMR leader that you will be able to conduct the assessment, even if all of the requested information is unavailable. Indicate that some information is more critical than other information (for example, number of IMR consumers and attendance sheets). Tell the contact person that you must observe at least one IMR session during your visit. This is an important factor in determining when you should schedule your visit.

Alert your contact person that you will need to sample 10 charts

From an efficiency standpoint, it is preferable that the charts be drawn beforehand, using a random selection procedure. There may be a concern that the evaluation may be invalidated if IMR practitioners hand-pick charts or update them before the visit. If you both understand that the goal is to better learn how the program is implementing services, this is less likely to occur.

In addition, you can further ensure some level of random selection by asking for 10 charts to rate, and randomly selecting 5 to review. Other options include asking the IMR program for a *de-identified list* (a list with names removed) of consumers and using the list to choose 5 charts to review.

Clarify reporting procedures

With the appropriate people (agency administrators, the mental health authority, or the IMR leader), clarify who should receive a report of the assessment results. Recipients may include the following:

- Agency administrators;
- Members of the agency's quality assurance team;
- Members of the IMR advisory group;
- The IMR leader, coordinator/director;
- IMR practitioners; and
- Consumers and families.

Assessors should also clarify how the agency would like the report to be distributed. For example, assessors may mail or fax the report and follow up to discuss the results in a meeting or by conference call.

Organize your assessment materials

Three forms have been created to help you conduct your assessment:

- The first form is the cover sheet for the IMR Fidelity Scale and General Organizational Index, which is intended to help you organize your process assessment. It captures general descriptive information about the agency, data collection, and community characteristics.
- The second and third forms are score sheets for two scales. They help you compare assessment ratings from one time period to the next. They may also be useful if you are interested in graphing results to examine your progress over time.

For the IMR Fidelity Scale and General Organizational Index instruments, cover sheet, and score sheets, see *Appendixes A, B,* and *D*. You can also print these forms from the CD-ROM in the KIT.

During your assessment visit

Tailor your terminology

To avoid confusion during your interviews, tailor the terminology you use. For example, an IMR program may use *member* for *consumer* or *clinician* for *practitioner*. Every agency has specific job titles for particular staff roles. By adopting the local terminology, you will improve communication.

Conduct your chart review

It is important that your chart review is conducted from a representative sample of charts. When you begin your chart review, note whether your sample reflects consumers in different stages of treatment. You should also note whether your sample includes consumer charts from each IMR practitioners' caseload. If your random sample is not representative in this manner, consider supplementing your sample with selected charts that will increase its representativeness.

Within each chart, examine the screening, referral, assessment, and treatment planning forms. Review recent Progress Notes to understand the amount and type of contact that IMR practitioners have with the consumers on their caseloads. If Progress Notes are not integrated into consumer charts, ask if IMR practitioners have any additional files that you may review.

In some cases, a lag may exist between when a service is given and when it is documented in the consumer's chart. To get the most accurate representation of services rendered when you sample chart data, try to gather data from the most recent time period in which documentation is completed in full.

To ascertain the most up-to-date time period, ask the IMR leader, practitioners, or administrative staff. Avoid getting an inaccurate sampling of data where office-based services might be charted more quickly than services given in the field.

If discrepancies between sources occur, query the IMR leader

The most common discrepancy is likely to occur when the IMR leader's interview gives a more idealistic picture of the team's functioning than the chart and observational data. For example, on the IMR Fidelity Scale, *Involvement of significant others* (Item 5) assesses the level of family member or other supporters' involvement in IMR services. Practitioners may report that involving significant others in the IMR program was a common practice, while involving significant others was not documented in the charts that were reviewed.

To understand and resolve this discrepancy, the assessor may ask the IMR leader the following:

> Our chart review shows very little family involvement, but your estimate is much higher. Would you help us to understand the difference?

Often the IMR leader can provide information that will resolve the discrepancy.

Before you leave, check for missing data

Fidelity scales should be completed in full, with no missing data on any items. Check in with the IMR leader at the end.

After your assessment visit

Follow up

It is important to collect any missing data before completing your rating. If necessary, follow up on any missing data (for example, by calling or sending an email). This would include discussing with the IMR leader any discrepancies between data sources that you notice after you've completed the visit.

Score your scales

Use the IMR Fidelity Scale and General Organizational Index Protocols to score the IMR program. If you assess an agency for the first time to determine which components of the evidence-based model the agency already has in place, some items may not apply. If an item cannot be rated, code the item as "1."

Ratings are based on current behavior and activities, not on planned or intended behavior. For example, to get full credit (to code the item as "5") *for Program Length* (Item 2), the agency must currently offer IMR sessions. If the agency plans future changes in this area but does not yet offer services, it would not receive credit

To receive full credit, many items require that the IMR leader and practitioners understand and apply the evidence-based practice principle. If IMR staff generally do not understand the concepts, then code that item as "1." If they understand parts of the concept and apply the understanding consistently, code the item as "3." To receive full credit, there must be evidence that the concepts are applied consistently.

For a complete explanation of how to rate each item, see the IMR Fidelity Scale and General Organizational Index Protocols in *Appendixes C* and *E*.

Complete scales independently

If you have two assessors, both should independently review the data collected and rate the scales. They should then compare their ratings, resolve any disagreements, and devise a consensus rating.

Complete the score sheets

Tally the item scores and determine which level of implementation was achieved.

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Monitor Outcomes

Unlike the IMR process measures that must be used in full to comprehensively understand how services are provided, you must decide which outcome measures will be most informative for your IMR program. Initially, your outcomes monitoring system should be simple to use and maintain. Complexity has doomed many well-intended attempts to collect and use outcome data.

One way to simplify is to limit the number of outcome measures used. Select your outcome measures based on the type of information that will be most useful to your agency.

Based on the research literature, we suggest that you monitor a core set of outcomes such as the following:

- Knowledge about mental illnesses;
- Psychiatric or substance abuse hospitalization;
- Distress from symptoms;
- Medication use;
- Independent living;
- Competitive employment;
- Educational involvement; and
- Stage of substance abuse treatment.

We also recommend that IMR practitioners and consumers complete the outcome surveys in *Appendixes F* and *G*. These outcomes reflect the primary goals of IMR.

What Is the Consumer Outcomes Monitoring Package?

Sponsored in part by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Consumer Outcomes Monitoring Package (COMP) was designed by a team at the School of Social Welfare, University of Kansas. This computer application allows agencies to choose from a pre-established list of outcomes developed for each evidence-based practice. Data may be entered for the chosen outcomes, and reports can be generated quarterly or monthly. The COMP also allows agencies to view their outcome data using tables and graphs.

The designers of COMP tried to make the computer application as easy and flexible to use as possible. You may access COMP through the Web. Agencies can download the computer application and print out *Installation Instructions* and a *User Manual,* which provides definitions and forms.

To download COMP:

- Go to **http://research.socwel.ku.edu/ebp**
- Click on the link to the download page.
- Click the links to download the *Installation Instructions* and a *User Manual*.
- Follow the instructions to install the application.

It is important for you to capture outcomes in a way that is most useful for your program. For data to be useful, they must be valid. That is, the data must measure what they are supposed to measure. Thus, the outcomes must be few and concrete for practitioners to focus on key outcomes, to understand them in a similar way, and to make their ratings in a consistent and error-free fashion.

To enhance validity, we recommend using simple ratings initially. Limiting your outcome measures to concrete measures will also allow you to collect data from IMR practitioners.

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Develop procedures

Agencies may choose to develop the outcomes portion of their quality assurance system from scratch or use existing outcomes monitoring systems. A number of electronic evaluation programs are available to help you develop comprehensive, integrated, user-friendly outcome monitoring systems. Examples include the following:

- Publicly available tools such as the Consumer Outcomes Monitoring Package (see the next page), and Decision Support 2000+ Online **(http://www.ds2kplus.org)**; or
- Various commercially available products.

When deciding whether to use an existing outcomes monitoring package or to design your own, it is important to keep your agency's capabilities in mind. The system must not create undue burden for IMR practitioners, and it must provide information to them that is useful in their jobs.

The system should fit into the workflow of the organization, whether that means making ratings on paper, using the COMP computer application, or developing your own outcomes monitoring package. Start with whatever means are available and expand the system from there. In the beginning, you may collect data with a simple report form and you can report hand-tallied summaries to IMR practitioners.

Computer software that allows for data entry and manipulation (for example, Microsoft Access, Excel, and Lotus) makes tabulating data and graphing easier than if done by hand. A computerized system for data entry and report generation presents a clear advantage and it may be the goal, but do not wait for it. Feedback does not have to come from a sophisticated computer system to be useful. It is more important that it is meaningful and frequent. For a sample Outcomes Report Form, which is an example of a simple, paper-based way to collect participation and outcome data regularly, see *Appendix H*. For instructions for using the Outcomes Report Form, see *Appendix I*.

Expanding Your Outcome Measures

Once you have established your core outcomes monitoring system, learned how to routinely collect data, and are accustomed to using it to improve your IMR program, you will be ready to expand your outcome measures. Consider asking consumers and families for input on improving your IMR program, both practically and clinically. Consumers and families are important informants for agencies that are seeking to improve outcomes. Agencies may want to know the following:

- If consumers and families are satisfied with their services;
- How services have affected their quality of life; and
- Whether consumers believe the services are helping them achieve their recovery goals.

While collecting data from consumers and families requires more staff time than the information that may be reported quickly by IMR practitioners, consumers and families can give valuable feedback.

We recommend the following surveys for collecting information from consumers and families:

- The Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey at **http://www.mhsip.org**
- Recovery measurement instruments such as those described in *Measuring the Promise: A Compendium of Recovery Measures, Volume II,* available through **http://www.tecathsri.org**

It is difficult to obtain a representative sample of consumer and family respondents since mailed surveys are often not returned and interviews may be done with people who are cooperative and easy to reach. Samples that are not representative may be biased.

Avoid bias in your consumer and family data by using different mechanisms to conduct your assessments. For example, consider combining feedback collected through surveys with that obtained through focus groups. Another option is to hire a consultant to conduct qualitative interviews with a small group of consumers or families.

How often should you collect outcomes data?

Plan to monitor the outcomes for consumers in your IMR program every 3 months and share the data with your IMR team. Collecting data at regular and short intervals will enhance the reliability of your outcome data.

While we recommend that you design a system for collecting outcomes early in the implementation process, IMR programs should not expect to see the desired results until the program is fully operational. Depending on the resources available to your program, this may take anywhere from 6 to 18 months to accomplish.

How should you identify data collectors?

Agency administrators or mental health authorities may assign the responsibility for collecting outcomes data to the following:

- The IMR leader, coordinator, or director;
- Members of the EBP advisory group;
- The quality assurance team;
- Independent consultants, including consumers and family members; and
- Other staff.

Unlike collecting process measures, collecting outcome measures does not require a daylong assessment process. Many standard outcome measures will be information that IMR practitioners can report from their daily work with consumers.

It is important to develop a quick, easy, standardized approach to collect outcome data. For example, create a simple form or computer database that IMR practitioners can routinely update

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EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Use Data to Improve Illness Management and Recovery Program

As you develop a quality assurance system, IMR leaders and practitioners will weave it into the fabric of their daily routines. Process assessments will give you a window into the demanding work done every day. Outcome reports will give you tangible evidence of the use and value of services, and they will become a basis for decisionmaking and supervision.

At some point, your IMR team may wonder how they did their jobs without an information system. They will come to view it as an essential ingredient of well-implemented evidence-based practices.

Create reports from your assessments

For your process data, in addition to completing the IMR Fidelity Scale, General Organizational Index, and score sheets, assessors should write a report explaining their scores. The report should include the following:

- An interpretation of the results of the assessment;
- Strengths and weaknesses of the IMR program; and
- Clear recommendations to help the program improve.

The report should be informative, factual, and constructive.

When summarizing outcome data, start with simple, easy-to-read reports. Then let experience determine what additional reports you need. You can design your reports to give information about individual consumers, a single practitioner's caseload, or the program as a whole. For example, reports generated for individual consumers may track the consumer's participation in specific IMR services and outcomes over time. You could enter these reports in consumers' charts and they could be the basis for discussions about the consumer's progress.

Use tables and graphs to understand your outcomes data

After the first process and outcome assessments, it is often useful to provide a visual representation of a program's progress over time. We recommend that you use tables and graphs to report the results.

By graphing your fidelity score, you have a visual representation of how your IMR program has changed over time. For an example, see Figure 1. For your process data, you may simply graph the results using a spreadsheet and include this in your report.

When your program shows greater fidelity over time, the graph will display it and reinforce your efforts. In addition, as you can see in Figure 1, the graph allows you to quickly compare how one team compares to another. In this example, Team A struggled in the first 6 months. Understanding Team A's progress compared to Team B's allowed the teams to partner and share strategies. Consequently, Team A improved dramatically over the next 6-month period.

Figure 1. Fidelity Over Time

Note: 52 – 65 = good implementation
39 – 51 = fair implementation
38 and below = not evidence-based practice

Another feature of graphing assessment scores is to examine the cut-off scores for *"fair"* (39) or *"good"* (52) implementation. Your program can use these scores as targets.

Here are three examples of tables and graphs that can help you understand and use your outcomes data.

Example 1: Periodic summary tables

Periodic summary tables summarize your outcomes data each quarter and address these kinds of questions:

- How many consumers participated in our IMR program during the last quarter?
- What proportion of consumers in our IMR program was hospitalized last quarter?
- How did the hospitalization rate for those participating in IMR compare to the rate for consumers in standard treatment?

Agencies often use this type of table to understand consumer participation or to compare actual results with agency targets or goals. These tables are also frequently used to describe agencies' services in annual reports or for external community presentations.

Table 1: Sample Periodic Summary Table of Enrollment in Evidence-Based Practices

	Not eligible	Eligible but NOT in EBP service	Enrolled	Percent of eligible consumers enrolled
Illness Management and Recovery	0	30	60	67
Supported Employment	30	25	90	78

This agency provides both Illness Management and Recovery and Supported Employment (SE) services. The IMR team identified 90 consumers for the program. Of those, 60 receive IMR, while 30 consumers are eligible but receive another service. Consequently, 67 percent of consumers eligible for IMR currently participate in the program.

Example 2: Movement tables

Tables that track changes in consumer characteristics (called *movement tables*) can give you a quick reference for determining service effectiveness. For example, Table 2 compares consumers' residential status between two quarters.

Table 2: Sample Movement Table

		To FY '06 Qtr 3				
		Institutional	Substantial care	Semi-independent	Independent	Total
From: FY '01 Qtr: 2	Institutional	2	1	1	3	7
	Substantial care	3	8	1	3	15
	Semi-independent	1	0	2	4	7
	Independent	1	3	2	100	106
	Totals	7	12	6	110	135

Above the diagonal
Below the diagonal
Within the diagonal

To create this table, the data were collapsed into the four broad categories. The vertical data cells reflect the residential status for consumers for the beginning quarter. The horizontal data cells reflect the most recent quarterly information. The residential status categories are then ordered from the most restrictive setting *(institutional)* to the least restrictive *(independent)*.

The data in this table are presented in three colors. The purple cells are those above the diagonal, the green cells are those below the diagonal, and the white cells are those within the diagonal. The data cells above the diagonal represent consumers who moved into a less restrictive environment between quarters. As you can see, one consumer moved from institutional to substantial care, one to semi-independent care, and three to independent living. In addition, one consumer moved from substantial care to semi-independent care, three consumers moved from substantial care to independent living, and four consumers moved from semi-independent

care to independent living. These 13 consumers (10% of the 135 consumers in the program) moved to a more desirable stage of treatment between quarters.

The data reported in the diagonal cells ranging from the upper left quadrant to the lower right reflect consumers who remained in the same residential status between quarters. Two consumers were in an institution for both quarters of this report; 8 remained in substantial care, 2 in semi-independent and 100 in independent living. These 112 consumers (83% of the 135 consumers in the program) remained stable between quarters.

The cells below the diagonal line represent consumers who moved into a more restrictive setting between quarters. Three consumers moved from substantial to institutional care, one consumer moved from semi-independent care to institutional care, one consumer moved from independent living to institutional care, three moved from independent living to substantial care, and two moved from independent living to semi-independent care. These 10 consumers (7% of the 135 consumers in the program) experienced some setbacks between quarters. The column totals show the number of consumers in a given residential status for the current quarter, and the row totals show the prior quarter.

You can use movement tables to portray changes in outcomes that are important to consumers, supervisors, and policymakers. The data may stimulate discussion around the progress that consumers are making or the challenges with which they are presented.

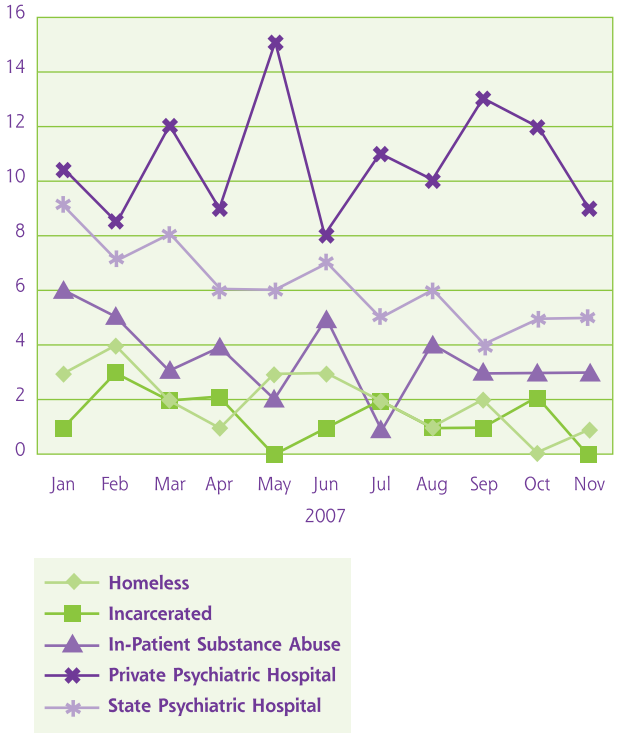
Example 3: Longitudinal plots

A longitudinal plot is an efficient and informative way to display participation or outcome data for more than two successive periods. The goal is to view performance in the long term. You can use a longitudinal plot for a consumer, a caseload, a specific EBP, or an entire program. A single plot can also contain longitudinal data for multiple consumers, caseloads, or programs for comparison. Figure 2 presents an example of a longitudinal plot comparing critical incidents for one IMR team over an 11-month period.

incidents for the IMR team appear to be going in a positive direction (that is, there is a reduction in incidence).

Longitudinal plots are powerful feedback tools because they permit a longer range perspective on participation and outcome, whether for a single consumer or a group of consumers. They enable a meaningful evaluation of the success of a program, and they provide a basis for setting goals for future performance.

Figure 2. Sample Longitudinal Plot for Monthly Frequency of Negative Incidents for Consumers



Share your results

The single factor that will most likely determine the success of a quality assurance system is its ability to give useful and timely feedback to key stakeholders. It is fine to worry about what to enter into a system, but ultimately its worth is in converting data into meaningful information. For example, the data may show that 20 consumers worked in a competitive job during the past quarter, but it is more informative to know that this represents only 10 percent of the consumers in the IMR program.

For information to influence practice, it must be understandable and meaningful, and it must be delivered in a timely way. In addition, the quality-assurance system must tailor the information to suit the needs of various users and to answer their questions.

Sharing results with IMR practitioners

After each assessment, dedicate time during a supervisory meeting to discuss the results. Numbers that reflect above average or exceptional performance should trigger recognition, compliments, or other rewards. Data that reflect below average performance should provoke a search for underlying reasons and should generate strategies that offer the promise of improvement. By doing this regularly, IMR leaders will create a learning organization characterized by adaptive responses to information that aim to improve consumer outcomes.

Sharing results with your IMR advisory group or quality assurance team

You may also use this information to keep external stakeholders engaged. Sharing information with vested members of the community, staff from your mental health authority, and consumer and family advocates can be valuable. Through these channels, you may develop support for the IMR program, increase consumer participation, and raise private funds for your agency.

Sharing results internally

Agencies may distribute reports during all staff and manager-level meetings to keep staff across the agency informed and engaged in the process of implementing IMR. Agencies with successful IMR programs highlight the importance of developing an understanding and support for the IMR model across the agency.

In addition, integrating consumer-specific reports into clinical charts may help you monitor consumers' progress over time. Reporting consumer-specific outcome information at the treatment team meetings also helps keep the team focused on consumers' goals.

Sharing results with consumers and families

Agencies may highlight assessment results in consumer and family meetings. Increasing consumers' and families' understanding of the IMR program may motivate them to participate in the treatment process and build trust in the consumer-provider relationship.

Also, sharing results may create hope and enthusiasm for your IMR program. Sharing information motivates people and stimulates changes in behavior. Sharing the results of your assessments with a variety of stakeholders is the key to improving your program

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix A: Cover Sheet—Illness Management and Recovery Fidelity Scale and General Organizational Index

Cover Sheet: Illness Management and Recovery Fidelity Scale and General Organizational Index

Assessors' names: _____ **Today's date:** _____/___/_____

_____

_____

Program name (or program code): _____

Agency name: _____

Agency address: _____
Street

_____
City State ZIP code

IMR leader or contact person: _____

Names of the IMR practitioners: _____

Telephone: (___) _____–_____ **E-mail:** _____

Sources used for assessments:

- ❑ **Chart review:** **Number reviewed:** _____
- ❑ **Progress Notes reviewed:** **Number reviewed:** _____
- ❑ **IMR curriculum review**
- ❑ **Brochure review**
- ❑ **IMR session/group observation**
- ❑ **IMR director/coordinator interview**
- ❑ **IMR leader interview**
- ❑ **IMR practitioner interviews:** **Number interviewed:** ____
- ❑ **Consumer interviews:** **Number interviewed:** ____
- ❑ **Family member interviews:** **Number interviewed:** ____
- ❑ **Other staff interviews:** **Number interviewed:** ____
- ❑ **Other** _____

Number of IMR practitioners: _____

Number of current IMR consumers: _____

Number of consumers served last year: _____

Funding source: _____

Agency location:

- ❑ **Urban**
- ❑ **Rural**

Date program was started: _____/_____/_____

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix B: Illness Management and Recovery Fidelity Scale and Score Sheet

Illness Management and Recovery Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
Staffing						
1.	**Number of people in a session or group:** IMR is taught individually or in groups of 8 or fewer consumers.	Some sessions taught with more than 15 consumers	Some sessions taught with 13–15 consumers	Some sessions taught with 11–12 consumers	Some sessions taught with 9–10 consumers	All IMR sessions taught individually or in groups of 8 or fewer
2.	**Program length:** Consumers receive at least 3 months of weekly IMR sessions or equivalent (for example, every 2 weeks for at least 6 months).	Less than 20% of IMR consumers receive at least 3 months of weekly sessions	20–39% of IMR consumers receive at least 3 months of weekly sessions	40–69% of IMR consumers receive at least 3 months of weekly sessions	70–89% of IMR consumers receive at least 3 months of weekly sessions	At least 90% of IMR consumers receive at least 3 months of weekly sessions
3.	**Comprehensiveness of the curriculum:** ■ Recovery strategies ■ Practical facts about mental illnesses ■ Stress-Vulnerability Model and treatment strategies ■ Building social support ■ Using medication effectively ■ Drug and alcohol use ■ Reducing relapses ■ Coping with stress ■ Coping with problems and persistent symptoms ■ Getting your needs met in the mental health system.	■ Curriculum materials include only 1 topic OR ■ Educational handouts are not available	Curriculum materials include 2 or 3 topic areas	Curriculum materials include 4 or 5 topic areas	Curriculum materials include 6 or 7 topic areas	Curriculum materials include 8 or more topic areas
4.	**Provision of educational handoutst:** All consumers participating in IMR receive IMR handouts.	Less than 20% of IMR consumers receive educational handouts	20–39% of IMR consumers receive educational handouts	40–69% of IMR consumers receive educational handouts	70–89% of IMR consumers receive educational handouts	At least 90% of IMR consumers receive educational handouts
5.	**Involvement of significant others:** ■ At least 1 IMR-related contact in the last month OR ■ Involvement with the consumer in pursuing goals (for example, helping with homeworks.	Less than 20% of IMR consumers have significant others involved	20–29% of IMR consumers have significant others involved	30–39% of IMR consumers have significant others involved	40–49% of IMR consumers have significant others involved	At least 50% of IMR consumers have significant others involved

Illness Management and Recovery Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
Assignments						
6.	**IMR goal-setting:** ■ Realistic and measurable ■ Individualized ■ Pertinent to recovery process ■ Linked to IMR plan	Less than 20% of IMR consumers have at least 1 personal goal in chart	20%–39% of IMR consumers have at least 1 personal goal in chart	40–69% of IMR consumers have at least 1 personal goal in chart	70–89% of IMR consumers have at least 1 personal goal in chart	At least 90% of IMR consumers have at least 1 personal goal in their chart
7.	**IMR goal followup:** Practitioners and consumers collaboratively follow up on goals (See examples in *Training Frontline Staff* in this KIT.)	Less than 20% of IMR consumers have followup on goals documented in chart	20–39% of IMR consumers have followup on goals documented in chart	40–69% of IMR consumers have followup on goals documented in chart	70–89% of IMR consumers have followup on goals documented in chart	At least 90% of IMR consumers have followup on the goals documented in their chart
8.	**Motivation-based strategies:** ■ New information and skills ■ Positive perspectives ■ Pros and cons of change ■ Hope and self-efficacy	Less than 20% of IMR sessions use at least 1 motivation-based strategy	20–29% of IMR sessions use at least 1 motivation-based strategy	30–39% of IMR sessions use at least 1 motivation-based strategy	40–-49% of IMR sessions use at least 1 motivation-based strategy	At least 50% of IMR sessions use at least 1 motivation-based strategy
9.	**Educational techniques:** ■ Interactive teaching ■ Checking for understanding ■ Breaking down information ■ Reviewing information	Less than 20% of IMR sessions use at least 1 educational technique	20–29% of IMR sessions use at least 1 educational technique	30–39% of IMR sessions use at least 1 educational technique	40–49% of IMR sessions use at least 1 educational technique	At least 50% of IMR sessions use at least 1 educational technique
10.	**Cognitive-behavioral techniques:** ■ Reinforcement ■ Shaping ■ Modeling ■ Role playing ■ Cognitive restructuring ■ Relaxation training	Less than 20% of IMR sessions use at least 1 cognitive-behavioral technique	20–29% of IMR sessions use at least 1 cognitive-behavioral technique	30–39% of IMR sessions use at least 1 cognitive-behavioral technique	40–49% of IMR sessions use at least 1 cognitive-behavioral technique	At least 50% of IMR sessions use at least 1 cognitive-behavioral technique

Illness Management and Recovery Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
11.	**Coping skills training:** ■ Review current coping ■ Amplify current coping or develop new coping skills ■ Behavioral rehearsal ■ Review effectiveness ■ Modify as necessary	Few or none of the practitioners are familiar with the principles of coping skills training	Some of the practitioners are familiar with the principles of coping skills training, with a low level of use	Some of the practitioners are familiar with the principles of coping skills training, with a moderate level of use	The majority of the practitioners are familiar with the principles of coping skills training and use it regularly	All practitioners are familiar with the principles of coping skills training and use it regularly
12.	**Relapse Prevention Training:** ■ Identify triggers ■ Identify early warning signs ■ Stress management ■ Ongoing monitoring ■ Rapid intervention as needed	Few or none of the practitioners are familiar with the principles of relapse prevention training	Some of the practitioners are familiar with the principles of relapse prevention training, with a low level of use	Some of the practitioners are familiar with the principles of relapse prevention training, with a moderate level of use	The majority of the practitioners are familiar with the principles of relapse prevention training and use it regularly	All practitioners are familiar with the principles of relapse prevention training and use it regularly, as documented by relapse prevention plans in consumers' charts
13.	**Behavioral tailoring for medication:** Behavioral tailoring includes developing strategies tailored to each consumer's needs, motives, and resources (for example, choosing medication that requires less frequent dosing, and placing medication next to one's toothbrush).	Few or none of the practitioners are familiar with the principles of behavioral tailoring for medication	Some of the practitioners are familiar with the principles of behavioral tailoring for medication, with a low level of use	Some of the practitioners are familiar with the principles of behavioral tailoring for medication, with a moderate level of use	The majority of the practitioners are familiar with the principles of behavioral tailoring for medication and use it regularly	All practitioners are familiar with the principles of behavioral tailoring for medication and either teach or reinforce it regularly

Score Sheet: Illness Management and Recovery Fidelity Scale

Agency name: _____ **Date of visit:** _____/___/_____

Assessors' names: _____

_____

		Assessor 1	Assessor 2	Consensus
1	Number of people in session or group			
2	Program length			
3	Comprehensiveness of curriculum			
4	Provision of educational handouts			
5	Involvement of significant others			
6	IMR goal setting			
7	IMR goal followup			
8	Motivation-based strategies			
9	Educational techniques			
10	Cognitive-behavioral techniques			
11	Coping skills training			
12	Relapse prevention training			
13	Behavioral tailoring for medications			
	Total mean score			

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix C: Illness Management and Recovery Fidelity Scale Protocol

Illness Management and Recovery Fidelity Scale Protocol

The Illness Management and Recovery (IMR) Fidelity Scale Protocol explains how to rate each item of the IMR Fidelity Scale. In particular, it provides:

- A definition and rationale for each fidelity item. These items have been derived from controlled research on illness management.
- A list of data sources most appropriate for each fidelity item (such as chart review, IMR leader, coordinator or director, IMR practitioners, and consumer interviews).

When appropriate, a set of probe questions is provided to help you elicit the critical information needed to score the fidelity item. These probe questions were specifically generated to help you collect information from respondents that is relatively free from bias, such as social desirability.

Decision rules will help you score each item correctly. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

Note 1: Items 8-13 are rated on the practitioners' skill level. If all sources of information corroborate that the IMR practitioners embrace the principles of AND regularly use the skills and techniques identified in items 8-13, then the program would receive full credit for these items EVEN if the curriculum in these areas is poor or the program is new and not providing a full-fledged IMR.

Note 2: Items are rated on current behavior and activities, not planned or intended behavior. For example, to get full credit for Item 5 *(Involvement of significant others)*, it is not enough that the program is planning to ask consumers about involving family members or other supporters.

Initial questions

- Which practitioners are providing IMR training?
- Which consumers have you identified as receiving IMR?

The fidelity assessment refers only to these practitioners and consumers.

Note: Ask the program leader (that is, the IMR leader) to identify members of the IMR team and consumers in the program. The definition of the target population of consumers receiving the IMR interventions will influence the fidelity ratings. If the definition is inclusive, the site will have a high penetration rate but possibly a low fidelity rating. Conversely, if the group is restricted to a small number, the site will have a low penetration rate but possibly a high fidelity rating.

In the following questions, modify the wording of the program leader interview by beginning with the phrase, "Do the practitioners you supervise in providing IMR …"

1. Number of people in a session or group

Definition: IMR is taught individually or in groups of eight or fewer consumers.

Rationale: IMR can be taught using either an individual or group format; each has its advantages. The main advantages of the individual format include individualized pacing of the teaching and increased attention. The group format, on the other hand, gives consumers more sources of feedback, support, and role models and may be more economical; however, if the group size exceeds eight consumers, individualized attention and consumers' participation are likely to be compromised.

Sources of information:

1. **Program leader and practitioner interviews**
   - "Do you teach IMR both individually and in a group format?" [If *yes*, "On what condition do you provide individual sessions?"]
   - "How many consumers were in the largest group you have taught in the last 6 months?"
2. **Consumer interview**
   - "Do you attend individual or group IMR sessions? Did you have a choice between the two formats?"
   - "How many consumers were in the largest group you have ever attended?"

Item response coding: If all IMR sessions are taught individually or in groups of eight or fewer consumers, code the item as "5." In some programs, more than one practitioner may co-instruct a large group session. In such a case, the rating depends on the amount of individual attention given during the session. For

example, if three practitioners break up a class of 15 consumers into smaller groups of 5 for discussion or exercises, then code the item as "5."

2. Program length

Definition: Consumers receive at least 3 months of weekly IMR sessions or an equivalent number of IMR sessions (for example, twice a month for at least 6 months).

Rationale: In general, between 3 and 10 months of weekly or biweekly sessions are required to learn the information and skills in the IMR curriculum. The length of time depends on the frequency and duration of sessions, consumers' prior knowledge and level of skills, and the presence of cognitive impairment or symptoms. After completing all topics, consumers may also benefit from booster sessions or support groups aimed at using and expanding skills.

Note: Rate the scheduled duration of the training as planned by the practitioner. Exclude from consideration of program length consumers who drop out prematurely.

Sources of information:

1. **Chart review for consumers who completed the program:** Look for frequency of sessions and program length per consumer.
2. **Program leader and practitioner interviews**
   - "How long and how often are your IMR sessions?"
   - "On average, how long does it take for a consumer to complete your IMR program?"
   - "Do you find that some consumers require only a couple of sessions of IMR?"
3. **Customer interview**
   - "How often do you attend the IMR sessions here? How long is a session?"
   - "How long have you been with this program?" [*If less than 3 months,* "How long do you plan to continue with this program?"]

Item response coding: If 90 percent or more of IMR consumers receive weekly or an equivalent number of sessions for at least 3 months, code the item as "5."

3. Comprehensiveness of the curriculum

Definition:

- Recovery strategies;
- Practical facts about mental illnesses;
- The Stress-Vulnerability Model and treatment strategies;
- Building social support;
- Using medication effectively;
- Drug and alcohol use;
- Reducing relapses;
- Coping with stress;
- Coping with problems and symptoms; and
- Getting needs met in the mental health system.

Rationale: Studies have identified these 10 areas as key topics. More comprehensive curriculums are more beneficial for participating consumers.

Sources of information:

1. **Program leader and practitioner interviews**
   - "What kinds of topics are covered in the IMR sessions?"
   - "Is there an established curriculum for the IMR sessions?" [If *yes,* ask for a copy for review.] "Who developed the curriculum?"
   - [*To program leader*] "Do you train practitioners on the curriculum? How do you make sure that practitioners follow it?"
   - [*To practitioners*] "Have you received training on the curriculum?"

2. **Educational curriculum and handouts review**

   Look to see if the curriculum and handouts adequately cover the 10 areas. Do handouts reflect program philosophy and critical ingredients of IMR?

Item response coding: If the IMR curriculum materials cover eight or more topic areas, code the item as "5."

4. Provision of educational handouts

Definition: All consumers participating in IMR receive IMR handouts.

Rationale: An educational handout summarizes the main teaching points in plain language and includes useful forms and exercises. These handouts can be reviewed in the session as well as outside the session (such as for homework assignments). In addition, consumers can share the handouts with significant others to inform them about IMR.

Sources of information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of provision of educational handouts.
2. **Educational curriculum and handouts review**

   Look to see if the curriculum and handouts adequately cover the 10 areas.

   Do handouts reflect the program philosophy and critical ingredients of IMR? Are they written in simple language, tailored to both consumers and their significant others (such as information specifically for consumers as well as information specifically for significant others), and visually effective (for example, information is presented in an attractive and organized way)?
3. **Program leader and practitioner interviews**
   - "Do you provide consumers with educational materials? [If *yes*, ask for a copy for review.] "Who developed them?"
   - "Do all IMR consumers receive them? When do you provide them (for example, upon admission, in class)? How do you use them in the session?"
   - "What do you provide for consumers who cannot read?"
4. **Consumer interview**
   - "Do you use an educational handout or text in the IMR sessions?"
   - "When did you get the handout or text?
   - "How do you use the handout or text inside and outside the session?"

   Item response coding: If 90 percent or more of IMR consumers receive written (or alternative) educational materials, code the item as "5."

5. Involvement of significant others

Definition: *Significant other* refers to family members, friends, or any other person in consumer's support networks excluding professionals. *Involvement* means that the practitioner and the significant other had at least one IMR-related contact in the last month or that the significant other is involved with the consumer in pursuing goals identified in the IMR plan, such as helping the consumer with homework assignments.

Rationale: Research has shown that social support helps people generalize information and skills learned in sessions to their natural environment, leading to better social functioning. Social support also plays a critical role in reducing relapse and hospitalization for consumers. Because developing and enhancing natural support is one of IMR's goals, consumers are encouraged to identify significant others with whom they can share the handouts and who will support them in applying newly acquired skills. However, the decision to involve significant others is the consumer's choice.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation that significant others are involved.

2. Practitioner interviews

Go through the entire roster of IMR consumers. For each consumer, ask if a significant other has had a least one contact with IMR staff in the last month or worked with consumer to attain IMR goals.

- "In what way do you involve consumers' significant others?" [Then probe for specifics, for example, frequency of contact, frequency of homework assignments that require participation of significant others.]
- "What do you do if consumers refuse to involve their significant others?"

3. Consumer interview

- "Are your family members or friends involved in your treatment?" [If *yes*, "In what way?"]
- "Do they help you with your homework?"
- "Have they attended the sessions with you?"
- "Do they have regular contact with your practitioners?"
- "What has the program done to get them involved?"
- "Do you want them to be more involved?"

Item response coding: If 50 percent or more of IMR consumers involve significant others (that is, the practitioner reports at least monthly contact or the consumer reports involvement), code the item as "5."

6. IMR goal-setting

Definition: Practitioners help consumers identify meaningful personal goals that are realistic and measurable. The goals should be pertinent to the recovery process and very individualized. Goals in IMR reflect the desire to achieve specific, concrete changes in one's life and enjoyment of it. The more behaviorally specific the goal is, the better, although not all goals must be expressed in terms of behaviors. Goals generally involve at least one of the following themes:

- Improved role functioning (including ability to work, go to school, parent, or be a homemaker);
- Better social relationships (including quantity, quality, and enjoyment of relationships);
- Improved use of leisure time including both recreation (such as sports, hobbies, reading) and creativity (such as art, music, writing, or other forms of expressions);
- Reduced symptom severity or distress due to symptoms (including coping more effectively with specific symptoms);
- Improved health (such as increasing exercise, reducing the number of desserts, following through with doctor's recommendations for diabetes or hypertension, completing doses of antibiotics);
- Reduced alcohol or drug use or abuse (such as cutting down on the amount or frequency of drinking or using drugs, developing alternatives to using substances, developing relationships with people who don't use substances);
- Improved living situation (such as moving away from home, renting an apartment with roommates, living in supported housing, living independently, locating a better apartment, saving money to buy furnishings);
- More satisfying involvement in spirituality (including attending religious services, spending more time enjoying nature, meditating, volunteering for a charitable organization, reading religious works); or
- Improved finances (such as investigating ways to make more money, developing a budget, avoiding loaning money to others, decreasing expenses on specific items, reducing the number of meals eaten out).

Rationale: One of the objectives of the IMR program is to help consumers establish personally meaningful goals. In addition to being teachers, practitioners are collaborators in helping consumers learn how to cope with their illness and make progress toward their goals.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of IMR goals and collaborative goal-setting process.
2. **Program leader and practitioner interviews**
   - "Describe the process of IMR goal-setting."
3. **Consumer interview**
   - "What are your goals for IMR? Did your practitioner ask what your goals were?"

Item response coding: If 90 percent or more of IMR consumers have at least one measurable personal goal, code the item as "5."

7. IMR goal followup

Definition: Practitioners and consumers collaboratively follow up on goals identified in Item 6.

Rationale: A core value of IMR is to facilitate consumers' pursuit of their goals and progress in their recovery at their own pace. Therefore, the goals and the steps to be taken toward the goals need ongoing evaluation and modification.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of followup on IMR goals. (Examples are in *Training the Frontline Staff* in this KIT.)
2. **Program leader and practitioner interviews**
   - "Do you regularly review the consumers' progress towards achieving their IMR goals?" [If *yes*, "How often? Please describe the review process."]
   - "What do you do if consumers would like to change their IMR goals?"
3. **Consumer interview**
   - "Do you and your practitioner together review your progress toward achieving your personal goals? [If yes, How often? Please describe the review process."]

Item response coding: If 90 percent or more of IMR consumers have documentation of continued followup on their goals, code the item as "5."

8. Motivation-based strategies

Definition: Practitioners regularly use motivation-based strategies, which include the following:

- Helping consumers see how learning specific information and skills could help them achieve short- and long-term goals;
- Helping consumers explore the pros and cons of change;
- Helping consumers put past experiences in more positive perspectives; and
- Instilling hope and increasing self-efficacy (such as the belief that consumers can achieve the goal).

Rationale: Motivation-based strategies reflect the understanding that a therapeutic relationship must be established before attempts to provide IMR. Furthermore, unless consumers view learning specific information or skills as being relevant to their own needs or desires, they will not be motivated to learn.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of motivation-based strategies used in a session.

2. **Practitioner interview:** For each motivation-based strategy checked in the recent Progress Notes, probe for details by asking open-ended questions, for example, "I notice you checked 'explore pros and cons of change' in 6 of 10 sessions. Could you describe the process you used with the consumer to explore pros and cons of change in your most recent session?"

3. **Consumer interview:** For each of motivation-based strategies checked in the recent Progress Notes, probe for details using a layperson's language. For example, if most of the Progress Notes reviewed indicate "instilling hope and self-efficacy" as a common practice, ask, "Do the practitioners make you feel hopeful [confident]? Please describe how they made you feel that way in your most recent session."

Item response coding: If 50 percent or more of IMR sessions use at least one motivation-based strategy, code the item as "5."

9. Educational techniques

Definition: Practitioners embrace the concept of and regularly apply educational techniques, which include the following:

- Interactive teaching: Frequently pausing when presenting information to get consumers' reaction and perspective, talking about what the information means, and clarifying any questions that may arise.
- Checking for understanding: Asking consumers to summarize information in their own language rather than asking yes-or-no questions such as, "Did you understand?"
- Breaking down information: Providing information in small chunks.
- Reviewing information: Summarizing previously discussed information (both by the practitioner and the consumer).

Rationale: Educational techniques are the pillars in teaching basic information and ensuring that consumers understand. For example, interactive teaching not only makes learning an interesting and lively activity, but also conveys to consumers that they have important contributions to make to the learning process and that the practitioner is interested in what they have to say.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of educational techniques used in a session.

2. **Practitioner interview:** For each educational technique checked in the recent Progress Notes, probe for details by asking open-ended questions, for example, "I notice you checked 'interactive teaching' in 6 of 10 sessions. Could you describe the 'interactive teaching' in your most recent session?"

3. **Consumer interview:** For each educational technique checked in the recent Progress Notes, probe for details using a layperson's language. For example, if most of the Progress Notes reviewed show "checking for understanding" as a common practice, ask, "Do the practitioners check your understanding of the material covered during the session? Can you think about your most recent session and describe how they made sure you understood what was covered in the session?"

Item response coding: If 50 percent or more of IMR sessions use at least one educational technique, code the item as "5."

10. Cognitive-behavioral techniques

Definition: Practitioners regularly use cognitive-behavioral techniques to teach IMR information and skills, which include the following:

- Positive reinforcement: Positive feedback following a skill or behavior designed to increase it or to encourage consumers' efforts to use a skill.

- Shaping: Reinforcing successive approximations to a goal. The practitioner recognizes the multiple steps and individualized pacing necessary for consumers to learn complex skills and provides frequent reinforcement as they progress toward the goal.
- Modeling: Demonstration of skills.
- Role playing: A simulated interaction in which a person practices a behavior or skill.
- Cognitive restructuring: Practitioners help consumers describe the situation leading to the negative feeling, make a link between the negative emotions and the thoughts associated with those feelings, evaluate the accuracy of those thoughts, and, if they are found to be inaccurate, identify an alternative way of looking at the situation that is more accurate.
- Relaxation training: Teaching strategies to help consumers relax.

Rationale: There is strong evidence for the efficacy of cognitive-behavioral techniques in helping consumers develop and maintain social skills, use medication effectively, develop coping strategies for symptoms, and reduce relapses.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of cognitive-behavioral techniques used in a session.
2. **Practitioner interview:** For each cognitive-behavioral technique checked in the recent Progress Notes, probe for details by asking open-ended questions, for example, "I notice you checked 'cognitive restructuring' in 6 of 10 sessions. Could you describe the 'cognitive restructuring' in your most recent session?"
3. **Consumer interview:** For each cognitive-based strategy checked in the recent Progress Notes, probe for details using a layperson's language. For example, if most of the Progress Notes reviewed indicate "role playing" as a common practice, ask, "Do you get to practice new skills with others in the session [or as a homework]? How often? Could you give examples from your most recent session?"

Item response coding: If 50 percent or more of IMR sessions use at least one cognitive-behavioral technique, code the item as "5."

11. Coping skills training

Definition: Practitioners embrace the concept of, and systematically provide, coping skills training that includes the following:

- Exploring the coping skills that the consumer currently uses;
- Amplifying the current coping skills and teaching new coping strategies;
- Behaviorally rehearsing the coping skill;
- Evaluating the effectiveness of the coping skill; and
- Modifying the coping skill, as necessary.

Rationale: Coping skills training is used to improve consumers' ability to cope with persistent symptoms.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of coping skills training in a session.
2. **Practitioner interview:** For each practitioner who checked "coping skills training" in the recent Progress Notes, probe for details by asking open-ended questions, for example, "I notice you checked 'coping skills training' in 6 of 10 sessions. Could you describe the 'coping skills training' methods you used in your most recent session?"
3. **Consumer interview**

If coping skills training is shown as a common practice in the recent Progress Notes, probe for specific components by asking, "Have you talked about or learned new coping skills in your recent sessions? Could you give me some examples?"

- "Do you feel more confident today in your ability to cope with symptoms?"

Item response coding: If all practitioners are familiar with and regularly practice coping skills training, code the item as "5."

12. Relapse prevention training

Definition: Practitioners embrace the concept of relapse prevention training and systematically apply it, including the following:

- Identifying environmental triggers;
- Identifying prodromal signs;
- Stress management;
- Ongoing monitoring; and
- Rapid intervention when indicated.

Rationale: Studies have shown that training in relapse prevention strategies is effective in reducing symptom severity, relapses, and rehospitalization.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for actual relapse prevention plan or documentation of relapse prevention training in a session.
2. **Practitioner interview:** For each practitioner who checked "relapse prevention training" in the recent Progress Notes, probe for details by asking open-ended questions, for example, "I notice you checked 'relapse prevention training' in 6 of 10 sessions. Could you describe the 'relapse prevention training' methods you used in your most recent session?"
3. **Consumer interview:**

   If "relapse prevention training" is indicated in the recent Progress Notes as a common practice, probe for specific components using a layperson's language, for example, "Have you discussed ways that you can avoid going back to the hospital in your recent sessions? What kind of things did you learn about relapse prevention?"

   - "Do you feel more confident today in your skills in preventing a relapse?"

Item response coding: If all practitioners are familiar with and regularly practice relapse prevention training, code the item as "5."

13. Behavioral tailoring for medication

Definition: Practitioners embrace the concept of and use behavioral tailoring for medication. Behavioral tailoring includes developing strategies tailored to each consumer's needs, motives, and resources (for example, choosing medication that requires less frequent dosing or placing medication next to one's toothbrush so it is always taken before brushing teeth).

Rationale: Behavioral tailoring is especially effective in helping consumers manage their medication regime as prescribed.

Sources of Information:

1. **Chart review** (especially IMR Progress Notes): Look for documentation of behavioral tailoring in a session.
2. **Practitioner interview:** For each practitioner who checked "behavioral tailoring for medication" in the recent Progress Notes, probe for details by asking open-ended questions, for example, "I notice you checked 'behavioral tailoring for medication' in 6 of 10 sessions. Could you describe the 'behavioral tailoring for medication' methods you used in your most recent session?"
3. **Consumer interview:** If "behavioral tailoring for medication" is indicated in the recent Progress Notes as a common practice, probe for specific components using a layperson's language, for example, "Sometimes we miss taking medication and regret it later. Have you and your practitioner discussed what you can do at home to prevent that? Could you give us some examples of the strategies?"

   - "Do you feel more confident today in taking medication as prescribed?"

Item response coding: If all practitioners are familiar with and regularly either teach or reinforce behavioral tailoring, code the item as "5."

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix D: General Organizational Index and Score Sheet

General Organizational Index

	1	2	3	4	5
G1. Program philosophy Committed to clearly articulated philosophy consistent with specific evidence-based model, based on these 5 sources: ■ IMR leader ■ Senior staff (for example, executive director, psychiatrist) ■ Team members providing the EBP ■ Consumers and families receiving EBP ■ Written materials (such as, brochures)	No more than 1 of 5 sources shows clear understanding of program philosophy OR All sources have numerous major areas of discrepancy	2 of 5 sources show clear understanding of program philosophy OR All sources have several major areas of discrepancy	3 of 5 sources show clear understanding of program philosophy OR Sources mostly aligned to program philosophy, but have 1 major area of discrepancy	4 of 5 sources show clear understanding of program philosophy OR Sources mostly aligned to program philosophy, but have 1 or 2 minor areas of discrepancy	All 5 sources show clear understanding and commitment to program philosophy for specific EBP
***G2. Eligibility/Consumer identification** All consumers with serious mental illnesses in the community support program, crisis consumers, and institutionalized consumers are screened to determine whether they qualify for EBP using standardized tools or admission criteria consistent with EBP. Also, agency systematically tracks number of eligible consumers.	20% of consumers receive standardized screening and/or agency DOES NOT systematically track eligibility	21–40% of consumers receive standardized screening and agency systematically tracks eligibility	41–60% of consumers receive standardized screening and agency systematically tracks eligibility	61–80% of consumers receive standardized screening and agency systematically tracks eligibility	More than 80% of consumers receive standardized screening and agency systematically tracks eligibility
***G3. Penetration** Maximum number of eligible consumers served by EBP, as defined by the ratio: Number of consumers receiving EBP / Number of consumers eligible for EBP	Ratio .20	Ratio .21 – .40	Ratio .41 – .60	Ratio .61 – .80	Ratio > .80

* These two items coded based on all consumers with serious mental illnesses at the site or sites where EBP is being implemented; all other items refer specifically to those receiving the EBP.

	Total number of consumers in target population
	Total number of consumers eligible for EBP
	Total number of consumers receiving EBP

%	% eligible:
	Penetration rate

	1	2	3	4	5
G4. Assessment Full standardized assessment of all consumers who receive EBP services. Assessment includes: ■ History and treatment of medical; psychiatric; substance use disorders ■ Current stages of all existing disorders ■ Vocational history ■ Any existing support network ■ Evaluation of biopsychosocial risk factors	Assessments are completely absent or completely non-standardized	Pervasive deficiencies in 2 of the following: ■ Standardization ■ Quality of assessments ■ Timeliness ■ Comprehen-siveness	Pervasive deficiencies in 1 of the following: ■ Standardization ■ Quality of assessments ■ Timeliness ■ Comprehen-siveness	61%-80% of consumers receive standardized, high-quality assessments at least annually OR Information is deficient for 1 or 2 assessment domains	More than 80% of consumers receive standardized, high-quality assessments; the information is comprehensive across all assessment domains and updated at least annually
G5. Individualized treatment plan For all EBP consumers, an explicit, individualized treatment plan exists *related to the EBP* that is consistent with assessment and updated every 3 months	Less than 20% of consumers EBP serves have explicit individualized treatment plans, *related to EBP*, updated every 3 months	21–40% of consumers EBP serves have explicit individualized treatment plans, *related to EBP*, updated every 3 months	41–60% of consumers EBP serves have explicit individualized treatment plans, *related to EBP*, updated every 3 months OR Individualized treatment plan updated every 6 months for all consumers	61–80% of consumers EBP serves have explicit individualized treatment plans, *related to EBP*, updated every 3 months	More than 80% of consumers EBP serves have explicit individualized treatment plans *related to EBP*, updated every 3 months
G6. Individualized treatment All EBP consumers receive individualized treatment meeting goals of EBP	20% of consumers EBP serves receive individualized services meeting goals of EBP	21–40% of consumers EBP serves receive individualized services meeting goals of EBP	41–60% of consumers EBP serves receive individualized services meeting goals of EBP	61–80% of consumers EBP serves receive individualized services meeting goals of EBP	More than 80% of consumers EBP serves receive individualized services meeting goals of EBP
G7. Training All new team members receive standardized training in EBP (at least a 2-day workshop or equivalent) *within 2 months after hiring*. Existing team members receive annual refresher training (at least 1-day workshop or equivalent).	20% of program staff receive standardized training annually	21–40% of program staff receive standardized training annually	41–60% of program staff receive standardized training annually	61–80% of program staff receive standardized training annually	More than 80% of program staff receive standardized training annually
G8. Supervision IMR team members receive structured, weekly supervision (group or individual format) from a team member experienced in particular EBP. Supervision should be consumer-centered and explicitly address EBP model and its application *to specific consumer situations*.	20% of EBP practitioners receive supervision	21–40% of EBP practitioners receive weekly structured, consumer-centered supervision OR All EBP practitioners receive informal supervision	41–60% of EBP practitioners receive weekly structured, consumer-centered supervision OR All EBP practitioners receive monthly supervision	61–80% of EBP practitioners receive weekly structured, consumer-centered supervision OR All EBP practitioners receive supervision 2 times a month	More than 80% of EBP practitioners receive structured weekly supervision, focusing on specific consumers, in sessions *that explicitly address EBP model and its application*

	1	2	3	4	5
G9. Process monitoring Supervisors and IMR leaders monitor process of implementing EBP every 6 months and use the data to improve program. Monitoring involves a standardized approach, for example, using fidelity scale or other comprehensive set of process indicators.	No attempt at monitoring process is made	Informal process monitoring is used at least annually	Process monitoring is deficient on 2 of these 3 criteria: ■ Comprehensive and standardized ■ Completed every 6 months ■ Used to guide program improvements OR Standardized monitoring done annually only	Process monitoring is deficient on 1 of these 3 criteria: ■ Comprehensive and standardized ■ Completed every 6 months ■ Used to guide program improvements	Standardized comprehensive process monitoring occurs at least every 6 months and is used to guide program improvements
G10. Outcome monitoring Supervisors and IMR leaders monitor outcomes for EBP consumers every 3 months and share data with EBP team members. Monitoring involves standardized approach to assessing a key outcome related to EBP, such as, psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least 1 time a year, but results are not shared with team members	Standardized outcome monitoring occurs at least 1 time a year. Results are shared with team members	Standardized outcome monitoring occurs at least 2 times a year. Results are shared with team members	Standardized outcome monitoring occurs quarterly. Results are shared with EBP members
G11. Quality Assurance (QA) Agency has QA committee or implementation steering committee with an explicit plan to review EBP or components of the program every 6 months.	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review occurs every 6 months by QA group or steering committee for EBP
G12. Consumer choice about service provision All consumers receiving EBP services are offered choices; EBP team members consider and abide by consumer preferences for treatment when offering and providing services.	Consumer-centered services are absent (or practitioners make all EBP decisions)	Few sources agree that type and frequency of EBP services reflect consumer choice	Half of the sources agree that type and frequency of EBP services reflect consumer choice	Most sources agree that type and frequency of EBP services reflect consumer choice OR Agency fully embraces consumer choice with one exception	All sources agree that type and frequency of EBP services reflect consumer choice

Score Sheet: General Organizational Index

Agency name: _____ **Date of visit:** _____/___/_____

Assessors' names: _____

_____

		Assessor 1	Assessor 2	Consensus
G1	Program philosophy			
G2	Eligibility or consumer identification			
G3	Penetration			
G4	Assessment			
G5	Individualized treatment plan			
G6	Individualized treatment			
G7	Training			
G8	Supervision			
G9	Process monitoring			
G10	Outcome monitoring			
G11	Quality Assurance (QA)			
G12	Consumer choice regarding service provision			
Total mean score				

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix E: General Organizational Index Protocol

General Organizational Index Protocol

G1. Program Philosophy

Definition: The program is committed to a clearly articulated philosophy consistent with the specific evidence-based practice (EBP), based on the following five sources:

- IMR leader;
- Senior staff (such as executive director, psychiatrists);
- IMR practitioners;
- Consumers and family members (depending on EBP focus); and
- Written materials (such as brochures).

Rationale: In psychiatric rehabilitation programs that truly endorse EBPs, staff members at all levels embrace the program philosophy and practice it in their daily work.

Sources of information:

Overview: During the site visit, be alert to indicators of program philosophy that are either consistent with or inconsistent with the EBP, including observations from casual conversations, staff and consumer activities, and so forth. Statements that suggest misconceptions or reservations about the practice are negative indicators, while statements that show enthusiasm for and understanding of the practice are positive indicators.

The intent of this item is to gauge the understanding of and commitment toward the practice. It is not necessary that every element of the practice is currently in place (this is gauged by the IMR Fidelity Scale), but rather whether all those who are involved are committed to implementing a high-fidelity IMR..

The IMR practitioners rated for this item are limited to those implementing this practice. Similarly, the consumers rated are those receiving the practice.

1. **IMR leader, senior staff, and employment specialist interviews**

   At the beginning of interview, have team members briefly describe the program.

   - "What are the critical ingredients or principles of your services?"
   - "What is the goal of your program?"
   - "How do you define [EBP area]?"

2. **Consumer interview**

   - "What kind of services do you receive from this program?"
   - Using a layperson's language, describe to the consumer or family the principles of the specific EBP area. Probe if the program offers services that reflect each principle.
   - "Do you feel the team members of this program are competent and help you address your problems?""

3. **Written material review (for example, brochure)**

   - Does the site have written materials on EBP?
   - Does the written material articulate program philosophy consistent with EBP?

Item response coding: The goal of this item is not to quiz every team member to determine if they can recite every critical ingredient. Rather, the goal is to gauge whether the understanding is generally accurate and not contrary to the EBP. For example, if a senior staff member says, "Most of our consumers are not work ready," that would be a red flag for the practice of Supported Employment.

If all sources show evidence that they clearly understand the program philosophy, code the item as "5." For a source type that is based on more than one person (for example, team member interviews), determine the majority opinion when rating that source as endorsing or not endorsing a clear program philosophy. *Note*: If no written material, then count that source as *unsatisfactory*.

Difference between a major and minor area of discrepancy (needed to distinguish between a score of "4" and "3"): An example of a *minor* source of discrepancy for Assertive Community Treatment (ACT) might be larger caseload sizes (such as 20 to 1) or some brokering of services. An example of a *major* discrepancy would be if the team seldom made home visits or if the psychiatrist was uninvolved in the treatment team meetings.

G2. Eligibility/Consumer Identification

Definition: For EBPs implemented in a mental health center: All consumers in the community support program, crisis consumers, and institutionalized consumers are screened using standardized tools or admission criteria that are consistent with the EBP.

For EBPs implemented in a service area: All consumers within the jurisdiction of the service area are screened using standardized tools or admission criteria that are consistent with the EBP. For example, in New York, county mental health administrations are responsible for identifying consumers who will be served by Assertive Community Treatment (ACT) programs.

The **target population** refers to all adults with serious mental illnesses (SMI) served by the provider agency or service area. If the agency serves consumers at multiple sites, then assessment is limited to the site or sites that are targeted for the EBP. If the target population is served in discrete programs (for example, case management, residential, or day treatment), then ordinarily all adults with SMI are included in this definition.

Screening will vary according to the EBP. The intent is to identify all who could benefit from the EBP. For example, for IMR screening includes assessing the skills and issues addressed by this EBP

In every case, the program should have an explicit, systematic method to identify the eligibility of every consumer. Screening typically occurs at program admission; programs that are newly adopting an EBP should have a plan for systematically reviewing consumers who are already active in the program

Rationale: Accurately identifying consumers who would benefit most from the EBP requires routine review for eligibility, based on criteria consistent with the EBP.

Sources of information:

1. **IMR leader, senior staff, and employment specialist interviews**
   - "Describe the eligibility criteria for your program."
   - "How are consumers referred to your program? How does the agency identify consumers who would benefit from your program? Do all new consumers receive screening for substance abuse or SMI diagnosis?"
   - "What about crisis (or institutionalized) consumers?"
   - Ask for a copy of the screening instrument that the agency uses.
2. **Chart review:** Review documentation of screening process and results.
3. **County mental health administrators (where applicable):** If eligibility is determined at the service-area level (such as the New York example), then interview the people responsible for this screening.

Item response coding: This item refers to all consumers with SMI in the community support program or its equivalent at the sites where the EBP is being implemented; it is not limited to consumers who receive EBP services only. Calculate this percentage and record it on the fidelity rating scale in the space provided. If 80 percent of these consumers receive standardized screening, code the item as "5."

G3. Penetration

Definition: *Penetration* is defined as the percentage of consumers who have access to an EBP as measured against the total number of consumers who could benefit from the EBP. Numerically, this proportion is defined by:

$$\frac{\text{Number of consumers receiving an EBP}}{\text{Number of consumers eligible for the EBP}}$$

As in the preceding item, the numbers used in this calculation are specific to the site or sites where the EBP is being implemented.

Rationale: Surveys have repeatedly shown that people with SMI often have a limited access to EBPs. The goal of EBP dissemination is not simply to create small exclusive programs, but to make these practices easily accessible within the public mental health system.

Sources of information:

The calculation of the penetration rate depends on the availability of the two statistics defining this rate.

Numerator: The number receiving the service is based on a roster of names that the IMR leader maintains. Ideally, this total should be corroborated with service contact sheets and other supporting evidence that the identified consumers are actively receiving treatment. As a practical matter, agencies have many conventions for defining *active consumers* and *dropouts*, so that it may be difficult to standardize the definition for this item. Use the best estimate of the number actively receiving treatment.

Denominator: If the provider agency systematically tracks eligibility, then use this number in the denominator. (See rules listed above in G2 to determine target population before using estimates below.) If the agency doesn't track eligibility, then estimate the denominator by multiplying the total target population by the corresponding percentage based on the literature for each EBP.

According to the literature, the estimates for KITs available at this writing should be as follows:

- Supported Employment — 60 percent;
- Integrated Treatment for Co-Occurring Disorders — 40 percent;
- Illness Management and Recovery — 100 percent;
- Family Psychoeducation — 100 percent (some kind of significant other); and
- Assertive Community Treatment — 20 percent.

Example for calculating denominator:

Suppose you don't know how many consumers are eligible for Supported Employment (that is, the community support program has not surveyed consumers to determine those who are interested). Let's say the community support program has 120 consumers. Then you would estimate the denominator to be:

$$120 \times .6 = 72$$

Item response coding: Calculate this ratio and record it on the Fidelity Scale in the space provided. If the program serves >80 percent of eligible consumers, code the item as "5."

G4. Assessment

Definition: All EBP consumers receive standardized, high-quality, comprehensive, and timely assessments.

Standardization refers to a reporting format that is easily interpreted and consistent across consumers.

High quality refers to assessments that provide concrete, specific information that differentiates between consumers. If most consumers are assessed using identical words or if the assessment consists of broad, noninformative checklists, this would be considered low quality.

Comprehensive assessments include the following:

- History and treatment of medical, psychiatric, and substance use disorders;
- Current stages of all existing disorders;
- Vocational history;
- Any existing support network; and
- Evaluation of biopsychosocial risk factors.

Timely assessments are those updated at least annually.

Rationale: Comprehensive assessment/re-assessment is indispensable in identifying target domains of functioning that may need intervention, in addition to consumers' progress toward recovery.

Sources of information:

1. IMR leader, senior staff, and team member interviews

- "Do you give a comprehensive assessment to new consumers? What are the components that you assess?"
- Ask for a copy of the standardized assessment form, if available, and have IMR practitioners go through the form.
- "How often do you re-assess consumers?"

2. Chart review

- Look for comprehensiveness of assessment by looking at multiple completed assessments to see if they address each component of the comprehensive assessment every time an assessment is performed.
- "Is the assessment updated at least yearly?"

Item response coding: If more than 80 percent of consumers receive standardized, high-quality, comprehensive, and timely assessments, code the item as "5."

G5. Individualized Treatment Plan

Definition: For all EBP consumers, an explicit, individualized treatment plan exists (even if it is not called this) related to the EBP that is consistent with assessment and updated every 3 months.

Individualized means that goals, steps to reaching the goals, services and interventions, and intensity of involvement are unique to this consumer. Plans that are the same or similar across consumers are not individualized. One test is to place a treatment plan without identifying information in front of supervisors to see if they can identify the consumer.

Rationale: Core values of EBP include individualizing services and supporting consumers' pursuit of their goals and progress in their recovery at their own pace. Therefore, treatment plans need ongoing evaluation and modification.

Sources of information:

Note: This item and the next are assessed together; that is, follow up questions about specific treatment plans with questions about the treatment.

1. Chart review (treatment plan)

Using the same charts as examined during the EBP-specific fidelity assessment, look for documentation of specific goals and consumer-based, goal-setting process:

- "Are the treatment recommendations consistent with assessment?"
- "What evidence is used for a quarterly review?"

2. IMR leader interview

"Describe the process of developing a treatment plan. What are the critical components of a typical treatment plan and how are they documented?"

3. **Team member interview**

When feasible, use the specific charts selected above. Ask practitioners to go over a sample treatment plan.

- "How do you come up with consumer goals?" [Listen for consumer involvement and individualization of goals.]
- "How often do you review (or follow up on) the treatment plan?"

4. **Consumer interview**

- "What are your goals in this program? How did you set these goals?"
- "Do you and your employment specialist together review your progress toward achieving your goals?" [If *yes*, "How often? Please describe the review process."]

5. **Team meeting and supervision observation, if available**

Observe how the treatment plan is developed. Listen especially for discussion of assessment, consumer preferences, and individualization of treatment. Do they review treatment plans?

Item response coding: If more than 80 percent of EBP consumers have an explicit individualized treatment plan that is updated every 3 months, code the item as "5." If the treatment plan is individualized but updated only every 6 months, code then the item as "3."

G6. Individualized Treatment

Definition: All EBP consumers receive individualized treatment meeting the goals of the EBP.

Individualized treatment means that steps, strategies, services, interventions, and intensity of involvement are focused on specific consumer goals and are unique for each consumer. Progress notes are often a good source of what really goes on. Treatment could be highly individualized, despite the presence of generic treatment plans.

An example for a low score on this item for Assertive Community Treatment (ACT):

If most of the Progress Notes are written by day treatment staff who see the consumer 3 to 4 days per week, while the ACT team sees the consumer only about once a week to issue his check.

Rationale: The key to the success of an EBP is implementing a plan that is individualized and meets the goals for the EBP for each consumer.

Sources of information:

1. **Chart review (treatment plan)**

Using the same charts as examined during the EBP-specific fidelity assessment, examine the treatment provided. Limit the focus to a recent treatment plan related to the EBP. Judge whether an appropriate treatment occurred during the time frame indicated by the treatment plan.

2. **Team member interview**

When feasible, use the specific charts selected above. Ask IMR practitioners to go over a sample treatment plan and treatment.

3. **Consumer interview**

- "Tell me about how this program is helping you meet your goals."

Item response coding: If more than 80 percent of EBP consumers receive treatment that is consistent with the goals of the EBP, code the item as "5."

G7. Training

Definition: All new IMR practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) within 2 months after they are hired. Existing IMR practitioners receive annual refresher training (at least a 1-day workshop or its equivalent)..

Rationale: Practitioner training and retraining are warranted to ensure that evidence-based services are provided in a standardized manner, across IMR practitioners and over time.

Sources of information:

1. **IMR leader, senior staff, and team member interviews**
   - "Do you provide new IMR practitioners with systematic training for [EBP area]?" [If yes, probe for specifics: Mandatory or optional? Length? Frequency? Content? Group or individual format? Who trains? In-house or outside training?]]
   - "Do IMR practitioners receive refresher trainings?" [If *yes*, probe for specifics.]
2. **Review training curriculum and schedule, if available**

   Does the curriculum appropriately cover the critical ingredients for [EBP area]?
3. **Team member interview**
   - "When you first started in this program, did you receive a systematic and formal training for [EBP area]?" [If *yes*, probe for specifics: Mandatory or optional? Length? Frequency? Content? Group or individual format? Who trains? In-house or outside training?]]
   - "Do you receive refresher trainings?" [If *yes*, probe for specifics.]

Item response coding: If more than 80 percent of IMR team members receive at least yearly, standardized training for IMR, code the item as "5."

G8. Supervision

Definition: IMR practitioners receive structured, weekly supervision from practitioners experienced in the particular EBP. The supervision can be either group or individual, but CANNOT be peers-only supervision without a supervisor. The supervision should be consumer-centered and explicitly address the EBP model and how it applies to specific consumer situations. Administrative meetings and meetings that are not specifically devoted to the EBP do not fit the criteria for this item. The consumer-specific EBP supervision should be at least 1 hour long each week.

Rationale: Regular supervision is critical not only for individualizing treatment, but also for ensuring the standardized provision of evidence-based services.

Sources of information:

1. **IMR leader, senior staff, and team member interviews**

   Probe for logistics of supervision: length, frequency, group size, etc.
   - "Describe what a typical supervision session looks like."
   - "How does the supervision help your work?"
2. **Team meeting and supervision observation, if available**

   Listen for discussion of [EBP area] in each case reviewed.
3. **Supervision logs documenting frequency of meetings**

Item response coding: If more than 80 percent of IMR practitioners receive weekly supervision, code the item as "5."

G9. Process Monitoring

Definition: Supervisors and IMR leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Process monitoring involves a standardized approach, for example, using a fidelity scale or other comprehensive set of process indicators.

An example of a process indicator would be systematic measurement of how much time case managers spend in the community instead of in the office. Process indicators could include items related to training or supervision. The underlying principle is that whatever is being measured is related to implementing the EBP and is not being measured to track billing or productivity.

Rationale: Systematic and regular collection of process data is imperative in evaluating program fidelity to EBP.

Sources of information:

1. **IMR leader, senior staff, and team member interviews**
   - "Does your program collect process data regularly?" [If *yes*, probe for specifics: frequency, who, how (using the IMR Fidelity Scale vs. other scales), etc.]
   - "Does your program collect data on consumer service use and treatment attendance?"
   - "Have the process data affected how your services are provided?

2. **Review of internal reports and documentation, if available**

Item response coding: If evidence exists that standardized process monitoring occurs at least every 6 months, code the item as "5."

G10. Outcome Monitoring

Definition: Supervisors and IMR leaders monitor the outcomes of EBP consumers every 3 months and share the data with IMR practitioners in an effort to improve services. Outcome monitoring involves a standardized approach to assessing consumers.

Rationale: Systematic and regular collection of outcome data is imperative in evaluating program effectiveness. Effective programs also analyze such data to ascertain what is working and what is not working and use the results to improve the quality of services they provide.

Key outcome indicators for each EBP are discussed in the EBP KITs. A provisional list is as follows:

- Supported Employment—competitive employment rate;
- Integrated Co-Occurring Disorders Treatment—substance use (such as the Stages of Treatment Scale);
- Illness Management and Recovery—hospitalization rates, relapse prevention plans, medication compliance rates;
- Family Psychoeducation —hospitalization and family burden; and
- Assertive Community Treatment—hospitalization and housing.

Sources of information:

1. **IMR leader, senior staff, and team member interviews**
   - "Does your program have a systematic method for tracking outcome data?" [If *yes*, probe for specifics: How (computerized vs. chart only)? Frequency? Type of outcome variables? Who collects data?]

- "Do you use any checklist or scale to monitor consumer outcome (such as the Substance Abuse Treatment Scale)?"
- "What do you do with the outcome data? Do your IMR practitioners review the data regularly?" [If *yes*, "How is the review done (for example, cumulative graph)?"]
- "Have Have the outcome data affected how your services are provided? If so, how?

2. Review of internal reports and documentation, if available

Item response coding: If standardized outcome monitoring occurs quarterly and results are shared with IMR team members, code the item as "5."

G11. Quality Assurance

Definition: The agency's QA committee has an explicit plan to review the EBP or components of the program every 6 months. The steering group for the EBP can serve this function.

Good QA committees help the agency in important decisions, such as penetration goals, placement of the EBP within the agency, and hiring and staffing needs. QA committees also help guide and sustain the implementation by doing the following:

- Reviewing fidelity to the EBP model;
- Making recommendations for improvement;
- Advocating and promoting the EBP within the agency and in the community; and
- Deciding on and keeping track of key outcomes relevant to the EBP.

Rationale: Research has shown that programs that most successfully implement EBPs have better outcomes. Again, systematically and regularly collecting process and outcome data is imperative in evaluating program effectiveness.

Sources of information:

1. IMR leader interview

"Does your agency have an established team or committee that is in charge of reviewing the components of your [EBP area] program?" [If yes, probe for specifics. who, how, when, etc.]

2. QA committee member interview

- "Please describe the tasks and responsibilities of the QA committee." Probe for specifics: *purpose, who, how, when,* etc.
- "How do you use your reviews to improve the program's services?"

Item response coding: If the agency has an established QA group or steering committee that reviews the EBP or components of the program every 6 months, code the item as "5."

G12. Consumer Choice About Service Provision

Definition: All consumers who receive EBP services are offered a reasonable range of choices consistent with the EBP; IMR practitioners consider and abide by consumer preferences for treatment when they offer and provide services.

Choice is defined narrowly in this item to refer to services provided. This item does not address broader issues of consumer choice such as choosing to engage in self-destructive behaviors.

To score high on this item, it is not sufficient that a program offers choices. The choices must be consonant with EBP. So, for example, a program implementing Supported Employment would score low if the only employment choices it offered were sheltered workshops.

A reasonable range of choices means that practitioners offer realistic options to consumers rather than prescribe only one. It means that the practitioner does not dictate or prescribe a fixed sequence of conditions that a consumer must complete before .

Examples of relevant choices by EBPs
(current at this writing)

Supported Employment

- Type of occupation
- Type of work setting
- Schedules of work and number of hours
- Whether to disclose
- Nature of accommodations
- Type and frequency of followup supports

Integrated Treatment for Co-Occurring Disorders

- Group or individual counseling sessions
- Frequency of dual disorders treatment
- Specific self-management goals

Family Psychoeducation

- Consumer readiness for involving family
- Whom to involve
- Choice of problems and issues to address

Illness Management and Recovery

- Selection of significant others to be involved
- Specific self-management goals
- Nature of behavioral tailoring
- Skills to be taught

Assertive Community Treatment

- Type and location of housing
- Nature of health promotion
- Nature of assistance with financial management
- Specific goals
- Daily living skills to be taught
- Nature of medication support
- Nature of substance abuse treatment

Rationale: A major premise of EBP is that consumers are capable of playing a vital role in managing their illnesses and in making progress toward achieving their goals. Providers accept the responsibility for getting information to consumers so that they can more effectively participate in treatment.

Sources of information:

1. IMR leader interview

- "Tell us your program philosophy on consumer choice. How do you incorporate consumers' preferences in the services you provide?"
- "What options exist for your services? Give examples."

2. Team member interview

- "What do you do when a disagreement occurs between what you think is the best treatment for consumers and what they want?"
- "Describe a time when you were unable to abide by a consumer's preferences."

3. **Consumer interview**

   - "Does the program give you options for the services you receive?"
   - Are you receiving the services you want?"

4. **Team meeting and supervision observation**

   Look for discussion of service options and consumer preferences.

5. **Chart review (especially treatment plan)**

   Look for documentation of consumer preferences and choices.

Item response coding: If all sources indicate that type and frequency of EBP services always reflect consumer choice, code the item as "5." If the agency embraces consumer choice fully, except in one area (for example, requiring the agency to assume representative payee ships for all consumers), then code the item as "4."

Note: Ratings for both scales are based on current behavior and activities, not planned or intended behavior.

The standards used for establishing the anchors for the *fully implemented* ratings were determined through a variety of expert sources as well as empirical research.

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Appendix F: Consumer Outcome Survey: Illness Management and Recovery

Consumer Outcome Survey: Illness Management and Recovery

Please take a few minutes to fill out this survey. We are interested in the way things are for you, so there are no right or wrong answers. If you are unsure about a question, just answer it as well as you can. Check the box for the answer that best fits you.

Name or I.D. number: _____ Date: _____

1. **Progress toward goals:** In the past 3 months, you have come up with …
   - ❑ No personal goals
   - ❑ A personal goal, but have not done anything to achieve the goal
   - ❑ A personal goal and made it a little way toward achieving it
   - ❑ A personal goal and have gotten pretty far in achieving the goal
   - ❑ A personal goal and has achieved it

2. **Knowledge:** How much do you feel like you know about symptoms, treatment, coping strategies (coping methods), and medication?
   - ❑ Not very much
   - ❑ A little
   - ❑ Some
   - ❑ Quite a bit
   - ❑ A great deal

3. **Involvement of family and friends in my mental health treatment:** How much are family members, friends, boyfriends or girlfriends, and other people who are important to you (outside the mental health agency) involved in your treatment?
   - ❑ Not at all
   - ❑ Only when there is a serious problem
   - ❑ Sometimes, such as when things are starting to go badly
   - ❑ Much of the time
   - ❑ A lot of the time and they really help with the consumer's mental health

4. **Contact with people outside of your family:** In a normal week, how many times do you talk to someone outside of your family (a friend, co-worker, classmate, roommate, etc.)?
   - ❑ 0 times a week
   - ❑ 1 to 2 times a week
   - ❑ 3 to 4 times a week
   - ❑ 5 to 7 times a week
   - ❑ 8 or more times a week

5. **Time in structured roles:** How much time do you spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time do you spend doing activities that are expected of you for or with another person? (This would not include self-care or personal home maintenance.)
   - ❑ 2 hours or less a week
   - ❑ 3 to 5 hours a week
   - ❑ 6 to 15 hours a week
   - ❑ 16 to 30 hours a week
   - ❑ More than 30 hours a week

6. **Symptom distress:** How much do symptoms bother you?
   - ❑ Symptoms *really* bother me a *lot*
   - ❑ Symptoms bother me *quite a bit*
   - ❑ Symptoms bother me *somewhat*
   - ❑ Symptoms bother me *very little*
   - ❑ Symptoms don't bother me *at all*

7. **Impairment of functioning:** How much do symptoms get in the way of your doing things that you would like to do or need to do?
   - ❑ Symptoms *really* get in my way *a lot*
   - ❑ Symptoms get in my way *quite a bit*
   - ❑ Symptoms get in my way *somewhat*
   - ❑ Symptoms get in my way *very little*
   - ❑ Symptoms don't get in my way *at all*

8. **Relapse Prevention Planning:** Which of the following would best describe what you know and have done in order to not have a relapse?
   - ❑ Don't know how to prevent relapses
   - ❑ Know a little, but haven't made a relapse prevention plan
   - ❑ Know one or two things to do, but don't have a written plan
   - ❑ Know several things to do, but don't have a written plan
   - ❑ Have a written plan and have shared it with others

9. **Relapse of symptoms:** When is the last time you had a relapse of symptoms (that is, when symptoms have gotten much worse)?
   - ❑ Within the last month
   - ❑ In the past 2 to 3 months
   - ❑ In the past 4 to 6 months
   - ❑ In the past 7 to 12 months
   - ❑ Hasn't had a relapse in the past year

10. **Psychiatric hospitalizations:** When is the last time you have been hospitalized for mental health or substance abuse reasons?
    - ❑ Within the last month
    - ❑ In the past 2 to 3 months
    - ❑ In the past 4 to 6 months
    - ❑ In the past 7 to 12 months
    - ❑ No hospitalization in the past year

11. **Coping:** How well do you feel that you are coping with your mental or emotional illness from day to day?
    - ❑ Not well at all
    - ❑ Not very well
    - ❑ All right
    - ❑ Well
    - ❑ Very well

12. **Involvement with self-help activities:** How involved are you in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?
    - ❑ I don't know about any self-help activities.
    - ❑ I know about some self-help activities, but I'm not interested.
    - ❑ I'm interested in self-help activities, but I have not participated in the past year.
    - ❑ I participate in self-help activities occasionally.
    - ❑ I participate in self-help activities regularly.

13. **Using medication effectively:** How often do you take your medication as prescribed?
    - ❑ Never
    - ❑ Occasionally
    - ❑ About half the time
    - ❑ Most of the time
    - ❑ Every day

    ❑ **Check here if no psychiatric medications have been prescribed for you.**

14. **Functioning affected by alcohol use:** Drinking can interfere with functioning when it contributes to conflict in relationships; to money, housing, and legal concerns; to difficulty showing up at appointments or paying attention during them; or to increased symptoms. Over the past 3 months, how much did drinking get in the way of your functioning?
    - ❑ Alcohol use really gets in my way a lot.
    - ❑ Alcohol use gets in my way quite a bit.
    - ❑ Alcohol use gets in my way somewhat.
    - ❑ Alcohol use gets in my way very little.
    - ❑ Alcohol use is not a factor in my functioning.

15. **Functioning affected by drug use.** Using street drugs and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships; to money, housing, and legal concerns; to difficulty showing up at appointments or paying attention during them; or to increased symptoms. Over the past 3 months, how much did drug use get in the way of your functioning?
    - ❑ Drug use really gets in my way a lot.
    - ❑ Drug use gets in my way quite a bit.
    - ❑ Drug use gets in my way somewhat.
    - ❑ Drug use gets in my way very little.
    - ❑ Drug use is not a factor in my functioning.

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Appendix G: Practitioner Outcome Survey: Illness Management and Recovery

Practitioner Outcome Survey: Illness Management and Recovery

Please take a few moments to fill out the following survey about your perception of the consumer's ability to manage his or her illness, as well as his or her progress toward recovery. We are interested in the way you feel about how things are going for the consumer, so please answer with your honest opinion. If you are not sure about an item, just answer as well as you can. Please circle the answer that best fits the consumer.

IMR practitioner: _____ Date: _____

Consumer's name or I.D. number: _____

Reported by_____

1. **Progress toward goals:** In the past 3 months, the consumer has come up with …
   - ❑ No personal goals
   - ❑ A personal goal, but has not done anything to achieve the goal
   - ❑ A personal goal and made it a little way toward achieving it
   - ❑ A personal goal and has gotten pretty far in achieving the goal
   - ❑ A personal goal and has achieved it

2. **Knowledge:** How much do you feel the consumer knows about symptoms, treatment, coping strategies (coping methods), and medication?
   - ❑ Not very much
   - ❑ A little
   - ❑ Some
   - ❑ Quite a bit
   - ❑ A great deal

3. **Involvement of family and friends in the consumer's mental health treatment:** How much are family members, friends, boyfriends or girlfriends, and other people who are important to the consumer (outside the mental health agency) involved in his or her treatment?
   - ❑ Not at all
   - ❑ Only when there is a serious problem
   - ❑ Sometimes, such as when things are starting to go badly
   - ❑ Much of the time
   - ❑ A lot of the time and they really help with the consumer's mental health

4. **Contact with people outside of the family:** In a normal week, how many times does the consumer talk to someone outside of his or her family (a friend, co-worker, classmate, roommate, etc.)?
   - ❑ 0 times a week
   - ❑ 1 to 2 times a week
   - ❑ 3 to 4 times a week
   - ❑ 5 to 7 times a week
   - ❑ 8 or more times a week

5. **Time in structured roles:** How much time does the consumer spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does the consumer spend doing activities that are expected of him or her for or with another person? (This would not include self-care or personal home maintenance.)
   - ❑ 2 hours or less a week
   - ❑ 3 to 5 hours a week
   - ❑ 6 to 15 hours a week
   - ❑ 16 to 30 hours a week
   - ❑ More than 30 hours a week

6. **Symptom distress:** How much do symptoms bother the consumer?
   - ❑ Symptoms *really* bother the consumer a *lot*
   - ❑ Symptoms bother the consumer *quite a bit*
   - ❑ Symptoms bother the consumer *somewhat*
   - ❑ Symptoms bother the consumer *very little*
   - ❑ Symptoms don't bother the consumer *at all*

7. **Impairment of functioning:** How much do symptoms get in the way of the consumer's doing things that he or she would like to do or needs to do?
   - ❑ Symptoms *really* get in the consumer's way *a lot*
   - ❑ Symptoms get in the consumer's way *quite a bit*
   - ❑ Symptoms get in the consumer's way *somewhat*
   - ❑ Symptoms get in the consumer's way *very little*
   - ❑ Symptoms don't get in the consumer's way *at all*

8. **Relapse Prevention Planning:** Which of the following would best describe what the consumer knows and has done in order to not have a relapse?
   - ❑ Doesn't know how to prevent relapses
   - ❑ Knows a little, but hasn't made a relapse prevention plan
   - ❑ Knows one or two things to do, but doesn't have a written plan
   - ❑ Knows several things to do, but doesn't have a written plan
   - ❑ Has a written plan and has shared it with others

9. **Relapse of symptoms:** When is the last time the consumer had a relapse of symptoms (that is, when symptoms have gotten much worse)?
   - ❑ Within the last month
   - ❑ In the past 2 to 3 months
   - ❑ In the past 4 to 6 months
   - ❑ In the past 7 to 12 months
   - ❑ Hasn't had a relapse in the past year

10. **Psychiatric hospitalizations:** When is the last time the consumer has been hospitalized for mental health or substance abuse reasons?
    - ❑ Within the last month
    - ❑ In the past 2 to 3 months
    - ❑ In the past 4 to 6 months
    - ❑ In the past 7 to 12 months
    - ❑ No hospitalization in the past year

11. **Coping:** How well do you feel that the consumer is coping with his or her mental or emotional illness from day to day?
    - ❑ Not well at all
    - ❑ Not very well
    - ❑ All right
    - ❑ Well
    - ❑ Very well

12. **Involvement with self-help activities:** How involved is he or she in consumer-run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?
    - ❑ Doesn't know about any self-help activities
    - ❑ Knows about some self-help activities, but isn't interested
    - ❑ Is interested in self-help activities, but hasn't participated in the past year
    - ❑ Participates in self-help activities occasionally
    - ❑ Participates in self-help activities regularly

13. **Using medication effectively:** How often does the consumer take medication as prescribed?
    - ❑ Never
    - ❑ Occasionally
    - ❑ About half the time
    - ❑ Most of the time
    - ❑ Every day

    ❑ **Check here if no psychiatric medications have been prescribed for the consumer.**

14. **Impairment of functioning through alcohol use:** Drinking can interfere with functioning when it contributes to conflict in relationships; to financial, housing, and legal concerns; to difficulty attending appointments or focusing during them; or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of the consumer's functioning?
    - ❑ Alcohol use really gets in the consumer's way a lot
    - ❑ Alcohol use gets in the consumer's way quite a bit
    - ❑ Alcohol use gets in the consumer's way somewhat
    - ❑ Alcohol use gets in the consumer's way very little
    - ❑ Alcohol use is not a factor in the consumer's functioning

15. **Impairment of functioning through drug use:** Using street drugs and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships; to financial, housing, and legal concerns; to difficulty attending appointments or focusing during them; or to increases of symptoms. Over the past 3 months, did drug use get in the way of the consumer's functioning?
    - ❑ Drug use really gets in the consumer's way a lot
    - ❑ Drug use gets in the consumer's way quite a bit
    - ❑ Drug use gets in the consumer's way somewhat
    - ❑ Drug use gets in the consumer's way very little
    - ❑ Drug use is not a factor in the consumer's functioning

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Appendix H: Outcomes Report Form

Outcomes Report Form

Quarter ❑ January, February, March **Year** _____

❑ April, May, June

❑ July, August, September

❑ October, November, December

Reported by _____

Agency _____ **Team** _____

About the consumer

Consumer ID _____ **Discharge date** ___/___/___ **Date of birth** ___/___/___

❑ Male **Ethnicity** _____

❑ Female **Primary diagnosis** _____

What was the consumer's evidence-based service status on the last day of the quarter?

	Unknown	Not Eligible	Eligible	Enrolled
Integrated Treatment for Co-Occurring Disorders	❑	❑	❑	❑
Supported Employment	❑	❑	❑	❑
Assertive Community Treatment	❑	❑	❑	❑
Illness Management and Recovery	❑	❑	❑	❑
Family Psychoeducation	❑	❑	❑	❑

In the past 3 months, how often has the consumer...	Number of days	Number of incidents
Been homeless?		
Been incarcerated?		
Been in a state psychiatric hospital?		
Been in a private psychiatric hospital?		
Been hospitalized for substance abuse reasons?		

In the past 3 months, how many days was the consumer competitively employed? (Use 0 if the consumer has not been competitively employed.)

_____ Days

Was the consumer competitively employed on the last day of the reporting period?

- ❑ Yes
- ❑ No

What was the consumer's stage of substance abuse treatment on the last day of the quarter? *Check one.*

- ❑ Not applicable
- ❑ Pre-engagement
- ❑ Engagement
- ❑ Early persuasion
- ❑ Late persuasion
- ❑ Early active treatment
- ❑ Late active treatment
- ❑ Relapse prevention
- ❑ In remission or recovery

What was the consumer's living arrangement on the last day of the quarter? *Check one.*

- ❑ Not applicable or unknown
- ❑ Psychiatric hospital
- ❑ Substance abuse hospitalization
- ❑ General hospital psychiatric ward
- ❑ Nursing home
- ❑ Family care home
- ❑ Living with relatives (heavily dependent for personal care)
- ❑ Group home
- ❑ Boarding house
- ❑ Supervised apartment program
- ❑ Living with relatives (but is largely independent)
- ❑ Living independently
- ❑ Homeless
- ❑ Emergency shelter
- ❑ Other (specify) _____

_____

What was the consumer's educational status on the last day of the quarter? *Check one.*

- ❑ Not applicable or unknown
- ❑ No educational participation
- ❑ A vocational/educational involvement
- ❑ Pre-educational explorations
- ❑ Working on GED
- ❑ Working on English as Second Language
- ❑ Basic educational skills
- ❑ Attending vocational school, vocational program, apprenticeship, or high school
- ❑ Attending college: 1-6 hours
- ❑ Attending college: 7 or more hours
- ❑ Other (specify) _____

What is the consumer's highest level of education? *Check one.*

- ❑ No high school
- ❑ High school diploma or GED
- ❑ Some college
- ❑ Associates degree
- ❑ Vocational training certificate
- ❑ Bachelor of Arts or Bachelor of Science
- ❑ Master's degree or Ph.D.

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Appendix I: Instructions for the Outcomes Report Form

Instructions for the Outcomes Report Form

Before you fill out the *Outcomes Report Form*, become familiar with the definitions of the data elements to provide consistency among reporters.

General data

Quarter: Check the time frame for the reporting period.

Year: Fill in the current year.

Reported by: Fill in the name and title of the person who completed the form.

Agency: Identify the agency name.

Team: Write the team name or number.

About the consumer

Consumer ID: Write the consumer ID that is used at your agency, usually a name or an identifying number. This information will be accessible only to the agency providing the service.

Discharge date: If the consumer has been discharged during this report period, fill in the discharge date.

Date of birth: Fill in the consumer's date of birth (example: 09/22/1950).

Gender: Check the appropriate box.

Ethnicity: Fill in the consumer's ethnicity.

Primary diagnosis: Write the DSM diagnosis.

Evidence-based service status

What was the consumer's evidence-based service status on the last day of the quarter? Check the appropriate boxes according to these definitions:

Eligible: Does the consumer meet the participation criteria for a specific EBP? Each EBP has criteria for program participation that should be used to determine eligibility.

Enrolled: Is the consumer participating in a particular EBP service or has the consumer participated in the EBP in the past period? *Note*: Aggregate data about eligibility and enrollment can be used to determine the percentage of eligible consumers who received services.

Incident reporting

For the following outcomes, record the number of days and number of incidents that the consumer spent in each category during the reporting period.

Categories:

Been homeless: Number of days that the consumer was homeless and how many times the consumer was homeless during the reporting period. *Homeless* refers to consumers who lack a fixed, regular, and adequate nighttime residence.

Been incarcerated: Number of days and incidents that the consumer spent incarcerated in jails or in other criminal justice lock-ups.

Been in a state psychiatric hospital: Number of days and incidents that the consumer spent hospitalized primarily for treatment of psychiatric disorders in a state psychiatric hospital.

Been in a private psychiatric hospital	Number of days and incidents that the consumer spent hospitalized primarily for treatment of psychiatric disorders in a private psychiatric hospital
Been hospitalized for substance abuse reasons:	Number of days and incidents that the consumer spent hospitalized primarily for treatment of substance-use disorders, including both public and private hospitals whose primary function is treating substance-use disorders.

Competitive employment

In the past 3 months, how many days was the consumer competitively employed? *Competitive employment* means working in a paid position (almost always outside the mental health center) that would be open to all community members to apply. *Competitive employment* excludes consumers working in sheltered workshops, transitional employment positions, or volunteering. It may include consumers who are self-employed but only if the consumer works regularly and is paid for the work.

Stage of substance abuse treatment

What was the consumer's stage of substance abuse treatment on the last day of the quarter? Record the consumer's stage of substance abuse recovery, according to the following nine categories:

- **Not applicable:** No history of substance abuse disorder.
- **Pre-engagement:** No contacts with a case manager, mental health counselor, or substance abuse counselor.
- **Engagement:** Contact with an assigned case manager or counselor, but does not have regular contacts. The lack of regular contact implies lack of a working alliance.
- **Early persuasion:** Regular contacts with a case manager or counselor, but has not reduced substance use for more than a month. Regular contacts imply having a working alliance and a relationship in which substance abuse can be discussed.
- **Late persuasion:** Engaged in a relationship with a case manager or counselor, is discussing substance use or attending a group, and shows evidence of reducing use for at least one month (fewer drugs, smaller quantities, or both). External controls (such as Antabuse) may be involved in reduction.
- **Early active treatment:** Engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though consumer may still be abusing.
- **Late active treatment:** Engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) but for less than 6 months.
- **Relapse prevention:** Engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least 6 months. Occasional lapses, not days of problematic use, are allowed.
- **In remission or recovery:** No problems related to substance use for more than 1 year and is no longer in any type of substance abuse treatment.

Living arrangement

What was the consumer's living arrangement on the last day of the quarter? These data give your agency an ongoing record of the consumer's residential status.

- **Not applicable or unknown**
- **Psychiatric hospital:** Those hospitals, both public and private, whose primary function is treating mental disorders. This includes state hospitals and other freestanding psychiatric hospitals.
- **Substance-use hospitalization:** Those hospitals, both public and private, whose primary function is treating substance use disorders.
- **General hospital psychiatric ward:** Psychiatric wards located in general medical centers that provide short-term, acute crisis care.
- **Nursing home:** Facilities that are responsible for the medical and physical care of consumers and have been licensed as such by the state.
- **Family care home:** Consumers live in single-family dwellings with nonrelatives who provide substantial care. *Substantial care* is determined by the degree to which nonrelatives are responsible for the daily care of consumers. Such things as medication management, transportation, cooking, cleaning, restrictions on leaving the home, and money management are considered. Nonrelatives may have guardianship responsibilities. If consumers are unable to do most daily living tasks without the aid of caretakers, consider caretakers to be providing substantial care.
- **Lives with relatives (heavily dependent for personal care):** Consult consumers and relatives about how much family members are responsible for the daily care of consumers. An important distinction between this status and *supervised apartment program* is to ask, "If the family were not involved, would the consumer be living in a more restrictive setting?" In assessing the extent to which family members provide substantial care, consider such things as taking medication, using transportation, cooking, cleaning, having control of leaving the home, and managing money. If consumers are unable to independently perform most daily living functions, consider family members to be providing substantial care.
- **Group home:** A residence that is run by staff who provide many functions (shopping, meal preparation, laundry, etc.) that are essential to living independently.
- **Boarding house:** A facility that provides a place to sleep and meals, but it is not seen as an extension of a mental health agency nor is it staffed with mental health personnel. These facilities are largely privately run and consumers have a high degree of autonomy.
- **Supervised apartment program:** Consumers live (fairly independently) in an apartment sponsored by a mental health agency. In determining whether someone fits this category, look at the extent to which mental health staff have control over key aspects of the living arrangements. Example characteristics of control include the following:
  - The mental health agency signs the lease.
  - The mental health agency has keys to the house or apartment.
  - Mental health agency staff provides onsite day or evening coverage.
  - The mental health agency mandates that consumers participate in certain mental health services—medication clinic, day program, etc., to live in the house or apartment.

  Note: Consumers who receive only case management support or financial aid are NOT included in this category; they are considered to be living independently.

- **Lives with relatives (but is largely independent):** An assignment to this category requires having information from consumers and families. The key consideration relates to the degree to which consumers can perform most tasks essential to daily living without being supervised by family members.
- **Living independently:** Consumers who live independently and are capable of self-care, including those who live independently with case management support. This category also includes consumers who are largely independent and choose to live with others for reasons unrelated to mental illness. They may live with friends, a spouse, or other family members. The reasons for shared housing could include personal choice related to culture or financial considerations.
- **Homeless:** Consumers who lack a fixed, regular, and adequate nighttime residence.
- **Emergency shelter:** Temporary arrangements due to a crisis or misfortune that are not specifically related to a recurrence of the consumer's illness. While many emergency shelters provide emotional support, the need for emergency shelter is due to an immediate crisis unrelated to the consumer's mental illness.
- **Other:** Those who complete the form should clearly define this status in the space provided.

Educational status

What was the consumer's educational status on the last day of the quarter? These data provide your agency with an ongoing record of the consumer's educational status.

- **Not applicable or unknown**
- **No educational participation:** Consumer is not participating in educational activities.
- **Avocational/educational involvement:** These are organized classes in which consumers enroll consistently and expect to take part for the purpose of life enrichment, hobbies, recreation, etc. These classes must be community based, not run by the mental health center. Classes are those in which anyone could participate, not just consumers. If any of these activities involve college enrollment, use the categories below.
- **Pre-educational explorations:** Consumers in this status are engaged in educational activities with the specific purpose of working toward an educational goal. This includes consumers who attend a college orientation class with the goal of enrolling, meet with the financial aid office to apply for scholarships, or apply for admission to enroll. This status also includes consumers who attend a mental health center-sponsored activity focusing on an educational goal (for example, campus visits with a case manager to survey the location of classrooms; meetings with the case manager and college staff to secure entitlements).
- **Working on General Educational Develpoment (GED):** Consumers who are taking classes to obtain their GED dilpoma.

- **Working on English as Second Language:** Consumers who are taking classes in English as a Second Language in a community setting.
- **Basic educational skills:** Consumers who are taking adult educational classes focused on basic skills, such as math and reading.
- **Attending vocational school or apprenticeship, vocational program or high school:** Consumers who are –
  - Participating in community-based vocational schools;
  - Learning skills through an apprenticeship, internship, or in a practicum setting;
  - Involved in on-the-job training to acquire more advanced skills;
  - Participating in correspondence courses which lead to job certification; and
  - Young adults attending high school.
- **Attending college: 1 to 6 hours.** Consumers who attend college for 6 hours or less per term. This status continues over breaks, etc., if consumers plan to continue enrollment. This status suggests that consumers regularly attend college and includes correspondence, TV, or video courses for college credit.
- **Attending college: 7 or more hours.** Consumers who attend college for more than 7 hours per term. This status continues over breaks, etc., if consumers plan to continue enrollment.

  Regular attendance with expectations of completing course work is essential for assignment to this status.
- **Other:** Those who complete the form should clearly define this status in the space provided.

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix J: Assessor Training and Work Performance Checklist

Assessor Training and Work Performance Checklist

Assessment date ____/____/____

Assessor's name _____ _____
First Middle Initial Last Title

Agency visited _____

Agency address _____
Street

_____
City State ZIP code

EBP assessed _____

Assessor qualifications

Yes

- ❑ 1a. **Data collection and skills:** Assessor's skills are evidenced by his or her prior work experience, credentials, or supervisor's observations.
- ❑ 1b. **EBP knowledge:** Assessor's knowledge is evidenced by his or her prior work experience, credentials, or passing a knowledge test on a specific EBP.
- ❑ 1c. **Training:** Assessors receive at least 8 hours of systematic training on chart review, interviewing techniques, and process assessment.
- ❑ 1d. **Shadowing:** Assessors complete at least 1 assessment with an experienced assessor before the first official process assessment.
- ❑ 1e. **Practice rating:** Assessors co-rate as practice before being official assessors and agree exactly with an experienced assessor on ratings for at least 80 percent of items.

_____/5 **Subtotal**

Data Collection

- ❑ 2a. **Contact and scheduling:** With contact person, assessors identify a date convenient to site, explain purpose of the assessment, identify information to be assembled ahead of time, and develop specific schedule of interviews and assessment activities.
- ❑ 2b. **Number of assessors:** Two or more assessors are present during the assessment visit and independently rate all items. If agency is working with a consultant, assessor may join with consultant to conduct assessments.
- ❑ 2c. **Time management:** Sufficient time is allotted and all necessary materials reviewed (2 days for 2 assessors).
- ❑ 2d. **Interviewing:** Interview all the sources stipulated in the protocol (for example, interviews with the program leader, team members, and consumers).
- ❑ 2e. **Completion of documents:** Complete score sheet, cover sheet, and any other supplemental documents relating to the agency.
- ❑ 2f. **Documentation supporting rating:** Each assessor provides written documentation for evidence supporting the rating for each item (such as marginal notes).
- ❑ 2g. **Chart selection and documentation:** Chart selection follows guidelines provided in the protocol (for example, appropriate type and number of charts). Assessors note discrepancies (such as chart unavailability).
- ❑ 2h. **Chart review:** Both assessors review all charts and rate them independently.
- ❑ 2i. **Resolution of discrepancies:** When a discrepancy exists between sources (such as charts and SE team members), assessors follow up with an appropriate informant (typically the SE leader or relevant staff members).
- ❑ 2j. **Independent ratings:** No later than 1 day after the assessment, assessors independently complete scales before discussing ratings.

_____/10 **Subtotal**

Post-assessment visit

- ❑ 3a. **Timely consensus:** Within 5 working days after the assessment, assessors discuss their ratings to determine consensus ratings, identifying any followup information needed. A third assessor (for example, supervisor) may be consulted to resolve difficult ratings.
- ❑ 3b. **Inter-rater reliability:** Raters agree exactly on ratings for at least 80 percent of the items. Sources of unreliability are discussed with supervisor and strategies developed to reduce future unreliability.
- ❑ 3c. **Follow up on missing data:** If followup calls are needed to complete an item, information obtained within 3 working days.

_____/3 **Subtotal**

Comprehensive report writing

- ❑ 4a. **Documentation of background information:**
  - List recipients of report in the header (usually the agency director and IMR leader; add others by mutual agreement).
  - Summarize time, place, and method.
  - Provide background about scale.
- ❑ 4b. **Site and normative fidelity data:** Provide a table with item-level (consensus) scores, along with normative data (if available). Normative data include both national and state norms. In this table, provide comparative site data from prior assessments. On second and later assessments, provide a graph of global fidelity ratings over time for the site *(trend line)*.
- ❑ 4c. **Quantitative summary:** Provide narrative summary of quantitative data. List strengths and weaknesses.
- ❑ 4d. **Score interpretations:**
  - Interpret overall score
  - Include other pertinent observations
  - Provide overall summary
  - Provide opportunity for site to comment and clarify
- ❑ 4e. **Report editing:** If agency is working with a consultant, consultant may write report. Assessor and supervisor review draft of the report before it is submitted to the agency.

_____/5 **Subtotal**

Report submission and followup

- ❑ 5a. **Timely report:** Report sent to agency director within 2 weeks of visit.
- ❑ 5b. **Follow up on report:** If agency is working with a consultant, consultant discusses report with designated agency staff within 1 month of assessment.

_____/2 **Subtotal**

Quality control

- ❑ 6. **Quality control:** Supervisor reviews assessments and gives feedback, as necessary, to assessors. Depending on skill level of assessors, supervisor periodically accompanies assessors on assessment for quality assurance purposes.

_____/1 **Subtotal**

_____/27 **Total —** Add the subtotals.

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SAMHSA

Substance Abuse and Mental Health Services Administration

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