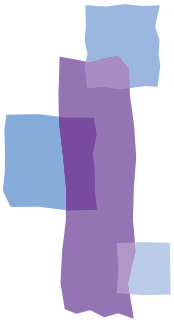

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Integrated Treatment for Co-Occurring Disorders

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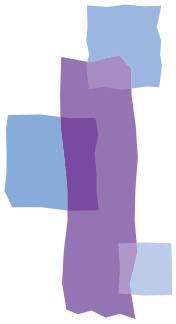

EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Integrated Treatment for Co-Occurring Disorders

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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Originating Office

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
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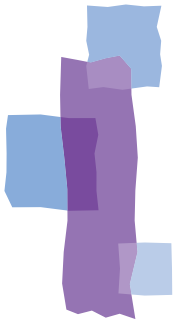


EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Evaluating Your Program shows quality assurance team members how to evaluate the effectiveness of your Integrated Treatment for Co-Occurring Disorders program. It includes the following:

- A readiness assessment;
- The Integrated Treatment Fidelity Scale;
- The General Organizational Index; and
- Outcome measures that are specific to your Integrated Treatment program.

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

Integrated Treatment for Co-Occurring Disorders

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 Integrated Treatment for Co-Occurring Disorders KIT that includes a DVD, CD-ROM, and seven booklets:

How to Use the Evidence-Based Practices KITs

Getting Started with Evidence-Based Practices

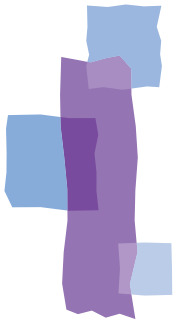
Building Your Program

Training Frontline Staff

Evaluating Your Program

The Evidence

Using Multimedia to Introduce Your EBP



EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Integrated Treatment for Co-Occurring Disorders

What's in *Evaluating Your Program*

EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

Evaluating Your Program

Why Evaluate Your Integrated Treatment Program

Key stakeholders who are implementing Integrated Treatment programs may find themselves asking two questions:

- **Has the program been implemented as planned?**
- **Has the program 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 Integrated Treatment program.

To answer the first question, collect **process measures** (by using the Integrated Treatment 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 your program, 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 Integrated Treatment 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 and substance abuse authorities a comparative framework to evaluate the quality of Integrated Treatment programs across the state. They allow mental health and substance abuse authorities to identify statewide trends and exceptions to those trends.

Research has shown that you can expect these outcomes from your Integrated Treatment program

- Reduced substance use
- Improvement in psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

Why you should collect outcome measures

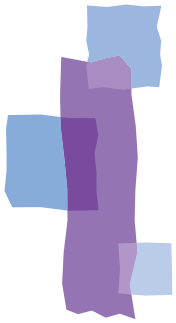
While process measures capture how services are provided, outcome measures capture the program's results. Every service intervention has both immediate and long-term consumer goals. In addition, consumers have goals for themselves, which they hope to attain by receiving mental health and substance abuse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

Consumer outcomes are the bottom line for mental health and substance abuse 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 your mental health and substance abuse system, you should develop a quality assurance system that collects not only process measures such as those on the Integrated Treatment Fidelity Scale and General Organizational Index, but also outcome measures, such as those specified above, to show the effect that integrated treatment has for consumers with co-occurring disorders. 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 and substance abuse services both efficiently and effectively.



EVIDENCE-BASED PRACTICES

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Knowledge Informing Transformation

Evaluating Your Program

Conduct a Readiness Assessment

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

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

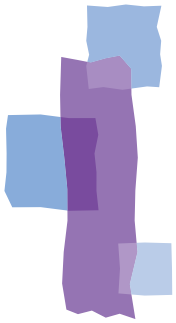
Answering these questions will help you generate an ongoing "to-do" list (or implementation plan) to guide your steps in implementing your Integrated Treatment program. Your answers will also help you understand the components of the evidence-based model that are already in place in your agency and the work that still remains.

Readiness Assessment

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

- ❑ Which practitioners will be designated as staff (integrated treatment specialists) for your Integrated Treatment program?
- ❑ Who will supervise and direct the Integrated Treatment program (Who will be the program leader)?
- ❑ What are the roles of the program leader and integrated treatment specialists?
- ❑ What is the size of the integrated treatment specialists' caseloads?
- ❑ What is the size of the program leader's caseload?
- ❑ What is the supervisory structure (How often does the program leader meet with integrated treatment specialists and the agency director)?
- ❑ How will your integrated treatment specialists be supervised?
- ❑ How will you screen and diagnose consumers with co-occurring disorders?
- ❑ What are your procedures for assessing consumers' stage of treatment?
- ❑ How will you identify and refer consumers to your Integrated Treatment program?
- ❑ How will you inform consumers, families, and others of your Integrated Treatment program?
- ❑ How will you provide access to comprehensive services for consumers in your Integrated Treatment program?
- ❑ What are your assessment procedures for consumers in your program (Will you use integrated comprehensive, longitudinal, and context assessments)?
- ❑ What are your procedures for providing integrated treatment planning?
- ❑ How will integrated treatment specialists communicate and collaborate with other treatment team members, including medication prescribers?
- ❑ How will you educate medication prescribers about the evidence-based practice?
- ❑ What types of group treatment will you provide for consumers with co-occurring disorders?
- ❑ How will family interventions be provided to families or other supporters of consumers in your program?
- ❑ To which alcohol and drug self-help groups will you refer consumers in your program?
- ❑ What are your procedures for identifying consumers who do not respond to integrated treatment? What types of secondary interventions will you provide to them?
- ❑ How will you measure your program's fidelity to the evidence-based model?
- ❑ How does the system for collecting consumer outcome data work?
- ❑ How does your Integrated Treatment program staff relate to advisory groups?

Note areas where you still are unclear or have questions. Arrange to speak to an expert consultant or experienced Integrated Treatment program leader.



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Conduct Process Assessments

In addition to the Readiness Assessment, you should conduct your first process assessment before you begin providing any services for integrated treatment. By doing so you will determine whether your agency has core components of the evidence-based practice in place. During the first 2 years of implementing your Integrated Treatment program, plan to assess your program every 6 months.

After your program has matured and achieved high fidelity, you may choose to conduct assessments once a year. Agencies that have successfully implemented Integrated Treatment programs 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, integrated treatment specialists may tailor the program to meet individual needs of the community. If you continue to use process assessments along with outcomes 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 integrated services for co-occurring disorders are provided:

- The Integrated Treatment Fidelity Scale; and
- General Organizational Index.

You may administer both tools at the same time.

The Integrated Treatment Fidelity Scale has 14 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 program is provided as the evidence-based model prescribes.

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

For the Integrated Treatment Fidelity Scale and GOI, see *Appendixes B* and *D*. You can also print these forms from the CD-ROM in your KIT.

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 **Integrated Treatment Fidelity Scale** was developed by a group of researchers at Indiana University-Purdue University, Indianapolis, and Robert Drake, the developer of the KIT. 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. An earlier version of the Integrated Treatment Fidelity Scale has been extensively piloted in Ohio, with promising results regarding its utility. Revisions were also 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.

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 Integrated Treatment programs have taken different approaches to identify assessors. Some agencies train Integrated Treatment Advisory Committee members as assessors and rotate the responsibility of completing assessments. Others have pre-existing quality assurance teams and simply designate members of the team to complete assessments of their Integrated Treatment program. In other cases, the mental health or substance abuse authorities have designated staff to conduct assessments.

Assessments can be conducted either internally by your 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 evidence-based 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 internal staff to rate their own programs. The validity of these ratings (or any ratings, for that matter) depends on the following:

- 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 assessments 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 evidence-based 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, involve a practitioner who is not centrally involved in providing integrated services for co-occurring disorders.

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 the evidence-based model.

If your agency chooses to use a consultant or trainer to help implement your Integrated Treatment 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 H*.

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 program leader, integrated treatment specialists, consumers, and families;
- Interviewing other agency staff (for example, medication prescribers such as psychiatrists or nurses, therapists, case managers, employment specialists, or rehabilitation services practitioners);
- Observing one or more group or individual counseling sessions;
- Observing a treatment team and supervisory meeting; and
- Conducting a chart review.

Collecting information from multiples sources helps assessors more accurately capture how services are provided. A day-long site visit is the best way to learn this information.

To save time, interviews with integrated treatment specialists and consumers may be done in a group format. If the Integrated Treatment program has five or fewer integrated treatment specialists, it is desirable to interview all of them. If the program has more than five integrated treatment specialists, you should try to interview at least five of them.

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 Integrated Treatment 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 Integrated Treatment 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 Integrated Treatment 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 program resembles the evidence-based 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 Integrated Treatment 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 program 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 staff of the Integrated Treatment program

The most successful assessments are those in which assessors and the staff of the Integrated Treatment program share the goal of understanding how the program is progressing according to evidence-based principles. If administrators or integrated treatment specialists 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 assessment 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, who you must speak with, and how long each interview will take to complete.

The visit will be most efficient if the program leader gathers as much of the following information as possible:

- Roster of staff for the Integrated Treatment program—(roles and full-time equivalents [FTEs]);
- Number of consumers the agency serves;
- Number of consumers actively receiving integrated treatment for co-occurring disorders;
- Number of consumers actively attending the following—
  - Individual substance abuse counseling,
  - Group substance abuse counseling,
  - Family intervention,
  - Self-help groups, and
  - Additional rehabilitation services;

- Number of consumers served through the Integrated Treatment program in the past 6 months;
- Number of consumers who have dropped out of the Integrated Treatment program in the past 6 months;
- A copy of the agency's brochure or mission statement for the Integrated Treatment program;
- A copy of the policies, procedures, and forms used to screen consumers for substance abuse;
- A copy of the policies, procedures, and forms used with consumers in the Integrated Treatment program for assessment and treatment planning;
- A copy of the weekly schedule for substance abuse counseling;
- A copy of the curriculum and schedule used to train agency staff on the evidence-based model; and
- A copy of the agency's quality assurance procedures, specifically a list of process and outcome measures used to evaluate the Integrated Treatment program.

Reassure the program 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 (for example, the number of integrated treatment specialists and number of consumers in the Integrated Treatment program) than other information.

Tell the contact person that you must observe a treatment team meeting, a group supervision meeting, and a group or individual substance abuse counseling session during your visit. These are important factors 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 integrated treatment specialists hand-pick charts or update them before the visit. If you both understand that the goal is to learn how the program is implementing services, this is less likely to occur.

In addition, you can further ensure random selection by asking for 20 charts and randomly selecting 10 to review. Other options include asking for a *de-identified list* (a list with names removed) of consumers who receive Integrated Treatment for Co-Occurring Disorders and using the list to choose 10 charts to review.

If the program only has one integrated treatment specialist with fewer than 10 consumers on its caseload, then review the charts for all consumers in the program.

Clarify reporting procedures

With the appropriate people (agency administrators, the mental health and substance abuse authority, or the program 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 Integrated Treatment Advisory Committee;
- The program leader;
- Integrated treatment specialists; 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 followup 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 a cover sheet for the Integrated Treatment 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 the 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 Integrated Treatment Fidelity Scale and General Organizational Index instruments, cover sheet, and score sheets, see *Appendices 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 Integrated Treatment program may use *member* instead of *consumer* or *clinician* instead of *integrated treatment specialist*. 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 integrated treatment specialists' 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 integrated treatment specialists have with the consumers on their caseloads and with their treatment team members. If Progress Notes are not integrated into consumer charts, then ask if integrated treatment specialists 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 program leader, integrated treatment specialists, 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 program leader

The most common discrepancy is likely to occur when the program leader's interview gives a more idealistic picture of the team's functioning than the chart and observational data do. For example, on the Integrated Treatment Fidelity Scale, *Outreach* (Item 6) assesses whether integrated treatment specialists consistently demonstrate well thought-out strategies and connect consumers to community services, whenever appropriate, to keep consumers engaged in the Integrated Treatment program. The chart review may show that consumers who drop out of the program are not contacted, while the program leader may indicate that integrated treatment specialists expend considerable time reaching out to consumers who have disengaged from the program.

To understand and resolve this discrepancy, the assessor may say something like, "Our chart review shows 10 percent of consumers who disengage are contacted, but your estimate is much higher. Would you help us understand the difference?" Often the program leader can provide information that will resolve the discrepancy.

Before you leave, check for missing data

It is a good idea to check in with the program leader at the end of the visit to collect any additional information you may need.

After your assessment visit

Followup

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 e-mail). This would include discussing with the program leader any discrepancies between data sources that you notice after you've completed the visit.

Score the Fidelity Scale and GOI

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 *Access to comprehensive services* (Item 4), the agency must currently offer comprehensive services. If the agency plans future changes in this area but does not yet offer comprehensive services, it would not receive credit. 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.

Many agencies that are developing a new Integrated Treatment program will receive low fidelity ratings on items for which the agency has not yet formulated its policies and procedures. For example, several items are based on evaluating services that are provided by designated trained practitioners (integrated treatment specialists) to a targeted group of consumers who have co-occurring disorders. Agencies that have not yet hired or assigned and trained integrated treatment specialists and developed caseloads of consumers to receive integrated treatment for co-occurring disorders cannot be rated for these items.

The ratings of other items depend on whether the agency has developed integrated screening, assessment, and treatment planning procedures. If an item cannot be rated, code it as "1."

To receive full credit, many items require that the program leader and integrated treatment specialists both understand and apply the evidence-based practice principle. If integrated treatment specialists 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 at least 80 percent of the time.

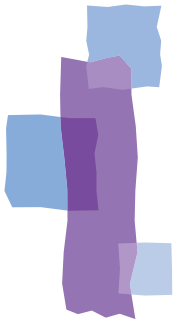
For a complete explanation of how to rate each item, see the Integrated Treatment Fidelity Scale Protocol and General Organizational Index Protocols in *Appendixes C* and *E*.

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 the level of implementation achieved.



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Conduct Outcomes Monitoring

Unlike process measures for your Integrated Treatment program, which must be used in full to comprehensively understand how services are provided, you must decide which outcome measures will be most informative for your 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. 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:

- Reduced substance use;
- Improvement in psychiatric symptoms and functioning;
- Decreased hospitalization;
- Increased housing stability;
- Fewer arrests; and
- Improved quality of life.

These few outcomes reflect the primary goals of Integrated Treatment for Co-Occurring Disorders. Specifically, the goal of this evidence-based practice is to help consumers move forward in the process of recovering from two serious illnesses and learn to manage both so that consumers can pursue meaningful life goals. For this reason, it is important for you to capture outcomes for recovery from both substance abuse and serious mental illness 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 integrated treatment specialists 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 integrated treatment specialists, without requiring data from consumers and families.

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:

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 EBP. Data may be entered for the chosen outcomes, and reports can be generated quarterly or monthly. The COMP also allows agencies to view their outcomes data using a variety of tables and graphs.

The designers of COMP tried to make the computer application as easy and as 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.
- Follow the prompt requesting a user name and password.
- Type in: User Name: **ebp**
  Password: **kujayhawks**
  Domain: (If this appears, leave it blank.)
- Click on the links to download the *Installation Instructions* and *User Manual*.
- Follow the instructions to install the application.

- Publicly available tools such as the Consumer Outcomes Monitoring Package (see the previous page) and the Decision Support 2000+ Online (**www.ds2kplus.org**); and
- Commercially available products such as Service Process Quality Management™ (**www.nccbh.org/spqm**).

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 integrated treatment specialists, and it must give them information that is useful in their jobs.

The system should fit into the workflow of the agency, 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 integrated treatment specialists.

Expanding Your Outcome Measures

Once you have established your core outcomes monitoring system, have learned how to routinely collect data, and are accustomed to using it to improve your Integrated Treatment program, you will be ready to expand your outcomes measures.

Consider asking consumers and families for input on improving your Integrated Treatment 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 are satisfied with their services;
- How services have affected their quality of life; and
- Whether they 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 integrated treatment specialists, 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: **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 get a representative sample of consumer and family respondents since mailed surveys are often not returned and interviews may only 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 a variety of mechanisms to conduct your assessments. For example, consider combining feedback collected through surveys with that obtained from focus groups. Another option is to hire a consultant to conduct qualitative interviews with a small group of consumers or families. SAMHSA's Co-Occurring Center for Excellence (**www.coce.samhsa.gov**) is one resource to find evaluation consultants.

Computer software that allows for data entry and manipulation (for example, Microsoft Access, Excel, and Lotus) makes tabulating data and graphing easier than doing them 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, see *Appendix F*, which is an example of a simple, paper-based way to collect participation and outcome data regularly. For instructions for using the Outcomes Report Form, see *Appendix G*.

How often should you collect outcomes data?

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

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

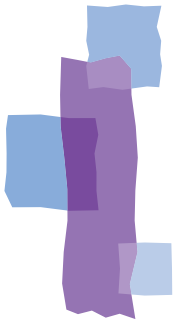
How should you identify data collectors?

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

- The program leader;
- Members of the Integrated Treatment Advisory Committee;
- 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 day-long assessment process. Many standard outcome measures will be information that integrated treatment specialists can report from their daily work with consumers.

It is important to develop a quick, easy, standardized approach to collect outcomes data. For example, create a simple form or computer database that integrated treatment specialists can routinely update.



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Use Data to Improve Your Integrated Treatment Program

As you develop a quality assurance system, program leaders and integrated treatment specialists 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 program staff 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 Integrated Treatment Fidelity Scale, GOI, 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 Integrated Treatment program; and
- Clear recommendations to help the program improve.

The report should be informative, factual, and constructive. Since some process measures assess adherence to the evidence-based model at both the *agency* and *program staff* levels, remember to target recommendations to administrators, the program leader, and integrated treatment specialists.

When summarizing outcomes 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 integrated treatment specialist's caseload, or the program as a whole. For example, reports generated for individual consumers may track the consumer's participation in specific stages of treatment and outcomes over time. You could enter these reports in consumers' charts and they could be the basis for discussions about consumers' progress.

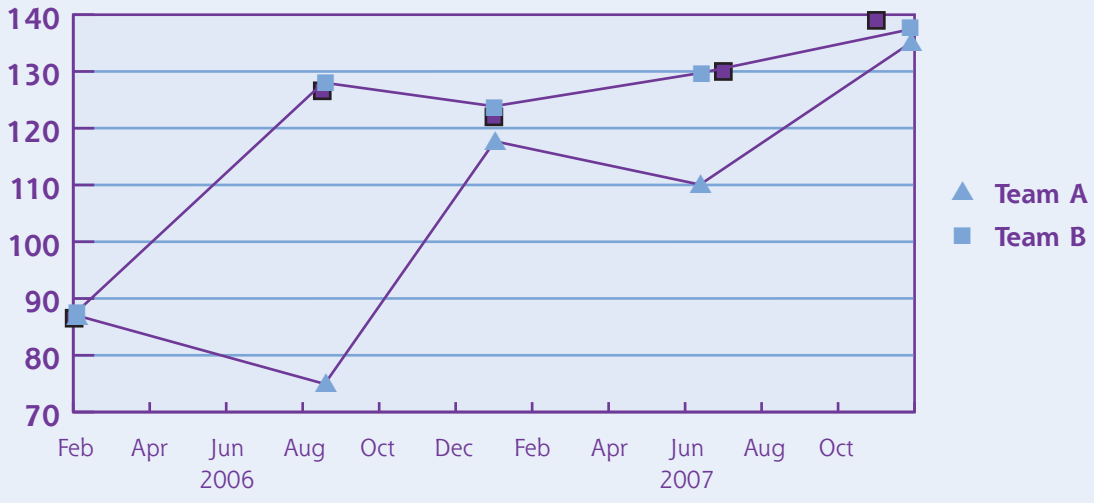
Use tables and graphs to understand your outcomes data

After the first process and outcomes 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 help understand and report the results.

By graphing your fidelity score, you have a visual representation of how your 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.

Figure 1. Fidelity Over Time



Date of Assessment

Note: 62 – 70 = good implementation
52 – 61 = fair implementation
51 and below = not evidence-based practice

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.

Another feature of graphing assessment scores is to examine the cut-off score for *fair* (52) or *good* (62) 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 Integrated Treatment program during the last quarter?
- How did the level of substance use for those participating in the Integrated Treatment program compare to substance use for consumers in standard treatment?
- How did the hospitalization rate for those participating in the Integrated Treatment program 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
Integrated Treatment for Co-Occurring Disorders	0	30	60	67%
Assertive Community Treatment	30	25	90	78%

This agency provides both Integrated Treatment for Co-Occurring Disorders and Assertive Community Treatment. The Integrated Treatment program serves 90 consumers. Of those, 60 receive Integrated Treatment for Co-Occurring Disorders, while 30 consumers are eligible but receive another service. Consequently, 67% of consumers who are eligible for the Integrated Treatment program 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' stages of treatment between two quarters.

Table 2: Sample Movement Table

		To FY '06 Qtr 3			
		Persuasion	Active treatment	Relapse prevention	
From: FY '06 Qtr: 2	Persuasion	2	1	3	
	Active treatment	3	8	3	
	Relapse prevention	1	3	100	
	Totals*	6	12	106	*Total 124

Above the diagonal
Below the diagonal
Within the diagonal

To create this table, the data were collapsed into the three broad categories. The vertical data cells reflect the stages of treatment for consumers for the beginning quarter. The horizontal data cells reflect the most recent quarterly information. The stages of treatment are then ordered from the least desirable (*persuasion*) to the most desirable (*relapse prevention*).

The data in this table are presented in three colors. The purple cells are those above the diagonal, the blue 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 more desirable stage of treatment between quarters. As you can see, one consumer moved from persuasion to active treatment, three consumers moved from persuasion to relapse prevention, and three consumers moved from active treatment to relapse prevention. These seven consumers (6% of the 124 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 stage of treatment between quarters. Two consumers were in the persuasion stage for both quarters of this report, eight consumers were in the active treatment stage for both quarters, and 100 consumers were in the relapse prevention stage for both quarters. These 110 consumers (88% of the 124 consumers in the program) remained stable between quarters.

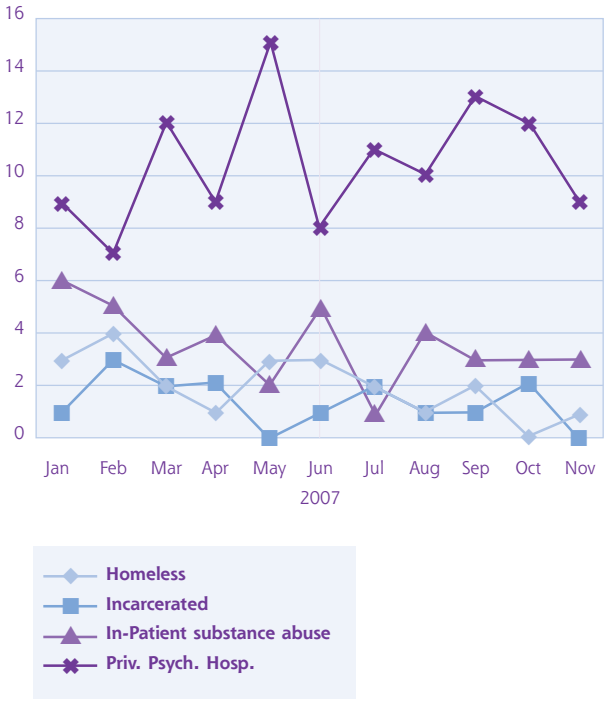
The cells below the diagonal line represent consumers who moved into a less desirable stage of treatment between quarters. Three consumers moved from active treatment to persuasion, one consumer moved from relapse prevention to persuasion, and three consumers moved from relapse prevention to active treatment. These seven consumers (6% of the 124 consumers in the program) experienced some setbacks between quarters. The column totals show the number of consumers in a given stage of treatment 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 Integrated Treatment program over an 11-month period.

Figure 2. Sample Longitudinal Plot for Monthly Frequency of Negative Incidents for Consumers in Integrated Treatment Programs



This plot reveals that with the exception of inpatient mental health treatment, all other critical incidents for the 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.

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 were homeless during the past quarter, but it is more informative to know that this represents 10 percent of the consumers in the Integrated Treatment 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.

If you are sharing the results beyond the treatment team, remember to report aggregate-level data only as shown in the previous example. It is important to protect consumers' confidentiality. Consumers with substance use disorders are particularly vulnerable since using and distributing illicit drugs is an illegal activity punishable by law. For this reason, they are afforded special protections under the Code of Federal Regulations.

For more information about the types of information you may share and how to protect consumers' confidentiality, see: **http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfr2_00.html.**

Sharing results with integrated treatment specialists

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 evoke a search for underlying reasons and should generate strategies that offer the promise of improvement. By doing this regularly, program leaders will create a "learning organization" characterized by adaptive responses to information that aim to improve consumer outcomes.

Sharing results with your Integrated Treatment Advisory Committee 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 and substance abuse authority, and consumers and family advocates can be valuable. Through these channels, you may develop support for the Integrated Treatment program, increase consumer participation, and raise private funds for your agency.

Sharing results internally

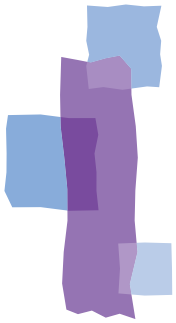
Agencies may distribute reports during all staff and manager-level meetings to keep staff across the agency informed and engaged in the process of implementing your Integrated Treatment program. Agencies with successful Integrated Treatment programs highlight the importance of developing an understanding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

In addition, integrating consumer-specific reports into clinical charts may help you monitor consumers' progress over time. Reporting consumer-specific outcomes 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 Integrated Treatment 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 Integrated Treatment 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—Integrated Treatment Fidelity Scale and General Organizational Index

Cover Sheet: Integrated Treatment Fidelity Scale and General Organizational Index

Today's date ____/____/____

Assessors' names _____

_____

_____

Program name (or Program code) _____

Agency name _____

Agency address _____
Street

_____
City State ZIP code

Names of integrated treatment specialists _____

Program leader or contact person _____

Telephone (___) ___ – _____ E-mail _____

Sources used for fidelity and GOI assessments:

- ❑ Chart review: Number reviewed _____
- ❑ Treatment team observation
- ❑ Supervisory meeting observation
- ❑ Group or individual counseling session observation
- ❑ Program leader interview
- ❑ Integrated treatment specialist interviews Number reviewed _____
- ❑ Consumer interviews Number reviewed _____
- ❑ Family member interviews Number reviewed _____
- ❑ Other staff interviews Number reviewed _____
- ❑ Brochure review
- ❑ Other _____

Number of integrated treatment specialists _____

Number of consumers in the program _____

Number of consumers who left the program in the past 6 months _____

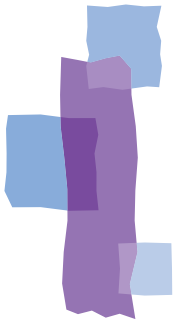
Number of consumers served in the past 6 months _____

Funding source _____

Agency location:

- ❑ Urban
- ❑ Rural

Date program was started ____/____/____



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix B: Integrated Treatment Fidelity Scale and Score Sheet

Integrated Treatment Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
1.	**Multidisciplinary team:** Case managers, psychiatrist, nurses, residential staff, employment specialists, and rehabilitation specialists work collaboratively on mental health treatment team.	≤20% of consumers receive care from multidisciplinary team (i.e., most care follows a brokered case management or traditional outpatient approach) OR Cannot rate due to no fit	21%–40% of consumers receive care from a multidisciplinary team	41%–60% of consumers receive care from a multidisciplinary team	61%–79% of consumers receive care from a multidisciplinary team	>80% of consumers receive care from a multidisciplinary team with a strong emphasis on accessing a broad range of services and excellent communication among all disciplines
2.	**Integrated treatment specialists:** Integrated treatment specialists work collaboratively with the multidisciplinary treatment team, modeling integrated treatment skills and training other staff in evidence-based practice principles and practice.	No integrated treatment specialist connected with agency OR Cannot rate due to no fit	Consumers with co-occurring disorders are referred to a separate Integrated Treatment program within the agency (for example, referred to integrated treatment specialists)	Integrated treatment specialists serve as consultants to treatment teams, do not attend meetings, are not involved in treatment planning	Integrated treatment specialists are assigned to treatment teams, but are not fully integrated; attend some meetings; may be involved in treatment planning but not systematically	Integrated treatment specialists are fully integrated members of the treatment team, attend all team meetings, are involved in treatment planning, model and train other staff in Integrated Treatment for Co-Occurring Disorders
3.	**Stage-wise interventions:** All services are consistent with and determined by each consumer's stage of treatment (engagement, persuasion, active treatment, relapse prevention).	≤20% of interventions are consistent with consumer's stage of treatment OR Cannot rate due to no fit	21%–40% of interventions are consistent with consumer's stage of treatment	41%–60% of interventions are consistent with consumer's stage of treatment	61%–79% of interventions are consistent with consumer's stage of treatment	≥80% of interventions are consistent with consumer's stage of treatment
4.	**Access to comprehensive services** Consumers in the Integrated Treatment program have access to comprehensive services including the following: ■ Residential services ■ Supported employment ■ Family interventions ■ Illness management and recovery ■ Assertive community treatment	Fewer than 2 services are provided by the agency or consumers do not have genuine access to these services, OR Cannot rate due to no fit	2 services are provided by the agency and consumers have genuine access to these services	3 services are provided by the agency and consumers have genuine access to these services	4 services are provided by the agency and consumers have genuine access to these services	All 5 services are provided by the agency and consumers have genuine access to these services
5.	**Time-unlimited services:** Consumers in the Integrated Treatment program are treated on a time-unlimited basis with intensity modified according to each consumer's needs.	Services are provided on a time-unlimited basis 20% or less of the time (for example, consumers are closed out of most services after a defined period of time), OR Cannot rate due to no fit	Services are provided on a time-unlimited basis 21%–40% of the time	Services are provided on a time-unlimited basis 41%–60% of the time	Services are provided on a time-unlimited basis 61%–79% of the time	Services are provided on a time-unlimited basis with intensity modified according to each consumer's needs ≥80% of the time

Integrated Treatment Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
6.	**Outreach:** Integrated treatment specialists demonstrate consistently well-thought out outreach strategies and connect consumers to community services, whenever appropriate, to keep consumers engaged in the Integrated Treatment program.	Integrated treatment specialists are passive in recruitment and re-engagement; almost never use outreach mechanisms, OR Cannot rate due to no fit	Integrated treatment specialists make initial attempts to engage, but generally focus efforts on most motivated consumers	Integrated treatment specialists try outreach mechanisms only as convenient	Integrated treatment specialists usually have plan for engagement and use most available outreach mechanisms	Integrated treatment specialists demonstrate consistently well-thought out outreach strategies and connect consumers to community services, whenever appropriate, to keep consumers engaged
7.	**Motivational interventions:** All interactions with consumers in the Integrated Treatment program are based on motivational interventions that include the following: ■ Expressing empathy ■ Developing discrepancy ■ Avoiding argumentation ■ Rolling with resistance ■ Instilling self-efficacy and hope	Integrated treatment specialists do not understand motivational interventions, ≤20% of interactions with consumers are based on motivational approaches, OR Cannot rate due to no fit	Some integrated treatment specialists understand motivational interventions, and 21%–40% of interactions with consumers are based on motivational approaches	Most integrated treatment specialists understand motivational interventions, and 41%–60% of interactions with consumers are based on motivational approaches	All integrated treatment specialists understand motivational interventions and 61%–79% of interactions with consumers are based on motivational approaches	All integrated treatment specialists understand motivational interventions and ≥80% of interactions with consumers are based on motivational approaches
8.	**Substance abuse counseling:** Consumers who are in the active treatment or relapse prevention stages receive substance abuse counseling that includes: ■ How to manage cues to use and consequences of use ■ Relapse prevention strategies ■ Drug and alcohol refusal skills training ■ Problem-solving skills training to avoid high-risk situations ■ Coping skills and social skills training ■ Challenging consumers' beliefs about substance abuse	Integrated treatment specialists do not understand basic substance abuse counseling principles and ≤20% of consumers in active treatment stage or relapse prevention stage receive substance abuse counseling, OR Cannot rate due to no fit	Some integrated treatment specialists understand basic substance abuse counseling principles and 21%–40% of consumers in active treatment stage or relapse prevention stage receive substance abuse counseling	Most integrated treatment specialists understand basic substance abuse counseling principles and 41%–60% of consumers in active treatment stage or relapse prevention stage receive substance abuse counseling	All integrated treatment specialists understand basic substance abuse counseling principles and 61% –79% of consumers in active treatment stage or relapse prevention stage receive substance abuse counseling	All integrated treatment specialists understand basic substance abuse counseling principles and ≥80% of consumers in active treatment stage or relapse prevention stage receive substance abuse counseling
9.	**Group treatment for co-occurring disorders:** Consumers in the Integrated Treatment program are offered group treatment specifically designed to address both mental health and substance abuse problems.	<20% of consumers regularly attend group treatment, OR Cannot rate due to no fit	20%–34% of consumers regularly attend group treatment	35%–49% of consumers regularly attend group treatment	50%–65% of consumers regularly attend group treatment	>65% of consumers regularly attend group treatment

Integrated Treatment Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
10.	**Family interventions for co-occurring disorders:** With consumers' permission, integrated treatment specialists involve consumers' family (or other supporters), provide education about co-occurring disorders, offer coping skills training and support to reduce stress in the family, and promote collaboration with the treatment team.	Consumers are not asked for permission to involve family (or other supporters) or < 20% of families (or other supporters) receive family interventions for co-occurring disorders OR Cannot rate due to no fit.	Consumers are asked for permission to involve family (or other supporters) and 20%–34% of families (or other supporters) receive family interventions for co-occurring disorders	Consumers are asked for permission to involve family (or other supporters) and 35%–49% of families (or other supporters) receive family interventions for co-occurring disorders	Consumers are asked for permission to involve family (or other supporters) and 50%–65% of families (or other supporters) receive family interventions for co-occurring disorders	Consumers are asked for permission to involve family (or other supporters) and > 65% of families (or other supporters) receive family interventions for co-occurring disorders
11	**Alcohol and drug self-help groups:** Consumers in the active treatment or relapse prevention stages attend self-help programs in the community.	< 20% of consumers in the active treatment or relapse prevention stages attend self-help programs in the community, OR Cannot rate due to no fit	20%–34% of consumers in the active treatment or relapse prevention stages attend self-help programs in the community	35%–49% of consumers in the active treatment or relapse prevention stages attend self-help programs in the community	50%–65% of consumers in the active treatment or relapse prevention stages attend self-help programs in the community	> 65% of consumers in the active treatment or relapse prevention stages attend self-help programs in the community
12.	**Pharmacological treatment:** Prescribers for consumers in the Integrated Treatment program are trained in the evidence-based model and use the following strategies: ■ Prescribe psychiatric medications despite active substance use ■ Work closely with consumers and the treatment team ■ Focus on increasing adherence to psychiatric medication ■ Avoid prescribing medications that may be addictive ■ Prescribe medications that help reduce addictive behavior	Prescribers use less than 2 of the strategies listed, OR Cannot rate due to no fit.	Approximately 2 of 5 strategies used	Approximately 3 of 5 strategies used	4 of 5 strategies used	Evidence that all 5 strategies are used: medications are prescribed despite active substance use, prescribers receive pertinent input from the treatment team about medication decisions, use strategies to maximize adherence to psychiatric medications; avoid prescribing medications that are addictive and offer medications known to be effective for reducing addictive behavior
13.	**Interventions to promote health:** Integrated treatment specialists promote health by encouraging consumers with co-occurring disorders to do the following: ■ Avoid high-risk behavior and situations that can lead to infectious diseases ■ Find safe housing ■ Practice proper diet and exercise.	Integrated treatment specialists offer no interventions to promote health, OR Cannot rate due to no fit	Integrated treatment specialists may have some knowledge of reducing negative consequences of substance abuse, but rarely use concepts	Less than half of all consumers receive services to promote health; integrated treatment specialists use concepts unsystematically	50%–79% of consumers receive services to promote health; all integrated treatment specialists are well versed in techniques to reduce negative consequences of substance abuse	> 80% of consumers receive services to promote health; all integrated treatment specialists are well versed in techniques to reduce negative consequences of substance abuse

Integrated Treatment Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
14.	**Secondary interventions for nonresponders:** The Integrated Treatment program has a protocol to identify consumers who do not respond to basic treatment for co-occurring disorders, to evaluate them, and to link them to appropriate secondary interventions.	≤20% of nonresponders are evaluated and referred for secondary interventions OR There is no recognition of a need for secondary interventions for nonresponders, OR Cannot rate due to no fit	21%–40% of nonresponders are evaluated and referred for secondary interventions OR Secondary interventions are not systematically offered or available to nonresponders	Program has protocol and 41%–60% of nonresponders are evaluated and referred for secondary interventions OR No formal method to identify nonresponders	Program has protocol to identify nonresponders and 61%–79% of nonresponders are evaluated and referred for secondary interventions	Program has protocol to identify nonresponders and >80% of nonresponders are evaluated and referred for secondary interventions

Score Sheet: Integrated Treatment Fidelity Scale

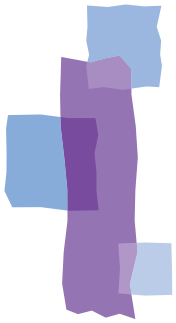
Date of visit ____/____/____

Agency name _____

Assessors' names _____ _____

		Assessor 1	Assessor 2	Consensus
1	Multidisciplinary team			
2	Integrated treatment specialist			
3	Stage-wise interventions			
4	Access to comprehensive services			
5	Time-unlimited services			
6	Outreach			
7	Motivational interventions			
8	Substance abuse counseling			
9	Group treatment for co-occurring disorders			
10	Family interventions for co-occurring disorders			
11	Alcohol and drug self-help groups			
12	Pharmacological treatment			
13	Interventions to promote health			
14	Secondary interventions for nonresponders			
	Total score			
	Items not rated			

62-70 = Good implementation
52-61 = Fair implementation
51 and below = Not evidence-based practice



EVIDENCE-BASED PRACTICES

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Evaluating Your Program

Appendix C: Integrated Treatment Fidelity Scale Protocol

Integrated Treatment Fidelity Scale Protocol

This protocol explains how to rate each item on the Integrated Treatment Fidelity Scale. In particular, it provides the following:

- A definition and rationale for each fidelity item. These items have been derived from comprehensive, evidence-based literature.
- A list of data sources most appropriate for each fidelity item (for example, chart review, program leader interview, team meeting observation). When appropriate, a set of probe questions is provided to help you elicit the critical information needed to code the item. These questions were specifically generated to help you collect information from respondents that is free from bias such as social desirability.
- Decision rules that will help 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.

1. Multidisciplinary Team

Definition: All consumers in the Integrated Treatment program receive care from a multidisciplinary team, consisting of two or more of the following:

- A psychiatrist;
- A nurse;
- A case manager;
- Residential staff;
- Employment specialists; and
- Practitioners of other ancillary rehabilitation services.

Rationale: Although a major focus of treatment is to eliminate or reduce substance abuse, this goal is more effectively met when other domains of functioning in which consumers are typically impaired are also addressed. Effective Integrated Treatment programs coordinate all elements of treatment and rehabilitation to ensure that everyone works collaboratively toward the same goals.

Sources of information:

1. Program leader and integrated treatment specialist interviews

Ask interviewees to briefly describe the program.

- "Thinking about the services offered to consumers in your program, who provides their mental health case management? Who provides their substance abuse treatment? Describe these services."
- "Do these practitioners have team meetings? How often? Who is present?"
- "Are nurses, residential staff, employment specialists, and psychiatrists involved in joint planning?"
- "In a typical week how much contact do practitioners have with other team members?"

2. Employment specialist and residential staff interview

- "How often do you attend treatment team meetings that include psychiatrists, nurses, case managers, and other practitioners?"
- "Are you consulted about treatment decisions?"
- "Do case managers help with housing and employment?"

3. Consumer interview

- "Do you also receive employment (housing, family, Illness Management and Recovery, or Assertive Community Treatment) services from this agency?" [If *yes*, "Do your (employment specialist, housing specialist, family counselor, or case manager) talk to one another so that they are on the same page in helping you?"]
- "Were there any other services that you wanted, but they were unavailable?"

Item response coding: First, determine if the agency's psychiatrists, nurses, case managers, employment specialists, and other practitioners, work together as

a team, as shown by regular contacts and collaborative treatment planning.

If this is generally not true (for example, if psychiatrists attend treatment team meetings less than once every 2 weeks), then score this item lower. If the treatment approach is mostly parallel or brokered (different practitioners work in different buildings or different parts of the same building but do not meet regularly), code the item as "1."

If the treatment approach is a mix between parallel and multidisciplinary (for example, some practitioners are present at weekly treatment team meetings, but other key staff are not), code the item as "3."

If the agency embraces a multidisciplinary approach but applies it inconsistently, then it may be more appropriate to determine the percentage of consumers who receive multidisciplinary services. Use team rosters as the primary data source, and determine whether the activities are documented in the charts.

2. Integrated treatment specialist

Definition: Integrated treatment specialists are fully integrated members of the treatment team, attend all team meetings, are involved in treatment planning, and model and train other staff in Integrated Treatment for Co-Occurring Disorders.

Rationale: Including experienced integrated treatment specialists on a multidisciplinary treatment team is essential to ensure a sustained focus on treating co-occurring disorders.

Sources of information:

1. **Program leader interview**
   - "How often do integrated treatment specialists attend team meetings?"
   - "How often do integrated treatment specialists contact consumers' case managers and other practitioners in a typical week?"
   - "Are integrated treatment specialists considered members of the team? How so? Do they carry a caseload?"
   - "Are consumers involved in integrated treatment planning in your program?"
2. **Integrated treatment specialists interview**
   - "Do you attend multidisciplinary treatment team meetings? How often?" [If there's contact with the team, probe to specify who is involved.]
   - "What is your role on the treatment team?"
   - "How many consumers in the Integrated Treatment program do you see? What is your role in their treatment?" [Probe for assessment, treatment planning, groups, individual, etc.]
   - "What other practitioners are involved in caring for consumers with co-occurring disorders on your caseload? What is their role in consumers' treatment?"
3. **Chart review**
   - Check for integrated treatment specialist involvement in treatment team meetings.
   - Check for individual and group counseling sessions that integrated treatment specialists conduct.

3. Stage-wise interventions

Definition: All services (including ancillary rehabilitation services) are consistent with and determined by consumers' stage of treatment. The stages of treatment include the following:

- **Engagement:** Forming a trusting, working alliance or relationship
- **Persuasion:** Helping engaged consumers develop the motivation to participate in recovery-oriented interventions
- **Active treatment:** Helping motivated consumers acquire skills and supports for managing illnesses and pursuing goals
- **Relapse prevention:** Helping consumers in stable remission from mental illness and substance use disorders develop and use strategies for maintaining recovery

Rationale: Research suggests that maladaptive behavior is most effectively modified when stages of treatment are considered.

Sources of information:

1. **Program leader interview**
   - "What is the process (or model) used to treat consumers with co-occurring disorders?"
   - "How do you deal with consumers who appear unwilling to change?" [Probe for whether confrontation is used.]
   - "At which point would you refer consumers to self-help groups such as Alcoholics Anonymous? What about detoxication programs?"
   - "Do you see abstinence as the goal of your program? How do you view abstinence versus reducing use?"
   - "What kind of relapse prevention skills do you teach? Do you teach relapse prevention skills to consumers who are actively using drugs or alcohol?"
   - "Has the agency ever offered training on stages of change and the stages of treatment?"

2. **Integrated treatment specialist interview**
   - "Are you familiar with a stage-wise approach to substance use treatment?" [If *yes*, "Which stages are defined in the approach your program uses?"]

If integrated treatment specialists say they use the stage-wise model, ask them to go through their caseload and identify the stage each consumer is in. Try to get an idea of what the integrated treatment specialist is trying to accomplish with each consumer (for example, trying to get someone in the engagement stage to attend a self-help group, building rapport, or providing support).

Labeling stages is not as critical as intention and actual practice. As you listen, try to identify how many active consumers currently fit into each of the four stages since Items 8 and 11 will need these numbers.

3. **Team meeting, supervision, individual or group counseling observations**

Listen for discussion of whether services are provided based on consumers' stage of treatment.

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

Review assessments and treatment plans to determine whether the services consumers are receiving match their stage of treatment.

Item response coding: Coding this item requires that the integrated treatment specialists both understand and apply that understanding. If integrated treatment specialists generally do not understand the concepts, then code the item as "1."

If they understand parts of the concept (for example, if they differentiate between engagement and active treatment), and if they apply the understanding consistently (for example, different goals for consumers in different stages), code the item as "3."

To code this item as "5," evidence must show that stage-wise concepts are applied consistently for 80 percent or more of consumers, as documented across different sources of evidence.

4. Access to comprehensive services

Definition: Consumers in the Integrated Treatment program have access to the following five ancillary rehabilitation services:

- **Residential services** includes supervised residential services, supported housing, and residential programs with onsite residential staff. Consumers with co-occurring disorders who live independently are counseled on their housing options, when needed. For this item, do not give credit for short-term residential services (for example, a month or less).
- **Supported Employment** (SE) includes services focused on helping consumers obtain and sustain competitive employment. Abstinence should not be required to obtain these services.
- **Family interventions** includes a collaborative relationship among the treatment team, consumer, and family (or other supporters) in which basic education about co-occurring disorders, coping

skills training, and support is offered to reduce stress in the family.

- **Illness Management and Recovery** (IMR) includes psychoeducation, behavioral tailoring, coping skills training, and cognitive-behavioral approaches to helping consumers learn to manage their illness, find their own goals for recovery, and make informed decisions about their treatment.
- **Assertive Community Treatment** (ACT) includes a multidisciplinary team approach to treatment (consumer-to-practitioner ratios of 15:1 or lower) with 24-hour access and at least 50 percent of consumer contact occurring in the community.

Rationale: Consumers in the Integrated Treatment program have a wide range of needs, such as developing a capacity for independent living, obtaining employment, or reaching other meaningful recovery goals, improving the quality of their family and social relationships, and managing anxiety and other moods. Effective Integrated Treatment programs must be comprehensive because the recovery process occurs longitudinally in the context of making many life changes.

Sources of information:

1. Program leader interview

- "Does your agency provide (Residential services, SE, Family interventions, IMR, or ACT) services?" [If *yes*, probe for specifics of each service area. For example, "What kind of residential services? How long are your residential services provided? What do you mean by Supported Employment?"]
- "Describe the referral process to these services. Are consumers in your program eligible for these services? What are the admission criteria?" [Probe and listen for exclusion criteria. For example, "The state vocational rehabilitation agency won't let us offer SE services to consumers with co-occurring disorders until they have been sober for 6 months."]
- "What is the waiting period for consumers in your Integrated Treatment program to obtain ancillary rehabilitation services after the referral is made?"
- Ask for a copy of the agency brochure, if available, and look for a description of available rehabilitation services.

2. Integrated treatment specialist interviews

"Review your caseload. List the types of services each consumer currently receives." [Probe for reasons that consumers are not receiving a relevant ancillary rehabilitation service.]

3. Other agency staff interviews

Interview other service providers (Residential services, SE, Family interventions, IMR, or ACT staff) to confirm whether they accept consumers with co-occurring disorders. Probe for their procedures for serving consumers with co-occurring disorders.

4. Chart review

Look for documentation of referrals made to the five ancillary rehabilitation services.

Item response coding: Evaluate the availability of each service above. To count as *available*, the agency must offer the service AND consumers in the program must have genuine access to the service if they need it.

To document access to a service, a minimum requirement is that at least one consumer must currently receive that service. If a service is not currently used by any consumers or is so restricted that consumers rarely receive it, then count that service as unavailable.

While agencies are encouraged to offer high-fidelity SE, IMR, and ACT programs, it is not necessary to conduct fidelity assessments of these ancillary programs for the purpose of scoring this item. You may give full credit as long as agencies have the key elements of the service in place as defined above.

If multiple sources confirm that all five services are available to consumers in the Integrated Treatment program, code the item as "5."

5. Time-unlimited services

Definition: Consumers in the Integrated Treatment program are treated on a time-unlimited basis with intensity modified according to each consumer's need.

Rationale: The evidence suggests that co-occurring disorders tend to be chronic and severe. A time-unlimited service that meets individual consumers' needs is believed to be the most effective strategy to treat this population.

Sources of information:

1. **Program leader interview**
   - "Are there any time limits for providing services to consumers in the Integrated Treatment program in your agency?" [If *yes*, "How long? How do you determine the duration of support that consumers receive?"]
   - "Do you graduate consumers from your Integrated Treatment program after they have completed a certain number of sessions or groups?"
   - "Which services are given on a time-unlimited basis?"
   - "Are consumers funded for a particular period of time to receive Integrated Treatment for Co-Occurring Disorders?"
2. **Integrated treatment specialist interviews**
   - "Have any consumers on your caseload graduated or left the Integrated Treatment program in the last 6 months?" [If *yes*, "Please describe the circumstances."]
3. **Other agency staff interviews**
   - "Are services to consumers with co-occurring disorders provided on a time-unlimited basis?"
4. **Chart review**

Examine the length of time in services and reasons for termination.

Item response coding: If services to consumers with co-occurring disorders are provided on a time-unlimited basis 80 percent or more of the time with intensity modified according to each consumer's needs, code the item as "5."

If the agency provides services on a time-unlimited basis 41 to 60 percent of the time, then code the item as "3."

6. Outreach

Definition: For all consumers in the Integrated Treatment program, but especially for those in the engagement stage, integrated treatment specialists provide assertive outreach by offering practical assistance or connecting consumers with other community services (for example, housing assistance, medical care, crisis management, legal aid, etc.) that meet their needs as a means of developing trust and a working alliance.

Rationale: Many consumers in the Integrated Treatment program tend to drop out of treatment due to problems in their lives, low motivation, cognitive impairment, and hopelessness. Effective Integrated Treatment programs use assertive outreach to keep consumers engaged.

Sources of information:

1. **Program leader and integrated treatment specialist interviews**
   - "Do you have a policy about discharging consumers who don't show up for treatment from the Integrated Treatment program?"
   - "It is common for consumers with co-occurring disorders to drop out of treatment. How do you engage or re-engage consumers who drop out? What kind of strategies do you use to develop a working alliance with your consumers?"
   - "How do you engage consumers who are homeless in your program?"

- "How do consumers in your program reach you in times of crisis?"
- "Describe a consumer you found hard to engage. How did you approach this consumer?"

2. Consumer interview

- "Have you ever told your integrated treatment specialist that you wanted to drop out of the program? What happened then?"
- "Do you feel that your integrated treatment specialist would help you when you are in trouble or need help urgently? Can you describe a time when this happened?"

3. Chart review

Examine charts of consumers who have dropped out of the program. What were their reasons for leaving?

Item response coding: If the program demonstrates consistently well thought-out outreach strategies and connects consumers to community services, whenever appropriate, to keep consumers engaged in the Integrated Treatment program, code the item as "5."

7. Motivational interventions

Definition: All interactions with consumers in the Integrated Treatment program are based on motivational interventions that include the following:

- Expressing empathy;
- Developing discrepancy between goals and continued use;
- Avoiding argumentation;
- Rolling with resistance; and
- Instilling self-efficacy and hope.

Rationale: Motivational interventions involve helping consumers identify their own goals and to recognize, through systematically examining the person's ambivalence, that not managing one's illnesses interferes with attaining those goals. Research has shown that consumers targeted for Integrated Treatment who are unmotivated can be readily identified and effectively helped with motivational interventions.

Sources of information:

1. Program leader and integrated treatment specialist interviews

- "Are you familiar with motivational interventions such as motivational interviewing, motivational counseling, or other motivational approaches?" [If *yes*, "Could you give examples of motivational interventions that you use?"]
- "Has your agency ever offered training on motivational interventions?"
- "How do you instill self-confidence and hope in consumers?"
- "Can you give an example of how you have used a motivational intervention to help a consumer on your caseload?"

2. Team meeting, supervision, individual or group counseling session observations

Listen for discussion of motivational interventions.

3. Chart review

Look for documentation of motivational interventions.

4. Consumer interview

- "Do you like your integrated treatment specialist? Do you have a good relationship? Was there a time when it wasn't a good relationship?"
- "Does your integrated treatment specialist help you identify your goals? Does he or she help you focus on your goals?"
- "Is your integrated treatment specialist a good listener? Does he or she do a good job making you feel hopeful, capable, and confident?"
- "Does your integrated treatment specialist keep you motivated to cut back or stay clean? How does he or she keep you motivated?"

Item response coding: Coding this item requires that the program staff both understand and apply that understanding. If integrated treatment specialists generally do not understand the concepts, then code the item as "1." If they understand parts of the concept

and apply the understanding consistently, code the item as "3."

To code the item as "5," evidence must show that the concepts are applied consistently for 80 percent or more of consumers for whom motivational interventions are indicated, as documented across different sources of evidence.

8. Substance abuse counseling

Definition: Consumers who are in the active treatment stage or relapse prevention stage receive substance abuse counseling aimed at teaching the following:

- How to manage cues to use and consequences of use;
- Relapse prevention strategies;
- Drug and alcohol refusal skills;
- Problem-solving skills training to avoid high-risk situations;
- Coping skills and social skills training to deal with symptoms or negative mood states; and
- How to challenge consumers' beliefs about substance use and substance abuse (for example, relaxation training, teaching sleep hygiene, cognitive-behavioral therapy for depression or anxiety, coping strategies for hallucinations).

Substance abuse counseling may take different forms and formats such as individual, group (including self-help programs), or family therapy, or a combination.

Rationale: Once consumers are motivated to manage their own illnesses, they need to develop skills and supports to control symptoms and to pursue an abstinent lifestyle. Effective Integrated Treatment programs provide substance abuse counseling that promotes cognitive-behavioral skills during the active treatment and relapse prevention stages.

Sources of information:

1. **Program leader interview**
   - "Could you tell me about the types of substance abuse counseling that your program offers? Do you offer individual [group or family] substance abuse counseling? How often?"
   - "Describe the program philosophy and strategies that your integrated treatment specialists use."
   - Ask for a copy of the program's substance abuse counseling schedule and curriculum.

2. **Integrated treatment specialist interviews**
   - "What kind of knowledge and skills do you teach in the individual [group or family] substance abuse counseling?" [Probe to confirm if each of the five areas listed above is addressed.]
   - "Do all consumers (in the active treatment or relapse prevention stage) receive some form of substance abuse counseling?" [If *no*, "Who does NOT receive substance abuse counseling?"] [Probe if the integrated treatment specialist takes into account consumers' stage of treatment when introducing substance abuse counseling.]

Note: To code this item, use information gathered for Stage-wise Interventions (Item 3). If this information is unavailable, then define each stage of treatment and ask integrated treatment specialists to estimate the number of consumers in each stage.

3. **Chart review**

Look for documentation of stage of treatment and substance abuse counseling.

4. **Observation of individual or group counseling sessions**

Listen for discussion of consumer's stage of treatment. Observe techniques and topics during sessions and assess whether they are appropriate for consumer's stage of treatment.

Item response coding: Coding this item requires that the integrated treatment specialists both understand and apply that understanding. If integrated treatment specialists generally do not understand the concepts, then code the item as "1."

If they understand parts of the concept and apply the understanding consistently, code the item as "3."

To code the item as "5," evidence must consistently show that more than 80 percent of consumers in active treatment stage or relapse prevention stage receive substance abuse counseling.

9. Group treatment for co-occurring disorders

Definition: All consumers in the Integrated Treatment program are offered group treatment specifically designed to address both mental health and substance abuse problems. Approximately two-thirds of consumers are regularly engaged (for example, at least weekly) in some type of group treatment. Groups can be family psychoeducation, persuasion, active treatment, self-help, etc.

Rationale: Research shows that better outcomes are achieved when consumers with co-occurring disorders participate in group treatment. The group format is an ideal setting for consumers to share experiences, support, and coping strategies.

Sources of information:

1. Program leader interview

- "Could you tell me about the types of groups that are available to consumers in your program? How many different groups are available?"
- "Do you have groups that address both mental health and substance abuse? How many consumers regularly attend such a group?"
- Ask for a copy of the program's group treatment schedule, if available.

2. Integrated treatment specialist interviews

- "Could you tell me about the types of groups that are available to consumers with co-occurring disorders? How many different groups are available?"
- "How do you determine which group each consumer should be in?"
- "Do you have groups that address both mental health and substance abuse?" [If *yes*, "Could you describe the group process?"] [Probe for the proportion of consumers who regularly attend groups.]

3. Chart review

Look for documentation to determine the number of consumers who regularly attend groups.

4. Observation of a group counseling session

Listen for discussion of both substance use and mental health topics and how they are related.

5. Consumer interview

- "Do you attend groups here? What kind of groups do you participate in?"
- "Do you attend a group that addresses both drug and alcohol use and mental health?"

Item response coding: If multiple sources confirm that more than 65 percent of consumers in the Integrated Treatment program regularly attend group treatment, code the item as "5."

10. Family interventions for co-occurring disorders

Definition: With consumers' permission, integrated treatment specialists involve consumers' family members (or other supporters), provide education about co-occurring disorders, offer coping skills training and support to reduce stress in the family, and promote collaboration with the treatment team.

Rationale: Research has shown that social support plays a critical role in reducing relapse and hospitalization in consumers. Family interventions can be a powerful approach for improving mental health and substance abuse outcomes. However, the decision to involve family or other supporters is the consumers' choice. Integrated treatment specialists should discuss with consumers the benefits of involving family members

and respect consumers' decisions about how and when to involve them.

Sources of information:

1. **Program leader and integrated treatment specialist interviews**
   - "Does your agency provide family interventions to consumers in your Integrated Treatment program?" [If *yes*, "Can you describe how you provide it? What do you cover in your sessions?"] [Probe for frequency and format (individual vs. multifamily group session). If a manual or guidebook is used, ask to review it.]
   - "Do you talk with consumers about involving family members or other supporters in family interventions?" [If *yes*, "Can you describe when and how this occurs?"]
   - "What happens if consumers refuse to involve their families?"
   - "What would you do if consumers are willing to involve their families, but the families refuse to participate? Do you attempt outreach to the families?"
   - "How many consumers in your program have weekly contact with family members or other supporters? (Estimates suggest about 60 percent have weekly contact with their families.) Of those consumers, how many receive family interventions?"

2. **Consumer interview**
   - "Has your integrated treatment specialist asked you whether you would like to involve a family member or other supporter in your treatment or in family interventions?" [If *yes*, "Did he or she follow your decision?"]
   - [*If the consumer's family participates*, "Can you describe how your family has been involved in your treatment? Have your family members received information about the mental health and substance abuse treatment that you are receiving?"] [Probe to understand the content of family interventions.]

3. **Chart review**

Look for documentation of family interventions.

Item response coding: If consumers are asked for their permission to involve a family member or other supporter and more than 65 percent of consumers' family members or other supporters are involved in treatment; receive information, support, and coping skills training about co-occurring disorders; or collaborate with the consumers' treatment team, code the item as "5."

11. Alcohol and Drug Self-Help Groups

Definition: Integrated treatment specialists connect consumers in the active treatment stage or relapse prevention stage with self-help programs in the community, such as Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous, Rational Recovery, Double Trouble, or Dual Recovery.

Rationale: Although pressuring consumers who are reluctant to participate in self-help groups is contraindicated, social contacts with other members of self-help groups play an important role in the recovery of consumers with co-occurring disorders who are motivated to achieve or maintain abstinence.

Sources of information:

1. **Program leader interview**
   - "How many consumers in your program regularly attend self-help groups in the community?"
   - "Does the agency have a designated staff person who is a liaison to self-help groups in the community?"

2. **Integrated treatment specialist interviews**
   - "Do you refer your consumers to self-help groups in the community such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine

Anonymous, Rational Recovery, Double Trouble, or Dual Recovery?"

- "At what point do you refer consumers to self-help groups?" (The goal here is to ascertain if the integrated treatment specialist takes into account consumers' stage of treatment when referring to self-help groups.)
- "Do you (or a designated liaison) ever attend self-help group meetings with consumers to help them identify suitable groups?"
- "How many consumers in your program regularly attend self-help groups in the community?"
- "How do you make sure that consumers follow through with referrals to self-help groups?"
- "When we talked about the stages of treatment some time ago, you identified the number of consumers who fit into each stage (engagement, persuasion, active treatment, and relapse prevention.) Now, how many consumers in the active treatment and relapse prevention stages currently attend self-help groups in the community?"

Note: If you were unable to assess the number of consumers in each stage of treatment (for Stage-wise Interventions, Item 3), then briefly define each stage, and estimate the number of consumers in each.

3. Chart review

Look for documentation of referrals to self-help groups and whether followup was offered.

Item response coding: If more than 65 percent of consumers in the active treatment stage or relapse prevention stage regularly attend self-help programs in the community, code the item as "5."

12. Pharmacological Treatment

Definition: Physicians or nurses prescribing medications are trained in the evidence-based model and work with consumers, integrated treatment specialists, and other team members to increase adherence to psychiatric medications, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as clozapine, disulfiram, or naltrexone that may help reduce addictive behavior. Five specific indicators are considered:

- Are psychiatric medications prescribed despite active substance use?
- Do prescribers work closely with consumers and team members?
- Do prescribers focus on increasing adherence?
- Are addictive medications, such as benzodiazepines, avoided?
- Are medications that reduce addictive behavior offered such as clozapine, naltrexone, or disulfiram?

Rationale: Research shows that psychotropic medications are effective in treating serious mental illnesses, including consumers who have active substance abuse problems. Access to such medications, including antipsychotics, mood stabilizers, and antidepressants, is critical to effectively treating serious mental illnesses.

Sources of information:

1. Integrated treatment specialist interview

- "Are psychotropic medications prescribed to consumers with active substance abuse problems? How many consumers in the Integrated Treatment program are currently taking psychotropic medication?"
- "Have any consumers in your program been prescribed benzodiazepines?"
- "Have any consumers in your program been prescribed clozapine to reduce addiction?"
- "Have any consumers in your program been prescribed disulfiram or naltrexone?"
- "How often do you contact your consumers' prescribers?"

- "What kind of strategies do you use for consumers who do not take medications as prescribed?"

2. Medication prescriber interview

- "Pharmacologically, do you approach consumers with mental illnesses and substance abuse problems differently than you approach consumers who do not have a substance abuse problem? Can you give me an example?"
- "What kinds of strategies do you use for consumers who are alcohol dependent?"
- "Are there any cases in which you would not prescribe a psychiatric medication to a consumer with serious mental illness and a substance abuse problem? Can you give me an example?" [Probe for the presence or absence of the five indicators listed in the definition.]
- "Do you attend multidisciplinary treatment team meetings? Do these meetings include integrated treatment specialists?"
- "How often do you contact your consumers' treatment team members? How often do you contact consumers' integrated treatment specialists?"

3. Chart review

Look for documentation of medication (including type, dosage, and rationale for prescription) and issues related to compliance and adherence.

Item response coding: If all five strategies are used, code the item as "5."

13. Interventions to promote health

Definition: Integrated treatment specialists promote health by encouraging consumers with co-occurring disorders to avoid high-risk behavior and situations that can lead to infectious diseases, find safe housing, and practice proper diet and exercise. The intent is to directly reduce the negative consequences of substance abuse using methods other than reducing substance use itself.

Typical negative consequences of substance abuse that are the focus of interventions include the following:

- Physical effects (for example, chronic illnesses or sexually transmitted diseases);
- Social effects (for example, loss of family support or victimization);
- Self-care and independent functioning (for example, mental illness relapses, malnutrition, housing instability, unemployment, or incarceration); and
- Use of substances in unsafe situations (for example, driving while intoxicated).

Other strategies designed to reduce negative consequences include supporting consumers who switch to less harmful substances, providing support to families, helping consumers avoid high-risk situations for victimization, encouraging consumers to pursue work, and helping consumers develop friendships with nonusers.

Rationale: Consumers with co-occurring disorders are at higher risk than the general population for detrimental effects of substance abuse described above.

Sources of information:

1. Program leader and integrated treatment specialist interviews

- "Do integrated treatment specialists work with consumers to promote a healthy lifestyle? Do they talk with consumers about infectious diseases and how to avoid them?"
- "Do they encourage consumers to switch to less harmful substances, to practice safe sex, to have a proper diet, and to exercise?" [If *yes*, "Can you describe how and when these issues are discussed?"]
- "What's your philosophy about treatment for consumers who continue to drink or use drugs?"

2. Chart review

Look for documentation of interventions to promote health and reduce negative consequences of substance abuse.

3. Consumer interview

- "Has your integrated treatment specialist talked with you about the negative effects of drug and alcohol abuse, for example, driving while intoxicated, having unprotected sex, or losing friends and family? Can you give me an example? Was this information discussed during an individual or group session?"

Item response coding: If integrated treatment specialists are well versed in techniques to reduce the negative consequences of substance abuse and 80 percent or more of consumers receive services to promote health, code the item as "5."

14. Secondary interventions for nonresponders

Definition: The Integrated Treatment program has a protocol to identify consumers who do not respond to basic treatment for co-occurring disorders, to evaluate them, and to link them with appropriate secondary interventions.

Secondary interventions are intensive interventions such as the following:

- Prescribing and monitoring medications that may help reduce addictive behavior (for example, clozapine, naltrexone, or disulfiram);
- Offering intensive psychosocial interventions (for example, intensive family treatment, additional trauma interventions, intensive outpatient treatment such as daily group programs, or long-term residential care); or
- Providing intensive monitoring, which the legal system usually imposes (for example, protective payeeship or conditional discharge).

Rationale: Approximately 50 percent of consumers with co-occurring disorders respond well to basic treatment and will attain stable remissions of their substance use disorders within 2 to 3 years. All consumers should be assessed regularly (at least every 3 months) to make sure they are progressing toward recovery. Those who are not progressing should be reviewed by a senior clinician and considered for more intensive interventions.

The idea is to use an algorithmic approach based on current knowledge and experienced clinical judgment. For example, consumers who experience increased nightmares, intrusive thoughts, and anxiety when sober that lead to relapse should be considered for a Post-Traumatic Stress Disorder (PTSD) intervention. Consumers who have regular family contact and are not progressing should be considered for an intensive family intervention. Consumers who experience severe craving should be considered for monitored naltrexone. Consumers who are impulsive drinkers should be considered for monitored disulfiram.

Sources of information:

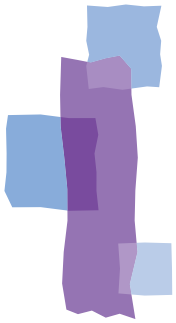
1. Program leader and integrated treatment specialist interviews

- "How do you review consumers' progress? Can you give me an example?"
- "Do you have a way to identify specific consumers who are not progressing?" [If *yes*, "What are your criteria?"]
- "If consumers do not progress, what do you do? Can you give me an example?" [Probe for the secondary interventions listed in the definition.]

2. Consumer interview

"Has there ever been a time when you weren't able to get or stay clean despite receiving both mental health and substance abuse treatment from this program?" [If *yes*, "Did staff here try anything new to help you or give you other options for treatment?"]

Item response coding: If the program has a protocol to identify nonresponders and more than 80 percent of nonresponders are evaluated and referred for secondary interventions, 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: ■ Program leader ■ Senior staff (for example, executive director, psychiatrist) ■ Practitioners providing the EBP ■ Consumers and families receiving EBP ■ Written materials (for example, 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 or consumer identification** All consumers with serious mental illnesses in the community support program, crisis consumers, and institutionalized consumers are screened to determine if 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	>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	% % eligible:
	Total number of consumers receiving EBP	Penetration rate

	1	2	3	4	5
G4. Assessment Full standardized assessment of all consumers who receive EBP services. Assessment includes the following: ■ 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	>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	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	>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	>80% of consumers EBP serves receive individualized services meeting goals of EBP
G7. Training All new program staff 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	>80% of program staff receive standardized training annually
G8. Supervision EBP practitioners receive structured, weekly supervision (group or individual format) from a supervisor experienced in a 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	>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 Program leaders and administrators 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 Program leaders and administrators monitor outcomes for EBP consumers every 3 months and share data with EBP practitioners. Monitoring involves standardized approach to assessing a key outcome related to EBP, for example, 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 EBP practitioners	Standardized outcome monitoring occurs at least 1 time a year. Results are shared with EBP practitioners	Standardized outcome monitoring occurs at least 2 times a year. Results are shared with EBP practitioners	Standardized outcome monitoring occurs quarterly. Results are shared with EBP practitioners
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 practitioners 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

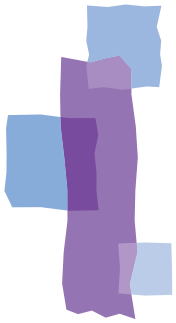
Score Sheet: General Organizational Index

Date of visit _____/_____/_____

Agency name _____

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

The General Organizational Index (GOI) Protocol explains how to rate each item of the GOI. In particular, it provides the following:

- A definition and rationale for each item; and
- A list of data sources most appropriate for each fidelity item (for example, chart review, program leader, practitioners, consumers, and family interviews).

When it is appropriate, a set of probe questions is provided to help you elicit the critical information needed to code 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 code each item correctly. As you collect information from various sources, these rules will help you determine the specific rating to give for each item.

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:

- Program leader;
- Senior staff (for example, executive director, psychiatrists);
- Integrated treatment specialists;
- Consumers and family members; and
- Written materials (for example, 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 or inconsistent with the EBP, including observations from casual conversations, staff and consumer activities, etc. 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 EBP-specific fidelity scale), but rather whether all those involved are committed to implementing a high-fidelity EBP.

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

1. Program leader, senior staff, and practitioner interviews

At the beginning of the interview, have practitioners briefly describe the program.

- "What are the critical elements 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 practitioners 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 the EBP? If not, then rate item down one scale point (i.e., lower fidelity).
- Does the written material articulate a program philosophy that is consistent with the EBP?

Item response coding: The goal of this item is not to quiz every practitioner to determine if each 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, "We are having trouble identifying consumers for our Integrated Treatment program since most of our consumers are not motivated to work on their substance abuse problem," then that would be a red flag for the practice of Integrated Treatment for Co-Occurring Disorders.

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, practitioner interviews) determine the majority opinion when rating whether that source endorses a clear program philosophy. *Note*: If no written material exists, then count that source as *unsatisfactory*.

G2. Eligibility/Consumer Identification

Definition: **For EBPs implemented in a mental health center:** All consumers in the community support program, consumers in crisis, and those in the hospital 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 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, day treatment, etc.), then ordinarily all adults with serious mental illnesses 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 Integrated Treatment for Co-Occurring Disorders, the KIT specifies the admission criteria and specific assessment tools are recommended for each. In every case, the program should have an explicit, systematic method for identifying 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 that are consistent with the EBP.

Sources of information:

1. Program leader, senior staff, and practitioner 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 consumers who are in crisis (or institutionalized)?"
- Ask for a copy of the screening instrument that the agency uses.

2. Chart review

Review documentation of the screening process and results.

3. County mental health administrators (where applicable)

If eligibility is determined at the service-area level (e.g., the New York example), then interview the people who are 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 scale in the space provided. If 100 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 program 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 agency systematically tracks eligibility, then use this number in the denominator. (See the rules listed in G2 to determine the 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 EBP KITs available at this writing should be as follows:

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

Example for calculating denominator:

Suppose you don't know how many consumers are eligible for Integrated Treatment for Co-Occurring Disorders. Let's say the community support program has 120 consumers. Then you would estimate the denominator to be:

$$120 \times .4 = 48$$

Item response coding: Calculate this ratio and record it on the fidelity scale. If the program serves more than 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 among consumers. If most consumers are assessed using identical

words or if the assessment consists of broad, noninformative checklists, then consider this to be 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 or 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. Program leader, senior staff, and practitioner 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 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: Assess this item and the next together; i.e., followup 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. Program 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. Practitioner 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 practitioners 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, then code 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 of a low score on this item for Integrated Treatment of Co-Occurring Disorders is the following:

Consumers in the engagement phase of recovery are assigned to a relapse prevention group and are constantly told they need to quit using, rather than using motivational interventions.

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. Practitioner interview

When feasible, use the specific charts selected above. Ask 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 practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) within 2 months after they are hired. Existing 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 practitioners and over time.

Sources of information:

1. Program leader, senior staff, and practitioner interviews

- "Do you provide new 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 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. Practitioners 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 practitioners receive at least yearly, standardized training for [EBP area], code the item as "5."

G8. Supervision

Definition: Integrated treatment specialists receive structured, weekly supervision from a supervisor 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 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. Program leader, senior staff, and practitioner 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 integrated treatment specialists receive weekly supervision, code the item as "5."

G9. Process Monitoring

Definition: Program leaders and administrators 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 a 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: Systematically and regularly collecting process data is imperative in evaluating program fidelity to EBP.

Sources of information:

1. **Program leader, senior staff, and practitioner interviews**
   - "Does your program collect process data regularly?" [If *yes*, probe for specifics. Frequency? Who? How (using [[EBP area]] 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: Program leaders and administrators monitor the outcomes of EBP consumers every 3 months and share the data with integrated treatment specialists to improve services. Outcome monitoring involves a standardized approach to assess consumers.

Rationale: Systematically and regularly collecting 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:

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

Sources of information:

1. **Program leader, senior staff, and practitioner interviews**
   - "Does your program have a systematic method for tracking outcome data?" [If *yes*, probe for specifics: How (computerized vs. chart only)? How often? Type of outcome variables? Who collects data?]
   - "Do you use any checklist or scale to monitor consumer outcome (for example, Substance Abuse Treatment Scale)?"

- "What do you do with the outcome data? Do your practitioners review the data regularly?" [If *yes*, "How is the review done (for example, cumulative graph)?"]
- "Have the outcome data affected how your services are provided?" [If *yes*, "How?"]

2. Review of internal reports and documentation, if available

Item response coding: If standardized outcome monitoring occurs quarterly and results are shared with integrated treatment specialists, code the item as "5."

G11. Quality Assurance (QA)

Definition: The agency's QA committee has an explicit plan to review the EBP or components of the program every 6 months. The steering committee 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. Program 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?"]

2. QA committee member interview

- "Please describe the tasks and responsibilities of the QA committee." [Probe for specifics. "What is the purpose? Who? How? When?"]
- "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; 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 offer choices. The choices must be consonant with the EBP. So, for example, an agency implementing Integrated Treatment for Co-Occurring Disorders would score low if it only worked with consumers who were abstinent.

A reasonable range of choices means that integrated treatment specialists offer realistic options to consumers rather than prescribing only one or a couple of choices or dictating a fixed sequence or prescribing conditions that consumers must complete before becoming eligible for a service.

A sample of relevant choices by EBPs current at this writing includes the following:

Integrated Treatment for Co-Occurring Disorders

- Group or individual counseling sessions
- Frequency of treatment
- Specific self-management goals
- Selection of other supporters to be involved

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

Family Psychoeducation

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

Illness Management and Recovery

- Selection of other supporters 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:

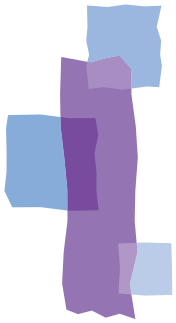
1. **Program leader interview**
   - "Tell us what your program philosophy is about consumer choice. How do you incorporate consumers' preferences in the services you provide?"
   - "What options exist for your services? Give examples."
2. **Practitioner interview**
   - "What do you do when a disagreement 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 payeeships 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. For example, to get full credit for Item O4 (*responsibility for crisis services*), it is not enough that the program is currently developing an on-call plan.

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.



EVIDENCE-BASED PRACTICES

KIT

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Appendix F: 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
- ❑ 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 largely independent)
- ❑ Living independently
- ❑ Homeless
- ❑ Emergency shelter
- ❑ Other (specify) _____

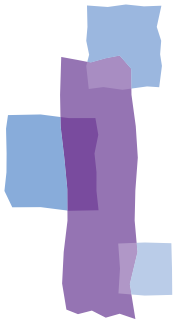
_____

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

- ❑ Not applicable or unknown
- ❑ No educational participation
- ❑ Avocational/Educational involvement
- ❑ Pre-educational explorations
- ❑ Working on GED
- ❑ Working on English as Second Language
- ❑ Basic educational skills
- ❑ Attending vocational school, vocational program (CNA training), 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
- ❑ Associate's degree
- ❑ Vocational training certificate
- ❑ Bachelor of Arts or Bachelor of Science
- ❑ Master's degree or Ph.D.



EVIDENCE-BASED PRACTICES KIT

Knowledge Informing Transformation

Evaluating Your Program

Appendix G: 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 contact with a case manager, mental health counselor, or substance abuse counselor.
- **Engagement:** The consumer has had 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:** The consumer has regular contact 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:** The consumer is 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 1 month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.
- **Early active treatment:** The consumer is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least 1 month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.
- **Late active treatment:** The consumer is 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:** The consumer is 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:** The consumer has had 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:** This category is for situations in which 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):** Here 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 *group home* is 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 *boarding home* is 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 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.

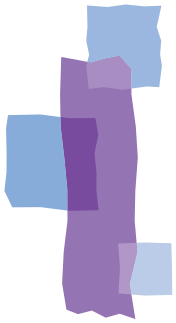
Educational status

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**
- **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 (e.g., 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 GED:** Consumers who are taking classes to obtain their GED.
- **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 (CAN training), or attending 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: 1–6 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.



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Appendix H: 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% 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 (e.g., for IMR, interviews with the program director, 3 ACT team members, and 3 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 (e.g., marginal notes).
- ❑ 2g. **Chart selection and documentation:** Chart selection follows guidelines provided in the protocol (e.g., randomized, appropriate type and number of charts). Assessors note discrepancies (e.g., chart unavailability).
- ❑ 2h. **Chart review:** Both assessors review all charts and rate them independently.
- ❑ 2i. **Resolution of discrepancies:** When a discrepancy exists between sources (e.g., charts and ACT team members), assessors make followup probes with an appropriate informant (typically the ACT 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 (e.g., supervisor) may be consulted to resolve difficult ratings.
- ❑ 3b. **Inter-rater reliability:** Raters agree exactly on ratings for at least 80% 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 ACT 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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A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services