**Attachment 3:** EBP Self-Assessment Part 1 & Part 2

OMB No. 0930-XXXX

Expiration Date XX/XX/XXXX

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**Substance Abuse and Mental Health Services Administration (SAMHSA)**

**National Evaluation of SAMHSA’s Homeless Programs**

**EBP Self-Assessment Part 1 – General Implementation Questions**

**Instructions**

The cross-program evaluation team is interested in learning more about the primary evidence-based service practices (EBPs) being implemented by SSH/GBHI/CABHI program grantees. We know some grantee projects are implementing multiple EBPs. Primary EBPs are defined as those that are received by the largest number of consumers or clients served by the SSH/GBHI/CABHI project. During the grantee Project Director interview, information was collected on the primary EBPs being implemented in your site, as well as who is delivering and receiving these EBPs.

The cross-program evaluation team will be seeking to confirm the extent to which key components of certain EBPs[[1]](#footnote-1) are being implemented, degree of implementation fidelity, and specific modifications that may have been made for use by local grantee programs. Information on practice-specific EBP implementation for these select EBPs will be collected from qualifying projects through a separate web-based self-assessment, and may also be explored and verified during key informant interviews and/or grantee site visits.

Here, we want to learn more generally about implementation of your site’s primary EBPs, and about factors that may serve as barriers or facilitators to implementation fidelity within grantee projects, such as readiness to implement the EBP, leadership, funding, training and supervision, quality improvement, and outcomes. Some of the questions are focused on the grantee agency and/or the overall grant project, and others are focused on the provider implementing the EBP, which may or may not be different from the grantee agency. Each SSH/GBHI/CABHI grantee project should have a key respondent which is typically the grantee Project Director or his/her appropriate designee (e.g., local site evaluator or other project staff familiar with EBP implementation at the site) or Program Manager/Supervisor at the provider agency implementing the primary EBP(s) complete the self-assessment. If needed, the key respondent may ask questions of staff familiar with the characteristics and implementation of your project’s EBP(s).

**Primary EBP Information [PREPOULATED FROM PD INTERVIEW & VERIFIED]**

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| --- | --- |
| **Questions** | **Response Options** |
| During the Project Director interview, the primary EBPs identified for this grantee program included: | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **EBP** | **Proposed for implementation in grant application?** | **Status of implementation** | **% program participants that receive** | **Who provides**  **(grantee or other agency); SAMHSA grant funds used** | **Where provided** | **If grant has ended, still implementing?** | | 1. |  |  |  |  |  |  | | 2. |  |  |  |  |  |  | | 3. |  |  |  |  |  |  | |

**Respondent Information**

|  |  |
| --- | --- |
| **Name/Title of Respondent #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Primary Role in SAMHSA Grantee Project:** *(check all that apply)*  Project Director  Project Coordinator  Program Manager  Local Evaluator  Housing Provider  Mental Health Counselor/Treatment Provider/Supervisor  Substance Abuse Counselor/Treatment Provider/Supervisor  Integrated Treatment (Mental Health & Substance Abuse) Counselor  Trauma Specialist  Case Manager  Benefits Specialist  Peer Specialist/Consumer  Housing Specialist  Vocational Specialist  Educational Specialist  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Respondent Agency/Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Agency’s Primary Role in SAMHSA Grantee Project:** *(check all that apply)*  Grantee agency  Administrative/Project Coordination/Oversight  Research/Evaluation  Substance abuse treatment provider  Mental health treatment provider  Integrated treatment (Mental Health & Substance Abuse) provider  Shelter  Housing provider  Case management provider  Medical (primary/specialized) care provider  Benefits assistance provider  Education provider  Employment or job training provider  Veterans Administration (VA) services provider  Justice/criminal justice services provider  Child and family services provider  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Basic Program Information [PREPOPULATED FROM PD INTERVIEW & VERIFIED]**

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| --- | --- |
| **Questions** | **Response Options** |
| 1. The target populations for this grantee program who is receiving this EBP includes:   *(Check all that apply)* | **EBP :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Mental Disorders Only  Substance Abuse/Dependence Only  Co-Occurring Mental and Substance Use Disorders  Veterans  Youth (under 18 years old)  Young adults (e.g., ages 18-21)  Older adults (e.g., 55 and over)  Immigrants  Criminal justice (e.g., previously incarcerated, reentry/diversion or on probation/adjudication)  Families  Persons at risk or living with HIV/AIDS  Chronic public inebriates  Domestic violence victims  Lesbian, gay, bisexual, transgender, questioning individuals and allies (LGBT/LGBTQA)  Pregnant  Developmentally or physically disabled  Other, specify:  None of the above specifically targeted  If not correct, explain: |
| 1. The homeless populations that participate in this grantee program & therefore receive this EBP includes: | At Risk for Becoming Homeless  Acute (first time) Homeless  Episodically Homeless  Chronically homeless  Homeless, Not Specified  If not correct, explain: |

| **EBP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| --- | --- |
| **Readiness to Implement EBP** | |
| 1. Why was this EBP selected by the grantee project?   *(check all that apply)* | Fit with population(s) served  Fit with overall organization philosophy  Already had the practice in place  Outcomes align with program goals  Required by SAMHSA grant  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. How long has the provider agency been implementing this EBP? | Haven’t started implementing yet  Less than one year  1-2 years  3-4 years  5 or more years |
| 1. Which of the following best describes the current stage of implementation of this EBP for program participants? | Preparation (e.g., hiring staff, conducting initial training, creating new operation polices & procedures, developing/finalizing strategic implementation plan)  Early Implementation (e.g., referrals, screening & assessments occurring, services are underway)  Full Implementation (e.g., staff skillful in service delivery, new policies & procedures are routine, practice is fully integrated into agency/program)  Sustainability (e.g., sustainability plan developed & underway, continuous staff training & funding secured for future, outcomes used for program improvement)  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. How is the priority the implementing agency places on this EBP demonstrated?   *(check all that apply)* | There is an agency plan to implement the EBP  Leadership frequently talks about the EBP  Recruitment/selection of staff to implement the EBP  Allocation of funding/other resources for the EBP  Other, specify­­­­\_\_\_\_\_\_\_ |
| 1. Does the implementing agency have a formal plan to guide implementation of this EBP? | No  Don’t know  Yes  **If yes**, which is true of the agency’s plan? (*check all that apply)*  It is a written document  It is discussed at staff meetings or meetings devoted to the plan  All project staff are fully aware of the plan  It has specific short- and long-term objectives regarding EBP implementation  It identifies strategies for stakeholder outreach/consensus building for the EBP  It identifies sources of funding for the EBP  It identifies training resources for EBP implementation  It identifies strategies for EBP implementation and outcomes evaluation  Other, specify­­­­\_\_\_\_\_\_\_ |
| 1. Is leadership within the implementing agency supportive of this EBP’s implementation? | Extremely supportive  Somewhat supportive  Not at all supportive  **If supportive**, at what leadership level(s) within the agency is this demonstrated? *(check all that apply)*  Executive Management (e.g., agency executive director)  Program Management  Clinical/Front Line Supervisors  Other, specify­­­­\_\_\_\_\_\_\_  **If supportive**, how is this demonstrated? *(check all that apply)*  Leadership is actively involved in EBP implementation  Barriers that impede implementation or effectiveness are addressed  Support exists for coaching/ active supervision of staff directly implementing EBP  Other, specify­­­­\_\_\_\_\_\_\_ |
| 1. Has a staff person at the implementing agency been assigned to lead implementation of the EBP? | No  Yes  **If yes**, what percent of his/her time is dedicated to the EBP’s implementation?  100%  76-99%  51-75%  25-50%  less than 25%  **If yes**, which of the following is true? *(check all that apply)*  S/he has the necessary authority to lead implementation  S/he has adequate training/expertise in the EBP  S/he has a good relationship with staff directly implementing the EBP  His/her leadership of EBP implementation is perceived positively by others |
| 1. Would you say the implementing agency’s interest in this EBP is: | Limited to this SAMHSA-funded grant program/project only  Extends beyond this program/project  Other, specify­­­­\_\_\_\_\_\_\_ |
| 1. Are there any explicit policies the implementing agency has that support implementation of this EBP? | No  Yes  **If yes**, explain: |
| 1. Are there any explicit policies the implementing agency has that serve as barriers to implementation of this EBP? | No  Yes  **If yes**, explain: |
| 1. Are there any state or local (e.g., mental health or substance abuse authority) regulations or policies that support implementation of this EBP? | No  Yes  **If yes**, explain: |
| 1. Are there any state or local regulations or policies that serve as barriers to implementation of this EBP? | No  Yes  **If yes**, explain: |
| 1. Are there state or local standards that have to be followed in implementing the EBP? For example, some states have specific implementation guidelines related to staffing, fidelity checks, satisfaction surveys, etc. | No  Yes  **If yes**, describe  **If yes**, how are these standards established and enforced?  Contracting  Licensing  Other, specify  **If yes**, which of the following consequences may occur for not meeting standards?  Corrective action plan  Financial consequences  Other, specify |
| **Funding** | |
| 1. How is this EBP funded?   *(check all that apply)* | Medicaid (fee-for-service, Waiver, etc.)  State agency funding, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SAMHSA grant funds, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other special grant funds, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other, specify­­­­\_\_\_\_\_\_\_  Don’t know |
| 1. How have start up or conversion costs associated with this EBP (e.g., lost productivity for training, hiring staff before clients enrolled, changing medical records and/or computer systems, etc.) been financed? | Costs were covered within the implementing agency’s own operating budget  There was a discreet funding source that covered all costs (specify\_\_\_\_\_\_\_\_\_\_\_)  There was a discreet funding source that covered some costs (specify\_\_\_\_\_\_\_\_\_)  Don’t know |
| 1. Which of the following best describes the financing for this EBP? | No components of service are reimbursable  Some costs are reimbursable  Most costs are reimbursable  Service pays for itself (i.e. all costs covered adequately, or funding of covered components compensates for non-covered components)  Service pays for itself and reimbursement rates are attractive relative to competing non-EBP services  Don’t know |
| 1. Is there a plan to continue the EBP once SAMHSA grant funding has ended? (Or if grant funding has already ended has the practice continued?) | Yes  Don’t know  No  **If no**, why not? *(check all that apply)*  Plan not developed yet but intend to continue the EBP  Insufficient funding  Lack of support from partnering agencies  Too many barriers to implementation  Insufficient numbers of eligible participants  Model was not viewed as successful  Other, specify:­­­­\_\_\_\_\_\_ |
| **Hiring, Training & Supervision** | |
| 1. Did the implementing agency receive expert advice/consultation regarding strategies to support implementation of this EBP? | No  Don’t know  Yes, initially only  Yes, initially & ongoing  **If yes**, who received this consultation? *(check all that apply)*  Agency Administrators  Program Directors/Supervisors  Other, specify \_\_\_\_\_\_\_\_\_\_\_  **If yes**, who supported/funded this consultation? *(check all that apply)*  SAMHSA  Other, specify \_\_\_\_\_\_\_\_\_\_\_  **If yes**, who provided this consultation? Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Did staff selection/recruitment include attention to ensuring staff have the pre-requisite skills and/or credentials required by this EBP? | No  Don’t know  Yes |
| 1. Was initial skills training provided to practitioners to support implementation of this EBP? | No  Yes  **If yes**, which of the following was true of this training? *(check all that apply)*  Trainer was an expert who is experienced or certified in the EBP  Training comprehensively addressed all elements of the EBP  Active learning strategies were used (e.g., role play, group work, feedback)  Teaching aides (e.g., worksheets, manuals, handouts) were used  A SAMHSA Took Kit was utilized or referenced as part of the training |
| 1. Is ongoing or refresher training available for practitioners to reinforce application of this EBP & help staff deal with emerging practice issues? | No  Yes  **If yes**, how often is this made available? *(check all that apply)*  Monthly or more frequently  Quarterly  Annually  Only as needed/requested |
| 1. Which of the following training methods are used? *(check all that apply)* | Computer assisted training  In-person training workshops  Staff provided with training materials to “self-teach”  Staff observe/shadow experienced staff person(s)  Other, specify \_\_\_\_\_\_\_\_\_ |
| 1. Does all staff implementing this EBP receive the same training? | Yes  No  **If no**, explain: |
| 1. Do all practitioners delivering this EBP receive ongoing supervision and oversight? | No  Yes  **If yes**, which of the following is true? (check all that apply)  Practitioners receive structured face-to-face supervision on a weekly basis  Practitioners receive supervision but less than weekly (specify:\_\_\_\_\_\_\_)  Supervision is provided by a practitioner experienced in this EBP  Supervision includes observation of EBP implementation, coaching & feedback  Supervision is provided but is not specific to the practice  Other, specify \_\_\_\_\_\_\_\_\_\_\_ |
| 1. Is there support/buy-in for implementation of this EBP among practitioners? | No  Yes  **If yes**, which of the following is true? (check all that apply)  Practitioners voice support for the EBP  Practitioners can describe how they’ve used the EBP  Practitioners can describe how the approach benefits/helps clients  Other, specify\_\_\_\_\_\_\_ |
| **Fidelity/Outcomes Monitoring & Performance Improvement** | |
| 1. Are all clients screened to determine whether they qualify for receiving this EBP using standardized tools or admission criteria? | Yes  No  **If no**, why not? *(check all that apply)*  All clients receive the intervention  No standardized tool or admission criteria available  Other, specify\_\_\_\_\_\_\_\_\_ |
| 1. To date, how many clients participated in this EBP during the grant period? | \_\_\_\_\_\_\_ |
| 1. How many clients were eligible to participate during the grant period? | \_\_\_\_\_\_\_ |
| 1. How is fidelity to this EBP monitored?   *(check all that apply)* | Regular use of a standardized fidelity tool/checklist, specify:­­­­\_\_\_\_\_\_\_\_  Direct observation  Document review  Focus groups or interviews with program participants  Key informant interviews  Tape/video recorded sessions/groups  Other, specify:\_\_\_\_\_\_\_\_\_  We do not monitor fidelity to this EBP (Skip 32 – 37) |
| 1. How often is fidelity data collected/assessed for this EBP? | Ongoing  Every six months  Annually  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Who conducts fidelity assessments for this EBP?   *(check all that apply)* | Staff internal to provider agency  Staff external to provider agency  Grant program evaluator  Consultant  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. When was the last fidelity assessment done and what were the results? | Date conducted:  Measure Used:  Score/results: |
| 1. To what degree have the core components of this EBP been implemented to fidelity so far? | Low – Less than 50% of components implemented to fidelity  Moderate 50-80% of components implemented to fidelity  High – 81-100% of components implemented to fidelity |
| 1. If this EBP has been implemented with moderate to low fidelity so far, why? | NA – Implemented with high fidelity  All components planned but not yet fully implemented  Some components were purposefully modified  **If modified**, describe how and why (e.g., why certain components were not implemented or revised or new components added) |
| 1. Which of the following is true regarding the use of fidelity performance data?   *(check all that apply)* | Data is shared with program staff  Data is shared with internal advisory groups, board members, etc.  Data is shared publicly via the web, agency annual reports, etc.  Data is used for quality improvement  Implementation adjustments have been made based on fidelity data |
| 1. Are there any plans to maintain fidelity to this practice beyond the grant period? | No  Don’t know  Yes  **If yes**, describe |
| 1. Are outcome data (e.g. changes in client functioning, access to treatment, housing/homeless status) related to this EBP collected? | No  Yes  **If yes**, how are these data used? (check all that apply)  Don’t know  Data are shared with practitioners to help them track/monitor client progress.  Data are shared with agency leadership to help inform implementation of the EBP.  Data are shared with stakeholders to solicit support (e.g. additional funding/ resources) for EBP implementation.  Other, specify: |
| **Overall Barriers/Facilitators** | |
| 1. Overall, what factors have served as barriers to implementation of this EBP during this project (i.e. have hindered successful implementation)? *(check all that apply)* | Lack of clear strategic plan for implementing the EBP  Inadequate financing for the EBP  Limited staff time/staff resources for EBP implementation  Lack of on-going training, supervision, and consultation on the EBP  Lack of positive practitioner attitudes toward the EBP  Lack of prior experience with this EBP  Lack of prior experience with other EBPs  State or local policy/regulations  Grantee or partner agency policies or practices  Lack of support for implementation from key leaders at grantee or partner agency  Lack of support for implementation from key external stakeholders  Other, specify­­­­\_\_\_\_\_\_\_  Other, specify­­­­\_\_\_\_\_\_\_  None |
| 1. Overall, what factors have served as facilitators to implementation of this EBP during this project (i.e. have helped with successful implementation)? *(check all that apply)* | Clear strategic plan for implementing the EBP  Adequate financing for the EBP  Adequate allocation of staff time/staff resources for EBP implementation  Access to on-going training, supervision, and consultation on the EBP  Positive practitioner attitudes toward the EBP  Prior experience with this EBP  Prior experience with other EBPs  Supportive state or local policy/regulations  Supportive grantee or partner agency policies or practices  Support for implementation from key leaders at grantee or partner agency  Support for implementation from key external stakeholders  Other, specify­­­­\_\_\_\_\_\_\_  Other, specify­­­­\_\_\_\_\_\_\_  None |

**[\*\*Repeat same questions for up to 2 more primary EBPs identified through the Project Director (PD) Interview]**

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

**National Evaluation of SAMHSA’s Homeless Programs**

**EBP Self-Assessment Part 2 – Practice Specific Questions**

**Instructions**

The cross-program evaluation team is interested in learning more about the primary evidence-based service practices (EBPs) being implemented by SSH/GBHI/CABHI program grantees. We know some grantee projects are implementing multiple EBPs. Primary EBPs are defined as those that are received by the largest number of consumers or clients served by the SSH/GBHI/CABHI project. During the grantee Project Director interview, information was collected on the primary EBPs being implemented in your site, as well as who is delivering and receiving these EBPs.

Through a separate web-based self-assessment, data is being collected from all grantees about general implementation of their site’s primary EBPs, and factors that may serve as barriers or facilitators to implementation fidelity within grantee projects, such as readiness to implement the EBP, leadership, funding, training and supervision, quality improvement, and outcomes.

Here, we are interested in confirming the extent to which key components of certain EBPs[[2]](#footnote-2) are being implemented, degree of implementation fidelity, and specific modifications that may have been made for use by local grantee programs. This self-assessment should only be responded to by SSH/GBHI/CABHI grantees that identified one or more (up to 3) of the selected EBPs as their primary EBP(s) being implemented. Grantees meeting this criteria should have a key respondent which is typically the grantee Project Director or his/her appropriate designee (e.g., local site evaluator or other project staff familiar with EBP implementation at the site) or Program Manager/Supervisor at the provider agency implementing the primary EBP(s) complete the self-assessment. If needed, the key respondent may ask questions of staff familiar with the characteristics and implementation of your project’s EBP(s).

Practice-specific EBP implementation may also be explored and verified during key informant interviews and/or grantee site visits.

**Basic Grantee/Program Information [PREPOPULATED FROM PD INTERVIEW & VERIFIED]**

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| **Questions** | **Response Options** |
| During the Project Director interview, the primary EBPs identified for this grantee program included: | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **EBP** | **Proposed for implementation in grant application?** | **Status of implementation** | **% program participants that receive** | **Who provides**  **(grantee or other agency); SAMHSA grant funds used** | **Where provided** | **If grant has ended, still implementing?** | | 1. |  |  |  |  |  |  | | 2. |  |  |  |  |  |  | | 3. |  |  |  |  |  |  | |

**Respondent Information**

|  |  |
| --- | --- |
| **Name/Title of Respondent #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Primary Role in SAMHSA Grantee Project:** *(check all that apply)*  Project Director  Project Coordinator  Program Manager  Local Evaluator  Housing Provider  Mental Health Counselor/Treatment Provider/Supervisor  Substance Abuse Counselor/Treatment Provider/Supervisor  Integrated Treatment (Mental Health & Substance Abuse) Counselor  Trauma Specialist  Case Manager  Benefits Specialist  Peer Specialist/Consumer  Housing Specialist  Vocational Specialist  Educational Specialist  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Respondent Agency/Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Agency’s Primary Role in SAMHSA Grantee Project:** *(check all that apply)*  Grantee agency  Administrative/Project Coordination/Oversight  Research/Evaluation  Substance abuse treatment provider  Mental health treatment provider  Integrated treatment (Mental Health & Substance Abuse) provider  Shelter  Housing provider  Case management provider  Medical (primary/specialized) care provider  Benefits assistance provider  Education provider  Employment or job training provider  Veterans Administration (VA) services provider  Justice/criminal justice services provider  Child and family services provider  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Assertive Community Treatment (ACT)/Intensive Case Management (ICM) Module**

| **Dimension** | **Measure** | **Question** | **Response** | |
| --- | --- | --- | --- | --- |
| *(Not visible to respondents)* | |
| Human Resources:  *Small caseload* | ACT consumer/ provider ratio = 10:1 | 1. What is the average case load size per ACT team member/ICM staff? | 50 consumers or more  35 to 49 consumers  21 to 34 consumers  11 to 20 consumers  10 or fewer consumers | |
| Human Resources:  *Team approach* | Provider group functions as a team; team members know and work with all consumers. | 1. Do ACT/ICM clients see the same staff person over and over (i.e. staff carry individual caseloads) or do they see different people (i.e. team shares caseload and members work with all clients)? | Staff members carry individual caseloads  Staff members share caseload and members work with all clients | |
| 1. In a typical 2-week period, what percentage of consumers has face-to-face contact with more than one member of the team? | 90% - 100%  64 - 89%  37 - 63%  11 - 36%  0 - 10% | |
| Human Resources:  *Program meeting* | Program meets frequently to plan and review services for each consumer. | 1. How often do the ACT team/ICM staff members meet as a full group to review services provided to consumers? | At least 4 days/week  At least 2 days/week but less than 4 times/week  1 day per week  At least twice per month but less than 1day/ week  Once per month or less  Staff do not meet as a full group to discuss consumers | |
| 1. How many consumers are reviewed at each meeting? | Each consumer reviewed at each meeting, even if briefly  Each consumer is not discussed each time staff meet  Staff do not meet as a full group to discuss consumers | |
| Human Resources:  *Practicing ACT lead* | Supervisor of front-line ACT team members provides direct service. | 1. Does the ACT team leader/ICM supervisor provide direct services to consumers? | Yes  No | |
| 1. What percentage of the ACT team leader/ICM supervisor’s time is devoted to direct services? | Over 50% of the time  25- 50% of the time  Less than 25% of the time or routinely as back-up  No regular percentage; only on rare occasions as back-up  Team leader/Supervisor does not provide direct services | |
| Human Resources:  *Continuity of staffing* | Program maintains the same staffing over time. | 1. What is the total number of staff positions on the ACT team/in the ICM program? | \_\_\_\_\_\_\_\_\_\_\_ | |
| 1. How many staff people have left the team/program? | *If team/program has been existence for at least 2 years:*  \_\_\_\_\_(#) staff who have left over the last 2 years  *If team/program has been existence for less than 2 years:*  \_\_\_\_\_(#) staff who have left over the last \_\_\_\_\_ (# months) since the team/program began | |
| Human Resources:  *Staff capacity* | Program operates at full staffing. | 1. Which of the following best represents ACT team/ICM program staffing capacity over the past 12 months? | Operated at 95% or more of full staffing  Operated at 80-94% of full staffing  Operated at 65-79% of full staffing  Operated at 50-64% of full staffing  Operated at less than 50% of full staffing | |
| Human Resources:  *Psychiatrist on staff* | For 100 consumers, at least 1 full-time psychiatrist is assigned to work with the program. | 1. How many consumers are served by the ACT/ICM program? | \_\_\_\_\_# consumers served by ACT team/ICM program | |
| 1. How many full-time equivalent (FTE) psychiatrists are assigned to work with the ACT/ICM program? | \_\_\_\_\_ FTE  A psychiatrist is not assigned to work with the program | |
| Human Resources:  *Nurse on staff* | At least 2 full-time nurses are assigned to work with a 100 consumer program. | 1. How many full-time equivalent (FTE) nurses are assigned to work with the ACT/ICM program? | \_\_\_\_\_ FTE  A nurse is not assigned to work with the program | |
| Human Resources:  *Substance abuse specialist on staff* | At least 2 staff members with at least 1 year of training or clinical experience in substance abuse treatment per 100 consumer program. | 1. How many full-time equivalent (FTE) substance abuse specialists are assigned to work with the ACT/ICM program? | \_\_\_\_\_ FTE  A substance abuse specialist is not assigned to work with the program | |
| 1. What types of training or clinical experience are assigned substance abuse specialists required to have? (check all that apply) | At least one year of substance abuse training  Less than one year of substance abuse training  At least one year of supervised substance abuse treatment experience  Less than one year of supervised substance abuse treatment experience  A substance abuse specialist is not assigned to work with the program | |
| Human Resources:  *Vocational specialist on staff* | At least 2 team members with 1 year training/ experience in vocational rehabilitation and support. | 1. How many full-time equivalent (FTE) vocational specialists are assigned to work with the ACT/ICM program? | \_\_\_\_\_ FTE  A vocational specialist is not assigned to work with the program | |
| 1. Are assigned vocational specialists required to have at least one year of training/experience in vocational rehabilitation and support? | Yes  No  A vocational specialist is not assigned to work with the program | |
| Human Resources:  *Program size* | Program is of sufficient size to consistently provide necessary staffing diversity and coverage. | 1. How many full-time equivalent (FTE) staff does the program have? | At least 10 FTE staff  7.5- 9.9 FTE staff  5.0- 7.4 FTE staff  2.5- 4.9 FTE staff  Less than 2.5 FTE staff | |
| Organizational Boundaries:  *Explicit admission criteria* | Clearly identified mission to serve a particular population; has and uses measureable, operationally defined criteria to screen out inappropriate referrals. | 1. Are there formal admission criteria the ACT/ICM program uses to screen potential consumers? | No  Yes  **If yes**, which of the following criteria are used *(check all that apply)?*  Diagnosis of serious mental illness  Diagnosis of co-occurring substance use disorder  Pattern of frequent hospital admissions  Frequent use of emergency services  Consumers discharged from long-term hospitalization  Homelessness  Involvement with the criminal justice system  Not adhering to medications as prescribed  Not benefitting from usual mental health services (e.g. day treatment)  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Do all consumers served by the program meet the admission criteria you indicated in your response to Question 19? | Yes, all cases comply with this admission criteria  Sometimes we accept clients who do not meet these criteria  We accept most referrals  There are no formal admission criteria for the program | |
| Organizational Boundaries:  *Intake rate* | Takes consumers in at a low rate to maintain stable service environment. | 1. On average, how many new consumers has the ACT/ICM program taken on per month during the last six months? | 6 or fewer consumers per month  7-9 consumers per month  10-12 consumers per month  13-15 consumers per month  16 or more consumers per month | |
| Organizational Boundaries:  *Full responsibility for treatment services* | In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services. | 1. Which of the following services are delivered to ACT/ICM program consumers directly by program staff, and which are delivered by another department or agency?   *(check all that apply)* | Directly by program staff:  Case management  Medication prescription, administration, monitoring, and documentation  Counseling/individual supportive therapy  Housing support  Substance abuse treatment  Employment or other rehabilitative services (e.g., ADLs) | By other department/agency:  Case management  Medication prescription, administration, monitoring, and documentation  Counseling/individual supportive therapy  Housing support  Substance abuse treatment  Employment or other rehabilitative services (e.g., ADLs) |
| Organizational Boundaries:  *Responsibility for crisis services* | Has 24-hour responsibility for covering psychiatric crises. | 1. What is the ACT team/ICM program staff role in providing 24 hour emergency services? | Provides 24 hour crisis coverage directly (i.e. a staff member is on-call at all times)  Provides back-up support to emergency/on-call service (e.g., crisis program is called first, makes decision about need for direct ACT/ICM program involvement)  Is available by phone, mostly in consulting role  Emergency service has program-generated protocol to follow for program consumers  Has no responsibility for handling crises after hours | |
| Organizational Boundaries:  *Responsibility for hospital admissions* | Is closely involved in hospital admissions | 1. How often are program staff involved in the decision to admit consumers for psychiatric hospitalization? | Program staff are involved in 95% or more of admissions  Program staff are involved in 65-94% of admissions  Program staff are involved in 35-64% of admissions  Program staff are involved in 5-34% of admissions  Program staff are involved in less than 5% of admissions | |
| Organizational Boundaries:  *Responsibility for hospital discharge planning* | Is involved in planning for hospital discharges | 1. How often is program staff involved with discharge planning when consumers are hospitalized for psychiatric or substance abuse reasons? | 95% or more of discharges planned jointly with program staff  65-94% of discharges planned jointly with program staff  35-64% of discharges planned jointly with program staff  5-34% of discharges planned jointly with program staff  Less than5% of discharges planned jointly with program staff | |
| Organizational Boundaries:  *Time-unlimited services* | Rarely closes cases; remains the point of contact for all consumers indefinitely as needed. | 1. Which of the following happens when a ACT/ICM consumer’s need for services is reduced? | They continue to be served on a time-unlimited basis  They are discharged because they have graduated from services  They are stepped down to less intensive services (specify:\_\_\_\_\_\_)  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. What percentage of consumers is expected to graduate from the program within the next 12 months? | Less than 5%  5-17 %  18-37%  38-90%  More than 90% | |
| Nature of Services:  *Community-based services* | Program works to monitor status, develop community living skills in community rather than in office. | 1. What percentage of face-to-face contacts with program consumers occur in the community (vs. in an office setting)? | 80% or more  60-79%  40-59%  20-39%  Less than 20% | |
| Nature of Services:  *No dropout policy* | Program retains high percentage of consumers. | 1. How many consumers dropped out of the program over the last 12 months for the following reasons? Do not include consumers who graduated because their services needs were reduced. | \_\_\_\_\_# who refused services  \_\_\_\_\_# who cannot be located  \_\_\_\_\_# who have been closed because staff determined they could not serve them  \_\_\_\_\_#who dropped out for other reasons (specify:\_\_\_\_\_\_\_\_\_) | |
| Nature of Services:  *Assertive engagement mechanisms* | Program uses street outreach, legal mechanisms, or other techniques to ensure ongoing engagement. | 1. What happens if a consumer continually refuses or does not comply with (e.g., misses appointments for) program services?   *(check all that apply)* | They are immediately discharged from the program  Staff initially attempts to engage but may eventually discharge  Staff attempt to engage using assertive techniques as much as possible  Staff consistently use assertive techniques to keep consumers involved in services  Other, specify:\_\_\_\_\_\_\_\_\_\_  None of the above | |
| 1. What methods do program staff use to keep consumers involved in services?   *(check all that apply)* | Outpatient commitment  Representative payee services  Contacts with probation/parole  Street/Shelter outreach after enrollment  Other, specify:\_\_\_\_\_\_\_\_\_\_  None of the above | |
| Nature of Services:  *Intensity of service* | High amount of face-to-face service time as needed. | 1. On average, how much face-to-face time do program staff have with consumers per week? | 2 hours/week or more  85-119 minutes/week  50-84 minutes/week  15-49 minutes/week  Less than 15 minutes/week | |
| Nature of Services:  *Frequency of contact* | High amount of face-to-face service contacts as needed. | 1. On average, how many face-to-face contacts do program staff have with consumers per week? | 5 or more contacts/week  3-4 contacts/week  1-2 contacts/week  No contacts/week | |
| Nature of Services:  *Work with informal support system* | Program provides support and skills for consumers’ informal support network. | 1. On average, how often do program staff work with the family, landlord, employer, or other informal support network members for each consumer with a support system in the community? | 5 or more contacts/month  3-4 contacts/month  1-2 contacts/month  No contacts/month | |
| Nature of Services:  *Individualized substance abuse treatment* | One or more team members provide direct substance abuse treatment for consumers with substance use disorders. | 1. Do program consumers with substance use disorders receive formal individual counseling for substance use from a team/program staff member? | Yes, on weekly basis or more  Yes, but not regularly  No | |
| Nature of Services:  *Co-occurring disorder treatment groups* | Program uses group modalities as a treatment strategy for consumers with dual disorders. | 1. What percentage of consumers with substance use disorders attend at least one substance abuse treatment group per month that is run by program staff? | 50% or more  35-49%  20-34%  5-19%  less than 5% | |
| Nature of Services:  *Co-occurring disorders model* | Program uses no-confrontational, stage wise treatment model, follows behavioral principles, consider interactions of mental illness and substance use, has gradual expectations for abstinence | 1. Which of the following principles and approaches does the program use to treat consumers with substance use issues?   *(check all that apply)* | Confrontation  Abstinence only  Reduction of use (i.e. harm reduction)  Stage wise approach  Referrals to rehab  Referrals to detox - only when medically necessary  Referrals to detox for other purposes  Referrals to AA, NA, etc.  Other, specify:\_\_\_\_\_\_\_\_\_ | |
| Nature of Services:  *Role of consumers on team* | Consumers are members of the team who provides direct services. | 1. How are consumers involved as team/program staff members?   *(check all that apply)* | As full-time paid employees  As part-time paid employees  As volunteers  As full professional team members/staff  As case managers with reduced responsibilities  As aides to the team/program staff  In consumer-specific roles (e.g., self-help)  Not at all | |
|  |  | 1. Were any components of the ACT program model difficult to implement? | No  Yes  **If yes**, which ones? *(check all that apply)*  Small caseload size (10:1)  Team approach  Frequent program meetings to review each consumer  Practicing program lead  Continuity of staffing  Operating at full staff capacity  1 FTE psychiatrist on staff per 100 consumers  2 FTE nurses on staff per 100 consumers  2 substance use specialists on staff per 100 consumers  2 vocational specialists on staff per 100 consumers  Program size (appropriate # of FTE staff)  Explicit admission criteria  Low intake rate  Full responsibility of treatment services  24 hour responsibility for crisis services  Responsibility for hospital admission  Responsibility for hospital discharge planning  Time-unlimited services  Services delivered in community (vs. office based settings)  No dropout policy  Assertive engagement mechanisms used  High intensity of services  High frequency of contacts  Work with informal support system  Direct provision of individualized substance abuse treatment  Co-Occurring disorder treatment groups provided  Co-occurring disorder model used  Consumers provide direct services | |
|  |  | 1. Did you make any adjustments or modifications to the program model? | No  Yes  If yes, please describe | |
|  |  | 1. Were any of the following types of evidence-based service interventions fully imbedded within your implementation of the ACT/ICM program model? | Motivational Interviewing  Cognitive Behavioral Therapy (CBT)  Motivational Enhancement Therapy (MET)  Peer Support  Strengths-Based Case Management/Approach  SSI/DI Outreach, Access & Recovery (SOAR)  Trauma-Specific Intervention (specify:\_\_\_\_\_\_\_\_\_\_\_)  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |

**Integrated Dual Disorders Treatment (IDDT) Module**

| **Dimension** | **Measure** | **Question** | **Response** |
| --- | --- | --- | --- |
| *(Not visible to respondents)* | |
| *Multidisciplinary team (MDT)* | Case managers, psychiatrist, nurses, residential staff, employment specialists, and rehab specialists work collaboratively on mental health treatment team. | 1. Do staff work with consumers individually or as part of a multidisciplinary team (MDT)? | Individually **(Skip to Q #4)**  As a MDT  Other (explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| 1. What staff members comprise the MDT? *(check all that apply)* | Psychiatrist  Nurse  Case manager  Employment specialist(s)  Integrated treatment specialist  Clinicians (e.g. psychologist, licensed social worker, etc.)  Practitioners of other ancillary rehabilitation services  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| 1. Are all members of the MDT required to attend treatment team meetings? | Yes  No |
| *Integrated treatment specialists* | Integrated treatment specialists work collaboratively with the MDT, modeling integrated treatment skills and training other staff in evidence-based practice principles and practice. | 1. Does your agency assign integrated treatment specialists to the program or are consumers referred to integrated treatment specialists (e.g., through a separate program within the agency)? | Integrated treatment specialists are assigned to program  Consumers are referred to integrated treatment specialists  No integrated treatment specialists connected with the agency |
| 1. How often do integrated treatment specialists attend MDT meetings? | Always  Frequently  Sometimes  Rarely  Never  NA |
| 1. How involved are integrated treatment specialists in treatment planning with other members of the treatment team? | Very involved  Somewhat involved  Not at all involved  NA |
| *Stage-wise interventions* | All services are consistent with and determined by each consumer’s stage of treatment. The stages of treatment include the following:   * Engagement * Persuasion * Active treatment * Relapse prevention | 1. Which of the following philosophies or goals are used by staff when treating individuals with co-occurring disorders? | Confrontation  Abstinence  Stages of change  Reduction of use  Relapse prevention  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_) |
| 1. How often would you say that interventions are consistent with the individual’s stage of treatment? | 80-100% of the time  61-79% of the time  41-60% of the time  21-40% of the time  0-20% of the time |
| 1. Are program staff offered training on stages of change and the stages of treatment? | Yes  No |
| *Access to comprehensive services* | Individuals in the program have access to comprehensive services including:   * Residential services * SE * Family interventions * IMR * ACT | 1. Which of the following services do program consumers have genuine access to at the agency? *(check all that apply)* | Residential Services  Supported Employment (SE)  Family Intervention  Illness Management and Recovery (IMR)  Assertive Community Treatment (ACT)  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| *Time-unlimited services* | Individuals in the program are treated on a time-unlimited basis with intensity modified according to each person’s needs. | 1. Does the program graduate consumers after they have completed a certain number of sessions or groups? | Yes  No |
| 1. Which of the following happens when a consumer’s need for services is reduced? | They are closed out of services after a defined period of time **(Skip to Q#13)**  They continue to be served indefinitely and the intensity of services is modified based on individual consumer need. *If yes*, how often is this true?  80-100% of the time  61-79% of the time  41-60% of the time  21-40% of the time  Less than 20% of the time |
| *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 program. | 1. What happens if a consumer continually refuses or does not comply with (e.g., misses appointments for) program services? *(check all that apply)* | They are immediately discharged from the program  Staff initially attempts to engage but may eventually discharge  Staff attempt to engage using assertive outreach techniques as much as possible  Staff consistently use assertive techniques to keep consumers involved in services  Other, specify:\_\_\_\_\_\_\_\_\_\_  None of the above |
| 1. What types of assistance do integrated treatment specialists offer to connect consumers with as a means of engagement? *(check all that apply)* | Housing assistance  Legal aid  Meals or other food resources  Clothing  Medical care  Crisis management  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_) |
| *Motivational interventions* | All interactions with consumers in the program are based on motivational interventions:   * Expressing empathy * Developing discrepancy * Avoiding argumentation * Rolling with resistance * Instilling self-efficacy and hope | 1. Are integrated treatment specialists offered training in motivational interventions? | Yes  No |
| 1. Which of the following techniques are used by integrated treatment specialists with program consumers? *(check all that apply)* | Expressing empathy  Developing discrepancy  Avoiding argumentation  Rolling with resistance  Instilling self-efficacy and hope  Other (specify:\_\_\_\_\_\_\_\_\_\_) |
| 1. How often do staff use a motivational approach in their interactions with consumers? | 80-100% of the time  61-79% of the time  41-60% of the time  21-40% of the time  0-20% of the time |
| *Substance abuse counseling* | Individuals 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 | 1. During which phase(s) of treatment are program consumers offered some form of substance abuse counseling?   *(check all that apply)* | Engagement: while forming a trusting working alliance/relationship  Persuasion: while helping engaged consumers become motivated to participate in recovery  Active Treatment: while helping motivated consumers acquire skills/supports for managing illness and pursuing goals  Relapse Prevention: while helping consumers in stable remission develop/use strategies to maintain recovery |
| 1. Which of the following knowledge/skills are taught to consumers who receive substance abuse counseling in the program? *(check all that apply)* | 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  Relaxation  Other (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| *Group treatment for co-occurring disorders* | All consumers in the program are offered group treatment specifically designed to address both mental health and substance use problems. | 1. Which of the following best describes the types of group treatment offered by the program? | No group treatment is offered **(Skip to Q#21)**  Substance use or mental health specific groups are offered only **(Skip to Q#21)**  Groups that address both mental health and substance use are offered |
| 1. What proportion of program consumers regularly attend group treatment focused on both mental health and substance use? | 65-100%  50-64%  35-49%  20-34%  Less than 20% |
| *Family interventions for co-occurring disorders* | With individuals’ permission program involves consumers’ family members (or other supports) 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. | 1. Are family interventions offered to consumers in the program? | No **(Skip to Q#25)**  Yes |
| 1. Are all consumers asked permission to involve family members or other supporters in family interventions? | No  Yes |
| 1. What proportion of consumers’ family members or other supporters receive family interventions for co-occurring disorders? | 65-100%  50-64%  35-49%  20-34%  Less than 20% |
| *Alcohol and drug self-help groups* | Individuals in the active treatment or relapse prevention stages attend self-help programs in the community. | 1. Does the program ever refer consumers to self-help groups in the community (e.g., AA, NA, etc)? | No **(Skip to Q# 28)**  Yes |
| 1. During which phase(s) of treatment do referrals to self-help groups occur?   *(check all that apply)* | Engagement: forming a trusting working alliance/relationship  Persuasion: helping engaged consumers become motivated to participate in recovery  Active Treatment: helping motivated consumers acquire skills/supports for managing illness and pursuing goals  Relapse Prevention: helping consumers in stable remission develop/use strategies to maintain recovery |
| 1. How many consumers in your program regularly attend self-help programs in the community? | 65-100%  50-64%  35-49%  20-34%  Less than 20% |
| *Pharmacological treatment* | Prescribers for consumers in the program are trained in the evidence-based model & use the following:   * Prescribe despite active substance use * Work closely with consumers and treatment team * Focus on increasing adherence to psych meds * Avoid prescribing meds that may be addictive * Prescribe meds that help reduce addictive behavior | 1. Are prescribers (e.g., physicians or nurses) who work with consumers in the program trained in the evidence-based model? | No  Yes |
| 1. Are psychotropic medications prescribed to consumers with active substance use problems? | No  Yes |
| 1. How often is the treatment team in contact with program consumers’ prescribers? | Always  Frequently  Sometimes  Rarely  Never |
| 1. What types of strategies do prescribers typically use for consumers who do not take psychiatric medications as prescribed? | Encourage consumers’ right to refuse medications  Encourage consumers’ adherence to medications  Other (specify:\_\_\_\_\_\_\_\_\_\_\_) |
| 1. Are consumers in the program prescribed medications that may be addictive? | Always  Frequently  Sometimes  Rarely  Never |
| 1. Are consumers in the program prescribed medications known to be effective in reducing addictive behavior? | Always  Frequently  Sometimes  Rarely  Never |
| *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 | 1. Do integrated treatment specialists offer consumers interventions to promote health? | No  Yes |
| 1. Which of the following areas do integrated treatment specialists typically address with program consumers? *(check all that apply)* | Switching to less harmful substances  Finding safe housing  Proper diet and exercise  Safe sex practices  The risk of losing friends and family  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| 1. How many program consumers receive interventions to help them reduce the negative consequences of substance abuse? | 80-100%  50-79%  Less than 50% |
| *Secondary interventions for non-responders* | 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. | 1. Does your program have a protocol to identify consumers who do not respond to basic treatment? | No  Yes |
| 1. How often are individuals assessed to determine if they are progressing toward recovery? | There is no evaluation or assessment process  Annually  At a minimum of every 6 months  At a minimum of every 3 months |
| 1. What percentage of consumers who do not respond to basic treatment are referred for secondary interventions? | 80-100%  61-79%  41-60%  21-40%  Less than 20% |
|  |  | 1. Were any components of this program model difficult to implement? | No  Yes  **If yes**, which ones? *(check all that apply)*  Staff work as a multidisciplinary team (MDT)  Integrated Treatment Specialists work collaboratively w/MDT  Services are consistent with consumers’ stage of treatment  Consumers have access to comprehensive services  Time-unlimited services  Outreach strategies used to keep consumers engaged  Motivational interventions used  Substance abuse counseling at appropriate stage  Group treatment for co-occurring disorders offered  Family interventions for co-occurring disorders offered  Alcohol & drug self-help groups offered at appropriate stage  Pharmacological treatment consistent with EBP  Interventions to promote health used  Secondary interventions for non-responders used |
|  |  | 1. Did you make any adjustments or modifications to the Integrated Treatment model? | No  Yes  **If yes**, please describe. |
|  |  | 1. Were any of the following types of evidence-based service interventions fully imbedded within your implementation of the Integrated Treatment program model? | Motivational Interviewing  Cognitive Behavioral Therapy (CBT)  Motivational Enhancement Therapy (MET)  Peer Support  Strengths-Based Case Management/Approach  SSI/DI Outreach, Access & Recovery (SOAR)  Trauma-Specific Intervention (specify:\_\_\_\_\_\_\_\_\_\_\_)  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |

**Illness Management and Recovery (IMR) Module**

| **Dimension** | **Measure** | **Question** | **Response** |
| --- | --- | --- | --- |
| *(Not visible to respondents)* | |
| Staffing:  *Number of people in a session/group* | IMR is taught individually or in groups of eight or fewer consumers | 1. Are IMR sessions taught individually, in a group format, or both? | Individually  In Groups  Both individually and in groups |
| 1. How many people typically participate in an IMR session or group? | 15 or more consumers  13-15 consumers  11-12 consumers  9-10 consumers  8 or fewer consumers  IMR is only taught individually |
| *Program length* | Consumers receive at least 3 months of weekly IMR sessions or an equivalent number of IMR sessions | 1. How often and for what length of time do consumers typically attend IMR sessions?   *Note: Exclude from consideration consumers who drop out prematurely*. | \_\_\_\_\_\_total # of sessions attended  \_\_\_\_\_\_total length of time attended (in months)  Are sessions held:  Weekly  Bi-weekly  Once per month  Other (specify:\_\_\_\_\_\_\_\_\_\_\_) |
| *Comprehensiveness of the curriculum* | Curriculum is comprehensive & includes:   * Recovery strategies * Practical facts about MI * Stress-Vulnerability Model & tx strategies * Building social support * Using medication effectively * Drug & alcohol use * Reducing relapses * Coping with stress * Coping with problems and persistent symptoms * Getting your needs met in the mental health system. | 1. Is there an established curriculum for the IMR sessions? | No  Yes |
| 1. Which of the following topics are covered in IMR sessions? *(check all that apply)* | Recovery strategies  Practical facts about mental illnesses  Stress-Vulnerability Model and treatment strategies  Building social support  Using medication effectively  Drug and alcohol use  Reducing relapses  Coping with stress  Coping with problems and persistent symptoms  Getting needs met in the mental health system  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| *Provision of educational handouts* | All consumers participating in IMR receive IMR handouts | 1. Do IMR consumers receive educational handouts as part of the program? | No  Yes  **If yes**, is this true:  90-100% of the time  70-89% of the time  40-69% of the time  20-39% of the time  Less than 20% of the time |
| *Involvement of significant others* | Developing and enhancing natural support is one of IMR’s goals. Social support helps people generalize information and skills learned in sessions to their natural environment. | 1. Does the IMR program involve consumers’ significant others (e.g. family, friends, other non-paid supports)? | No (Skip to Q#9)  Yes |
| 1. How are significant others involved:   *(check all that apply)* | IMR practitioners have regular contact with significant others  Significant others assist consumers in pursuing IMR goals  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Is this type of involvement true for:  At least 50% of IMR consumers  30-49% of IMR consumers  Less than 30% of consumers |
| Assignments:  *IMR goal setting* | One of the objectives of the IMR program is to help consumers establish personally meaningful goals. | 1. To what extent do IMR consumers have personally established goals that are realistic and measurable? | 90-100% of consumers have at least one such goal  70-89% of consumers have at least one such goal  40-69% of consumers have at least one such goal  20-39% of consumers have at least one such goal  Less than 20% of consumers have at least one such goal |
| Assignments:  *IMR goal follow-up* | Practitioners and consumers collaboratively follow up on goals identified above. | 1. How often is progress toward achieving consumers’ IMR goals reviewed? | At every session  Some other frequency (e.g. every other session, monthly, etc.)  Infrequently/only as needed  Progress is not reviewed  Is the above true for:  All IMR consumers  Most IMR consumers  Some IMR consumers |
| Assignments:  *Motivation-based strategies* | Practitioners regularly use motivation-based strategies. | 1. Which of the following strategies are used in IMR sessions? (*check all that apply*) | Teaching new information and skills to achieve goals  Encouraging positive perspectives of past experiences  Exploring the pros and cons of change  Instilling hope and belief in self-efficacy  Other (specify \_\_\_\_\_\_\_\_) |
| 1. How often are motivation based strategies used in IMR sessions? | They are used in at least half of the sessions  They are used in some sessions  They are used in a few sessions  They are never used in sessions |
| Assignments:  *Educational techniques* | Practitioners embrace the concept of and regularly apply educational techniques. | 1. Which of the following educational techniques are used in IMR sessions? *(check all that apply)* | Interactive teaching  Checking for understanding  Breaking down information  Reviewing information  Other (specify \_\_\_\_\_\_\_\_) |
| 1. How often are educational techniques used in IMR sessions? | They are used in at least half of the sessions  They are used in some sessions  They are used in a few sessions  They are never used in sessions |
| Assignments:  *Cognitive-behavioral techniques* | Practitioners regularly use cognitive-behavioral techniques to teach IMR information and skills. | 1. Which of the following techniques are used in IMR sessions? *(check all that apply)* | Reinforcement  Shaping  Modeling  Role playing  Cognitive restructuring  Relaxation training  Other (specify \_\_\_\_\_\_\_) |
| 1. How often are cognitive-behavioral techniques used in IMR sessions? | They are used in at least half of the sessions  They are used in some sessions  They are used in a few sessions  They are never used in sessions |
| Assignments:  *Coping skills training* | Practitioners embrace the concept of and systematically provide, coping skills training. | 1. Are IMR practitioners familiar with the principles of coping skills training? | No  Some are familiar  The majority are familiar  All practitioners are familiar |
| 1. How frequently do IMR practitioners use coping skills principles in their IMR sessions? | Regularly  Moderately  Not often  Never |
| Assignments:  *Relapse prevention training* | Practitioners embrace the concept of relapse prevention training and systematically apply it. | 1. Are IMR practitioners familiar with the principles of relapse prevention training? | No  Some are familiar  The majority are familiar  All practitioners are familiar |
| 1. How frequently do IMR practitioners use relapse prevention training in their IMR sessions? | Regularly  Moderately  Not often  Never |
| Assignments:  *Behavioral tailoring for medication* | Practitioners embrace the concept of and use behavioral tailoring for medication. | 1. Are IMR practitioners familiar with the principles of behavioral tailoring for medication? | No  Some are familiar  The majority are familiar  All practitioners are familiar |
| 1. How frequently do IMR practitioners use behavioral tailoring for medication techniques in their IMR sessions? | Regularly  Moderately  Not often  Never |
|  |  | 1. Were any components of this program model difficult to implement? | No  Yes  **If yes**, which ones? *(check all that apply)*  IMR taught individually or in groups of 8 or fewer consumers  At least 3 months of weekly sessions or equivalent  Comprehensiveness of curriculum  Provision of educational handouts  Involvement of significant others  IMR goal setting  IMR goal follow-up  Motivation-based strategies used  Educational techniques used  Cognitive-behavioral techniques used  Coping skills training provided  Relapse prevention training provided  Behavioral tailoring for medications used |
|  |  | 1. Did you make any adjustments or modifications to the IMR model? | No  Yes  **If yes**, please describe. |
|  |  | 1. Were any of the following types of evidence-based service interventions fully imbedded within your implementation of the IMR model? | Motivational Interviewing  Cognitive Behavioral Therapy (CBT)  Motivational Enhancement Therapy (MET)  Peer Support  Strengths-Based Case Management/Approach  SSI/DI Outreach, Access & Recovery (SOAR)  Trauma-Specific Intervention (specify:\_\_\_\_\_\_\_\_\_\_\_)  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |

**Supported Employment (SE) Module**

| **Dimension** | | **Measure** | **Question** | **Response** | |
| --- | --- | --- | --- | --- | --- |
| *(Not visible to respondents)* | | |
| Staffing:  *Caseload size* | | Employment specialists (ES) manage caseloads of up to 25 consumers | 1. What is the average caseload size for an employment specialist? | 81 or more consumers  61 to 80 consumers  41 to 60 consumers  26 to 40 consumers  25 or fewer consumers | |
| Staffing:  *Focus of vocational services staff time* | | ES provide only vocational services. | 1. What services do employment specialists provide? (check all that apply) | Vocational services  Case management  Individual or group therapy  Staffing for day or residential programming  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_)  *If only selected vocational services above,* ***SKIP to Q#4*** | |
| 1. How much of the time do employment specialists provide non-vocational services? | Less than 20%  20-39%  40-59%  60-79%  80% or more | |
| Staffing:  *Vocational generalists role/responsibilities* | | Each ES carries out all phases of vocational service including engagement, assessment, job development, job placement, job coaching, and follow-along supports. | 1. Which of the following most accurately describes the role of employment specialists (ES) in the program? | Each ES carries out all phases of vocational service, including engagement, assessment, job development, placement, and coaching, and follow-along supports.  ES provides 2 or more phases of vocational service but not the entire service (e.g. some do engagement and assessment only while others do job development and placement, etc.)  ES specializes in 1 aspect of vocational service  ES maintain caseloads but refer consumers to other programs for vocational service  ES do not carry caseloads and only provide vocational referrals to other vendors or programs  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| Organization:  *Integration of rehabilitation with mental health treatment* | | ES are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings and have frequent contact with treatment team members. | 1. Do employment specialists interact with the mental health treatment team? | No  Yes, but infrequently  Yes, regularly  **If yes***,* how & how frequently is contact made:  *(check all that apply)*  Telephone contact \_\_\_\_ times per month  Face-to-face contact \_\_\_\_ times per month  Attendance at treatment team meetings \_\_\_\_ times per month | |
| 1. Do employment specialists and case managers or case management teams participate in shared decision making about consumer services? | No  Yes | |
| Organization:  *Vocational unit functioning* | | ES function as a unit rather than a group of practitioners. They have group supervision, share information, and help each other with cases. | 1. Do all employment specialists have the same supervisor? | No  Yes  **If yes**, how & how frequently do they receive supervision:  Individually \_\_\_\_ times per month  As a group \_\_\_\_ times per month | |
| 1. Do employment specialists provide services for one another’s consumers? | No  Yes | |
| Organization:  *Zero-exclusion criteria* | | No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual function, and mild symptoms | 1. Must consumers meet certain eligibility criteria in order to receive supported employment services? | No  Yes  **If yes**, which of the following screening criteria are used (check all that apply):  Job readiness  Abstinence from substance use  No history of violent behavior  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| 1. Where does the supported employment program accept referrals from? | Case Managers  Therapists  Psychiatrists  Family members  Self-referral  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |
| Services:  *Ongoing, work-based vocational assessment* | | Vocational assessment is an ongoing process based on work experiences in competitive jobs. | 1. Are vocational assessments that are conducted in the supported employment program primarily: | Office-based assessments done prior to job placement?  Pre-vocational assessments conducted at a day program site?  Carried out in a sheltered work environment?  Based on a series of temporary job experiences?  Ongoing assessments that occur in community jobs?  Other (specify:\_\_\_\_\_\_\_\_\_\_\_) | |
| Services:  *Rapid search for competitive jobs* | | The search for competitive jobs occurs rapidly after program entry. | 1. Must consumers take any steps in the program before beginning a job search? | Yes, some pre-requisites exist (e.g. pre-vocational counseling, participation in an enclave or sheltered work, etc.) before search for a competitive job can begin.  No, the job search begins as soon as a consumer expresses interest in competitive employment | |
| 1. How soon after program entry does a consumer typically begin having contact with competitive employers (i.e. start their job search)? | Within 1 month  1-6 months  6-9 months  9-12 months  More than 12 months | |
| Services:  *Individualized job search* | | Employer contacts are based on consumers’ job preferences (relating to what they enjoy and their personal goals) and needs rather than the job market, that is, what jobs are readily available. | 1. How are employer contacts selected?   *(Check all that apply)* | Based on the local job market (i.e. which jobs are readily available)  Based on the employment specialists decisions  Based on the consumer’s preferences and needs  Other (specify:\_\_\_\_\_\_\_\_\_\_\_) | |
| 1. How often are employer contacts made based on consumer preferences and needs rather than the job market? | Most of the time  About 75% of the time  About 50% of the time  About 25% of the time  Never | |
| Services:  *Diversity of jobs developed* | | ES provide job options that are in different settings. | 1. What proportion of the types of job options and settings offered to consumers are: | The same/similar (e.g., all janitorial, or in food service settings)\_\_\_\_\_%  Different (e.g., consist of all types of jobs/settings) \_\_\_\_\_\_% | |
| 1. What percentage of consumers work in the same types of jobs or settings? | 75-100%  About 75%  About 50%  About 25%  Less than 10% | |
| Services:  *Permanence of jobs developed* | | ES provide competitive job options that have permanent status rather than temporary or time-limited status. | 1. Do employment specialists ever suggest jobs to consumers that are temporary, time-limited, or volunteer? | Yes, always  Yes, sometimes  No, never | |
| 1. How often do employment specialists provide options to consumers for permanent, competitive jobs? | 75-100% of the time  About 75% of the time  About 50% of the time  About 25% of the time  Employment specialists do not provide options for permanent, competitive jobs | |
| Services:  *Jobs as transitions* | | All jobs are viewed as positive experiences on the path of vocational growth and development. ES help consumers end jobs when appropriate and then find new jobs. | 1. When a job has ended, do employment specialists offer to assist consumers in finding another job? | Not usually  Yes always  Depends on the situation  **If it depends**, how often are they likely to assist?  About 75% of the time  About 50% of the time  About 25% of the time  Please provide an example of a reason an employment specialist might be less likely to assist a consumer in finding a new job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Services:  *Follow along supports* | | Individualized, follow-along supports are provided to employer and consumer on a time-unlimited basis. | 1. Are follow-along supports provided: | To consumers (e.g., job coaching/counseling, job support groups, etc.)?  No not provided  Yes provided to most  Provided to less than half | To employers (e.g., education, guidance)?  No not provided  Yes provided to most  Provided to less than half |
|  |  | | 1. Is there a time limit for providing supports: | To consumers?  No  Yes  **If yes**, what is the limit? \_\_\_\_ | To employers?  No  Yes  **If yes**, what is the limit? \_\_\_\_\_ |
| Services:  *Community-based services* | | Vocational services such as engagement, job-finding, and follow-along supports are provided in community settings | 1. What percentage the services employment specialists provide are in the community (vs. in an office or mental health facility)? | 70-100%  60-69%  40-59%  11-39%  0-10% | |
| Services:  *Assertive engagement and outreach* | | Assertive engagement and outreach are conducted as needed | 1. Do employment specialists conduct outreach to engage consumers? | Yes, initially  Avg. # of contacts: \_\_\_\_\_ OR frequency\_\_\_\_ (e.g., once per week, month, etc.)  Yes, if they stop attending vocational services  Avg. # of contacts: \_\_\_ OR frequency\_\_\_\_ (e.g., once per week, month, etc.)  No **(Skip to Q# 26)** | |
| 1. What types of outreach are typically used? (check all that apply) | Letters or other written materials sent to the consumer’s residence  Phone calls to the consumer  Phone calls to consumers’ case manager/other care provider (with consent)  Community visits with consumers | |
|  | |  | 1. Where there components of the Supported Employment program model that were difficult to implement? | No  Yes  **If yes**, which ones? (check all that apply)  Caseload size (1:25)  ES provide only vocational services  ES carry out all phases of vocational service  Integrating ES with mental health treatment team  ES share a supervisor and help each other with cases  Zero-exclusion criteria  Ongoing, work-based vocational assessments.  Rapid search for competitive jobs  Employer contacts based on consumer preferences/needs vs. job market  Job options provided are in different settings.  Providing permanent, competitive job options  Helping consumers find new jobs  Providing follow-along  Providing vocational services in community settings  Providing assertive engagement and outreach | |
|  | |  | 1. Did your agency make any adjustments or modifications to the Supported Employment model? | No  Yes  **If yes**, please describe. | |
|  | |  | 1. Were any of the following types of evidence-based service interventions fully imbedded within your implementation of the Supported Employment model? | Motivational Interviewing  Cognitive Behavioral Therapy (CBT)  Motivational Enhancement Therapy (MET)  Peer Support  Strengths-Based Case Management/Approach  SSI/DI Outreach, Access & Recovery (SOAR)  Trauma-Specific Intervention (specify:\_\_\_\_\_\_\_\_\_\_\_)  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |

**Critical Time Intervention (CTI) Module**

| **Component/Measure**  *(not visible to respondents)* | **Question** | **Response** | |
| --- | --- | --- | --- |
| Program Structure/Staffing | 1. Which settings are consumers who receive CTI services directly transitioning between? | Transitioning from:  Hospital  Shelter  Housing setting (e.g., residential, transitional housing) specify:\_\_\_\_\_\_\_  Streets  Prison  Jail  Other, specify\_\_\_\_\_\_\_ | Transitioning to:  Transitional housing  Permanent housing  Other, specify\_\_\_\_\_\_\_ |
| 1. In what setting is the CTI program based? | Drop-in center  Shelter  Mental health impatient unit  Other, specify\_\_\_\_\_\_\_ | |
| 1. What staff members comprise the CTI team? | Psychiatrist  Nurse  Team leader /coordinator (specify credentials, e.g., MSW\_\_\_\_\_\_\_\_\_\_\_)  Housing case manager or specialist  CTI case managers/workers (specify #\_\_\_\_\_)  Other, specify\_\_\_\_\_\_\_ | |
| 1. What is the average case load size per CTI worker? | 35 to 50 consumers  21 to 34 consumers  15 to 20 consumers  10 or fewer consumers  Does caseload size vary by phase of service? *If yes,* explain:\_\_\_\_\_ | |
| 1. Does CTI staff meet as a team to discuss clients’ needs and care? | No  Yes  **If yes**, how often are team meetings held?  Weekly  Bi-weekly  Monthly  Only as needed  Other, specify\_\_\_\_\_\_\_\_\_\_\_  **If yes**, who conducts the team meetings? \_\_\_\_\_\_\_\_  **If yes**, what percentage of CTI clients are reviewed at each team meeting: \_\_\_\_% | |
| 1. How often are each CTI client’s needs and care reviewed and discussed by CTI program staff? | Weekly  Bi-weekly  Monthly  Only as needed  Other, specify\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. What types of supervision and organizational support does CTI program staff receive? | Individual clinical supervision (specify frequency\_\_\_\_\_\_\_\_)  Field work observation/feedback  Team case presentations/feedback  Review/feedback of client case notes  Resources to support work in the field (specify:\_\_\_\_\_\_\_)  Other, specify\_\_\_\_\_\_\_\_\_\_\_ | |
| Early Engagement | 1. Are CTI workers able to establish relationships and begin to engage consumers prior to their transition to a new setting in the community? | Yes  No **(SKIP to Q 11)** | |
| 1. What is the typical length of time between initial contact and a consumers’ discharge or move to the community (i.e. length of pre-CTI period)? | Less than 1 week  1-2 weeks  2-4 weeks  More than 1 month  Other, specify\_\_\_\_\_\_ | |
| 1. How often do CTI workers typically meet with consumers during the ‘pre-CTI period’? | Once  2-3 times  4 times  Other, specify\_\_\_\_\_ | |
| Assessment/Treatment Planning | 1. Is a CTI intake assessment completed? | No **(SKIP to Q 13)**  Yes  **If yes**, when is it completed? \_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Which of the following are components of the intake assessment? | Demographic information  Psychiatric history (diagnosis, symptoms, medications, hospitalizations)  Substance use history (diagnosis, symptoms, treatment history)  Homelessness/housing history  Reasons for housing loss/risks to housing stability  Financial supports  Formal & informal supports  ADL skills  Strengths & interests of consumer  Other, specify\_\_\_\_\_\_ | |
| 1. Are CTI services delivered in phases? | No  Yes  **If yes**, how many phases? \_\_\_\_  **If yes**, how long does each phase last? \_\_\_\_\_ | |
| 1. Is a CTI treatment plan completed? | Yes, at the beginning of CTI services only  Yes, for each phase of service  Other, specify\_\_\_\_\_ | |
| 1. What is the typical timeframe for completion of the treatment plan? | Within two weeks prior to services/phase beginning  Within two weeks after services/phase beginning  3-4 weeks after services/phase beginning  Other, specify\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. What focus areas do CTI treatment plans typically address?   *(check all that apply)* | Psychiatric treatment & medication management  Money management  Substance abuse management  Housing crisis management & prevention  Family interventions  Life skills training  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. How many of the focus areas selected in Question #16 typically comprise a CTI treatment plan at any one time? | More than 6  6  4-5  1-3 | |
|  | 1. Which of the following best describes how treatment plan focus areas are chosen: | Based on consumer ‘s history of risk of homelessness  Based on goal attainment/new risk areas identified at end of previous phase of CTI service  Other, specify\_\_\_\_\_\_  Does this vary by phase of service? *If yes,* explain:\_\_\_\_\_ | |
| Outreach/Early Linking | 1. During the first phase (i.e. first 1-3 months) of CTI services, how is contact maintained between CTI workers and consumers? *(check all that apply)* | Phone contact is made  Home visits are made  **If home visits made**, how soon after the start of Phase One do they occur?  Within one week  Within two weeks  Within one month  Other, specify\_\_\_\_\_\_  Visits are made to clients at their treatment setting (e.g., day program)  **If clients visited at treatment setting**, how soon after the start of Phase One do they occur?  Within one week  Within two weeks  Within one month  Other, specify\_\_\_\_\_\_  Workers accompany consumers on appointments  Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. How often do CTI workers typically make contact with consumers during the initial phase (1-3 months) of service? | Once per month  2-3 times per month  4 times per month  Other, specify\_\_\_\_\_ | |
| 1. How often do CTI workers typically meet with primary mental health and/or substance use treatment providers during the initial phase (1-3 months) of service? | Once  2-3 times  4 times  Other, specify\_\_\_\_\_ | |
| 1. How often do CTI workers typically meet with housing providers including landlords during the initial phase (1-3 months) of service? | Once  2-3 times  4 times  Other, specify\_\_\_\_\_ | |
| 1. During the initial phase (1-3 months) of service, do CTI workers hold joint meetings between: | Consumers and their community linkages?  Yes  No  Linkages from different agencies?  Yes  No | |
| Nature/Length of Services | 1. Which of the following principles and approaches do CTI staff use in their work with consumers? *(check all that apply)* | Confrontation  Abstinence only  Harm reduction  Stage wise approach  Office-based assessments  Community-based assessment & skill building  Other, specify:\_\_\_\_\_\_\_\_\_ | |
| 1. What is the total length of time consumers typically receive CTI services? | 3 months  6 months  9 months  12 months  Other, specify\_\_\_\_ | |
| 1. Are consumers ever discharged from services early? | No  Yes  **If yes**, why*?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 1. Which of the following activities are most likely to occur during the initial phase (1-3 months) of CTI services? | CTI worker focuses with consumer on work accomplished and long-term goals  CTI worker focuses on assessment and linkage with supports  CTI worker accompanies consumer to appointments  CTI worker observes consumer trying out skills and adjusts consumer support network  CTI worker encourages consumer and caregivers to work out problems on their own  CTI worker substitutes for caregivers when necessary  CTI worker mediates conflicts between consumer and caregivers | |
| 1. Which of the following activities are most likely to occur during the middle phase (e.g., months 4-6) of CTI services? | CTI worker focuses with consumer on work accomplished and long-term goals  CTI worker focuses on assessment and linkage with supports  CTI worker accompanies consumer to appointments  CTI worker observes consumer trying out skills and adjusts consumer support network  CTI worker encourages consumer and caregivers to work out problems on their own  CTI worker substitutes for caregivers when necessary  CTI worker mediates conflicts between consumer and caregivers | |
| 1. Which of the following activities are most likely to occur during the final phase (e.g., months 7-9) of CTI services? | CTI worker focuses with consumer on work accomplished and long-term goals  CTI worker focuses on assessment and linkage with supports  CTI worker accompanies consumer to appointments  CTI worker observes consumer trying out skills and adjusts consumer support network  CTI worker encourages consumer and caregivers to work out problems on their own  CTI worker substitutes for caregivers when necessary  CTI worker mediates conflicts between consumer and caregivers | |
| 1. How often do CTI workers typically have contact with consumers during the final phase (e.g., months 7-9) of CTI services? | Once per month  2-3 times per month  4 times per month  Other, specify\_\_\_\_ | |
|  | 1. Were any components of this program model difficult to implement? | No  Yes  **If yes**, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | 1. Did you make any adjustments or modifications to the CTI model? | No  Yes  **If yes**, please describe | |
|  | 1. Were any of the following types of evidence-based service interventions fully imbedded within your implementation of the CTI program model? | Motivational Interviewing  Cognitive Behavioral Therapy (CBT)  Motivational Enhancement Therapy (MET)  Peer Support  Strengths-Based Case Management/Approach  SSI/DI Outreach, Access & Recovery (SOAR)  Trauma-Specific Intervention (specify:\_\_\_\_\_\_\_\_\_\_\_)  Other (specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | |

1. Defined as those primary EBPs that are program-level models being implemented in 14 or more sites for which a fidelity toolkit/scale exists. [↑](#footnote-ref-1)
2. Defined as those primary EBPs that are program-level models being implemented in 14 or more sites for which a fidelity toolkit/scale exists. [↑](#footnote-ref-2)