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

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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] 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]

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.						

[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.

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]

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: _____
2. 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

EBP:_____	
3. 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: _____
4. 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
5. 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:_____
6. 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_____

EBP:_____	
7. 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_____
8. 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_____

EBP:_____	
9. 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
10. 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_____
11. Are there any explicit policies the implementing agency has that support implementation of this EBP?	☐ No ☐ Yes **If yes**, explain: _____
12. Are there any explicit policies the implementing agency has that serve as <u>barriers</u> to implementation of this EBP?	☐ No ☐ Yes **If yes**, explain: _____
13. 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: _____
14. Are there any state or local regulations or policies that serve as <u>barriers</u> to implementation of this EBP?	☐ No ☐ Yes **If yes**, explain: _____

EBP:_____	
15. 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	
16. 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
17. 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
18. 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

EBP:_____	
19. 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	
20. 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:_____
21. 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
22. 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

EBP:_____	
23. 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
24. 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 _____
25. Does all staff implementing this EBP receive the same training?	☐ Yes ☐ No **If no**, explain: _____
26. 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 _____
27. 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_____

EBP:_____	
Fidelity/Outcomes Monitoring & Performance Improvement	
28. 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_____
29. To date, how many clients participated in this EBP during the grant period?	_____
30. How many clients were eligible to participate during the grant period?	_____
31. 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)
32. How often is fidelity data collected/assessed for this EBP?	☐ Ongoing ☐ Every six months ☐ Annually ☐ Other, specify:_____
33. 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:_____
34. When was the last fidelity assessment done and what were the results?	Date conducted: _____ Measure Used: _____ Score/results: _____
35. 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

EBP:_____	
36. 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)_____
37. 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
38. Are there any plans to maintain fidelity to this practice beyond the grant period?	☐ No ☐ Don't know ☐ Yes **If yes**, describe_____
39. 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	

EBP:_____	
40. 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
41. Overall, what factors have served as <u>facilitators</u> 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] 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.

[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.

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

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.	2. 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
		3. 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.	4. 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
		5. 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	6. Does the ACT team leader/ICM supervisor provide direct services to consumers?	☐ Yes ☐ No

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
	members provides direct service.	7. 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.	8. What is the total number of staff positions on the ACT team/in the ICM program?	_____
		9. 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.	10. 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.	11. How many consumers are served by the ACT/ICM program?	_____# consumers served by ACT team/ICM program
		12. 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.	13. 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	14. 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

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
	experience in substance abuse treatment per 100 consumer program.	15. 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.	16. 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
		17. 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.	18. 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

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
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.	19. 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:_____
		20. 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.	21. 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

Dimension	**Measure**	**Question**	**Response**	
(Not visible to respondents)				
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.	22. 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)*	<u>Directly by program staff</u>: ☐ 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)	<u>By other department/agency</u>: ☐ 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.	23. 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	24. 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	25. 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	

Dimension	**Measure**		
(Not visible to respondents)		**Question**	**Response**
Organizational Boundaries: *Time-unlimited services*	Rarely closes cases; remains the point of contact for all consumers indefinitely as needed.	26. 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:_____
		27. 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.	28. 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.	29. 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.	30. 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

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
		31. 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.	32. 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.	33. 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.	34. 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.	35. 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.	36. 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%

Dimension	**Measure**		
(Not visible to respondents)		**Question**	**Response**
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	37. 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.	38. 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

Dimension	Measure		
(Not visible to respondents)		**Question**	**Response**
		39. 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

Dimension	Measure	Question	Response
(Not visible to respondents)			
		40. Did you make any adjustments or modifications to the program model?	☐ No ☐ Yes If yes, please describe_____
		41. 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:_____)
		2. 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:_____)
		3. 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.	4. 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
		5. How often do integrated treatment specialists attend MDT meetings?	☐ Always ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never ☐ NA
		6. 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

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
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	7. 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:_____)
		8. 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
		9. 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	10. 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	11. Does the program graduate consumers after they have completed a certain number of sessions or groups?	☐ Yes ☐ No

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
	basis with intensity modified according to each person's needs.	12. 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.	13. 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
		14. 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	15. Are integrated treatment specialists offered training in motivational interventions?	☐ Yes ☐ No

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
	on motivational interventions: • Expressing empathy • Developing discrepancy • Avoiding argumentation • Rolling with resistance • Instilling self-efficacy and hope	16. 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:_____)
		17. 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	18. 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

Dimension	Measure	Question	Response
(Not visible to respondents)			
	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	19. 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.	20. 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
		21. 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	22. Are family interventions offered to consumers in the program?	☐ No **(Skip to Q#25)** ☐ Yes

Dimension	Measure	Question	Response
(Not visible to respondents)			
	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.	23. Are all consumers asked permission to involve family members or other supporters in family interventions?	☐ No ☐ Yes
		24. 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.	25. Does the program ever refer consumers to self-help groups in the community (e.g., AA, NA, etc)?	☐ No **(Skip to Q# 28)** ☐ Yes
		26. 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
		27. 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	28. Are prescribers (e.g., physicians or nurses) who work with consumers in the program trained in the evidence-based model?	☐ No ☐ Yes

Dimension	Measure	Question	Response
(Not visible to respondents)			
	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	29. Are psychotropic medications prescribed to consumers with active substance use problems?	☐ No ☐ Yes
		30. How often is the treatment team in contact with program consumers' prescribers?	☐ Always ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
		31. 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:_____)
		32. Are consumers in the program prescribed medications that may be addictive?	☐ Always ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
		33. 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	34. Do integrated treatment specialists offer consumers interventions to promote health?	☐ No ☐ Yes

Dimension	Measure	Question	Response
(Not visible to respondents)			
	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	35. 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:_____)
		36. 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.	37. Does your program have a protocol to identify consumers who do not respond to basic treatment?	☐ No ☐ Yes
		38. 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
		39. 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%

Dimension	Measure	Question	Response
(Not visible to respondents)			
		40. 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
		41. Did you make any adjustments or modifications to the Integrated Treatment model?	☐ No ☐ Yes **If yes**, please describe._____
		42. 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
		2. 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	3. 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	4. Is there an established curriculum for the IMR sessions?	☐ No ☐ Yes

Dimension	Measure	Question	Response
(Not visible to respondents)			
	• 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.	5. 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	6. 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	7. Does the IMR program involve consumers' significant others (e.g. family, friends, other non-paid supports)?	☐ No (Skip to Q#9) ☐ Yes

Dimension	Measure	Question	Response
(Not visible to respondents)			
	IMR's goals. Social support helps people generalize information and skills learned in sessions to their natural environment.	8. 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.	9. 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.	10. 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.	11. 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 _____)

Dimension	Measure	Question	Response
(Not visible to respondents)			
		12. 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.	13. 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 _____)
		14. 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.	15. 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 _____)
		16. 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	17. Are IMR practitioners familiar with the principles of coping skills training?	☐ No ☐ Some are familiar ☐ The majority are familiar ☐ All practitioners are familiar

Dimension	Measure	Question	Response
(Not visible to respondents)			
	provide, coping skills training.	18. 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.	19. Are IMR practitioners familiar with the principles of relapse prevention training?	☐ No ☐ Some are familiar ☐ The majority are familiar ☐ All practitioners are familiar
		20. 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.	21. Are IMR practitioners familiar with the principles of behavioral tailoring for medication?	☐ No ☐ Some are familiar ☐ The majority are familiar ☐ All practitioners are familiar
		22. How frequently do IMR practitioners use behavioral tailoring for medication techniques in their IMR sessions?	☐ Regularly ☐ Moderately ☐ Not often ☐ Never

Dimension	Measure	Question	Response
(Not visible to respondents)			
		23. 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
		24. Did you make any adjustments or modifications to the IMR model?	☐ No ☐ Yes **If yes**, please describe._____
		25. 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.	2. 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***
		3. How much of the time do employment specialists provide non-vocational services?	☐ Less than 20% ☐ 20-39% ☐ 40-59% ☐ 60-79% ☐ 80% or more

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
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.	4. 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.	5. 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
		6. 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	7. 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

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
	help each other with cases.	8. 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	9. 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:_____)
		10. 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.	11. 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.	12. 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

Dimension	**Measure**	**Question**	**Response**
(Not visible to respondents)			
		13. 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.	14. 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:_____)
		15. 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.	16. 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) _____%
		17. 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	18. Do employment specialists ever suggest jobs to consumers that are temporary, time-limited, or volunteer?	☐ Yes, always ☐ Yes, sometimes ☐ No, never

Dimension	Measure	Question	Response	
(Not visible to respondents)				
	rather than temporary or time-limited status.	19. 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.	20. 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 <u>less</u> 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.	21. Are follow-along supports provided:	<u>To consumers</u> (e.g., job coaching/counseling, job support groups, etc.)? ☐ No not provided ☐ Yes provided to most ☐ Provided to less than half	<u>To employers</u> (e.g., education, guidance)? ☐ No not provided ☐ Yes provided to most ☐ Provided to less than half
		22. Is there a time limit for providing supports:	<u>To consumers</u>? ☐ No ☐ Yes **If yes**, what is the limit? ____	<u>To employers</u>? ☐ No ☐ Yes **If yes**, what is the limit? _____

Dimension	**Measure**		
(Not visible to respondents)		**Question**	**Response**
Services: *Community-based services*	Vocational services such as engagement, job-finding, and follow-along supports are provided in community settings	23. 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	24. 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)**
		25. 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

Dimension	Measure		
(Not visible to respondents)		**Question**	**Response**
		26. 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
		27. Did your agency make any adjustments or modifications to the Supported Employment model?	☐ No ☐ Yes **If yes**, please describe._____
		28. 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_____
	2. In what setting is the CTI program based?	☐ Drop-in center ☐ Shelter ☐ Mental health impatient unit ☐ Other, specify_____	
	3. 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_____	
	4. 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:_____	

Component/Measure *(not visible to respondents)*	**Question**	**Response**
	5. 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: ____%
	6. 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_____
	7. 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	8. 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)**
	9. 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_____

Component/Measure *(not visible to respondents)*	**Question**	**Response**
	10. 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	11. Is a CTI intake assessment completed?	☐ No **(SKIP to Q 13)** ☐ Yes **If yes**, when is it completed? _____
	12. 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_____
	13. Are CTI services delivered in phases?	☐ No ☐ Yes **If yes**, how many phases? ____ **If yes**, how long does each phase last? _____
	14. Is a CTI treatment plan completed?	☐ Yes, at the beginning of CTI services only ☐ Yes, for each phase of service ☐ Other, specify_____
	15. 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_____

Component/Measure *(not visible to respondents)*	**Question**	**Response**
	16. 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:_____
	17. 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
	18. 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	19. 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:_____

Component/Measure *(not visible to respondents)*	**Question**	**Response**
	20. 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_____
	21. 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_____
	22. 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_____
	23. 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	24. 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:_____
	25. What is the total length of time consumers typically receive CTI services?	☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other, specify____
	26. Are consumers ever discharged from services early?	☐ No ☐ Yes **If yes**, why*?* _____

Component/Measure *(not visible to respondents)*	**Question**	**Response**
	27. 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
	28. 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
	29. 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

Component/Measure *(not visible to respondents)*	**Question**	**Response**
	30. 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____
	31. Were any components of this program model difficult to implement?	☐ No ☐ Yes **If yes**, specify_____
	32. Did you make any adjustments or modifications to the CTI model?	☐ No ☐ Yes **If yes**, please describe_____
	33. 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:_____)