Decision Support 2000+

Report on Fidelity Measures for Evidence-Based Practices

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Introduction

Treatment technologies for specific mental and substance use conditions have advanced dramatically in recent years, as have the technologies to measure their effectiveness. With these advances have come an emerging evidence base of selected treatments that work best for consumers with specific conditions. This development has profound implications for policy initiatives.

The 2005 Institute of Medicine report *Improving the Quality of Health Care for Mental and Substance Use Conditions* differentiated between variations in care that are "appropriate and therapeutic" versus those variations that diverge from established best practices for unwarranted reasons that could lead to deficient and at times harmful care. The report called for the Department of Health and Human Services and its branches to "substantially expand efforts to attain widespread adoption of evidence-based practices…" and for clinicians and organizational providers to "use measures of the processes and outcomes of care to continuously improve the quality of the care they provide."

SAMHSA's Center for Mental Health Services (CMHS) initiated a multi-year program to encourage widespread adoption of evidence-based practices and multiple measures to evaluate the fidelity and effectiveness of their implementation. Six evidence-based practices were initially targeted for attention, and Toolkits were developed to facilitate training for their widespread adoption. The Toolkits were widely disseminated, and grants were given to states for implementation and evaluation. Additional toolkits are under development.

In addition to CMHS, other public agencies at Federal, state and county levels have launched initiatives to promote implementation of EBPs, as have private sector systems of care. In addition to stimulating numerous EBP training programs and implementations, these initiatives have also prompted an intense nationwide discussion among all stakeholders about EBPs. Among the many concerns raised are whether: 1) findings from randomized clinical trial research used to establish EBPs are fully generalizable to field settings, 2) non-specific factors such as therapeutic alliance contribute as much to consumer outcomes as the EBP techniques themselves, and 3) EBP policy initiatives, if too rigidly applied, might have a dampening effect on innovations in treatment.

It is beyond the scope of this report to address these important concerns and the debates they have engendered. They are addressed in numerous books and articles elsewhere. While these concerns have not overridden the established value of EBPs and interest in dissemination and adoption, they have contributed to refining how EBPs are promulgated and evaluated.

The main purpose of EBPs is to enhance consumer outcomes. There is a growing body of evidence that, in many circumstances, closer adherence to EBP models does result in better outcomes. For that reason, measures of fidelity to EBP models are important as are measures that monitor the extent and quality of EBP implementation in organizations and systems of care.

The long-term goals for the EBP component of the DS2000+ data standards initiative are to enable systems of care, managed care organizations, and treatment provider organizations to:

- report on the extent of their implementation of EBPs and EBP-specific fidelity measures and compare their progress to that of similar organizations;
- upload data collected on fidelity measures for comparison with data from similar organizations that have also implemented EBPs and EBP-specific fidelity measures.

Several activities were undertaken in the design effort for this component:

- A Technical Expert Workgroup was formed of leaders in EBP-related measurement. They worked as advisors to the 2000+ Team throughout the project. The members of the Workgroup and the Team are included in Appendix A.
- A basic conceptual framework was developed that encompasses the types of EBP implementation measures for different levels of care (see Table 1).
- Criteria were determined for what qualified as an EBP fidelity measure, including a decision to be inclusive when in doubt as to whether a practice targeted for measurement of its implementation fidelity might qualify as evidence-based. The criteria were that a measure must be:
    - either in widespread use, or anticipated to be in wide use
    - have established psychometric credibility, or have the potential for it with ensuing research
- Workgroup and DS2000+ Team members nominated EBP measures that fit these criteria.
- The Workgroup and others were asked to identify EBP fidelity measures and specify the following in a questionnaire (see Appendix B)
    - name of the measure
    - how to find the measure (url or in the appendices of the report)
    - what it intended to measure
    - extent of current use
    - types of settings and users for its future use
    - characteristics likely to contribute to widespread use (administrative cost,
    - incentives, utility for quality improvement, other)
    - psychometric characteristics (substantiating research, reliability, validity)
    - overall evaluation (strengths, weaknesses)

Based on the survey of experts and others, 12 measures were nominated for inclusion in this report. Each measure has an accompanying questionnaire in the next section of this report that includes key descriptors as well as links to view the actual measures.

Conceptual Framework for EBP Fidelity Measures

One of the initial premises of this report is that measures of EBP implementation have importance at all levels of care. The levels were categorized hierarchically:

- consumer/family member
- individual clinician (providing a specific EBP)
- clinical and related service program (e.g., ACT, integrated dual diagnosis treatment, supportive employment, etc.)
- treatment organization (e.g. community mental health center, psychiatric hospital, etc.)
- system of care (e.g., state and county mental health departments, managed behavioral health organizations)

Persons at each of these levels can provide data on EBP fidelity measures, as characterized in the following table:

Table 1. Conceptual Framework for EBP Fidelity Measures

Data Source	Measures of Fidelity to Specific EBPs	Generic Measures of EBP Fidelity	Measures of Utilization of EBPs
Consumer/Family Member	FACIT		
Individual clinician	Some elements of MedMAP and several proprietary EBP fidelity measures for such disorders as panic, anxiety, and depression		
Clinical and related services programs	SAMHSA Toolkit fidelity measures, FACIT, ISRRI		
Treatment organization		General Organizational Index (GOI) from SAMHSA Toolkits	
System of care		State Health Authority Yardstick (SHAY)	NASMHPD NRI Survey and URS developmental measures

Persons at each of these levels are also potential users of the data to monitor performance and help guide implementation improvements. For example, system administrators may complete the SHAY or the URS tables based upon information derived from fidelity measures completed by administrators of clinical and service programs and organizations. Individual clinicians may receive data on system implementation of EBPs that benchmark their own efforts against those of others with implications for quality improvement. Finally, consumers and family members may use results of the measures as guides to their decision-making about which programs they select for their own treatment.

The Technical Expert Workgroup specified several other framing considerations:

- Criteria for what qualifies as an EBP should err on the side of inclusiveness. Since the EBP component of DS2000+ is focused on fidelity measures and the uses of the data that such measures provide, it is not the place for addressing debates within the field about what qualifies as an EBP. However, this position and rationale should be clear and the debates encouraged.
- Fidelity measures for EBPs in most common usage are retrospective rather than real-time. The advent of electronic health record (EHR) systems and computerized clinical decision support will make it possible to document fidelity to evidence-based practices in real time. This will be a much more reliable, valid and useful approach to fidelity measurement of EBPs.
- Many fidelity measures described in this report are being newly developed and subject to change. Indeed, most of the measures described in this report involve items for which definitions are being refined and revised. For instance, a national Data Infrastructure Grant (DIG) Workgroup is developing guidelines for reporting on system implementation of EBPs. As one example, competitive employment options must be a component of a supported employment program.
- There are hundreds of EBPs. Similarly, there are hundreds of fidelity measures that were used in the research to establish the evidence for the EBPs' efficacy. Further efforts should involve development of an electronic reference library of all these measures with processes to revise and update as measures evolve.

Guide to This Report

This report provides the findings of the EBP Workgroup. Table 2 summarizes all the fidelity measures identified that met the selection criteria. Tables 3 through 4 provide developers' responses to the questionnaire. In the appendices are workgroup members, the questionnaire, the original responses to the questionnaires, and two measures, the State Health Authority Yardstick and the Inventory of Seclusion and Restraint Reduction Interventions. Responses to the questionnaires and available instruments are in Appendices C, D, and E.

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Uniform Reporting System www.nri-inc.org/SDICC/SDICC05/05devel.xls						
Extent of implementation of selected EBPs within a state mental health system of care	Across most state mental health systems of care	Implemented throughout most states	Unknown			High cost to implement; high incentives to use the measure; high utility for quality improvement
SMHA Profiling System, Services Component www.nri-inc.org/Profiles/Profiles05/Services05.pdf						
For state systems of care, types of EBPs being implemented, for which age groups and types of conditions, and within what number of treatment programs? Also, extent and methods of measuring fidelity to the EBPs being implemented, funding sources for EBPs being implemented, extent of staff training for each EBP, barriers to EBP implementation, and initiatives to promote EBP implementation.	Across most state mental health systems of care	State systems of care	Unknown	Enables benchmarking of EBP implementation across states to support policy development, funding and quality improvement both nationally and for states	Methods of data collection vary by state	High cost to implement; medium incentives to use the relevant EBP; high incentives to use the measure; high utility for quality improvement

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
State Health Authority Yardstick (SHAY)[1]						
How state-wide systems of care and other large systems of care with authority over multiple treatment programs use levers to promote EBP implementation.	Fairly widespread including Japan and about 15 state systems within the United States	State systems and other large systems of care	High	The empirical research used to develop the measure was sound. It predicts successful implementation of EBPs. Since states are being asked to invest considerable resources in EBP implementation, this measure is very useful to them in planning strategies for EBP implementation, measuring the results of those strategies, and using those results for quality improvement. It is also useful as a guide to consultants working with states on EBP implementation strategies.	The language in the items is geared more for researchers than state administrators. The measure is most easily and reliably used by independent evaluators. Some state administrators will want to use it themselves for system self-assessment and find it somewhat difficult to do so.	Low cost to implement; high incentives to use the relevant EBP; medium incentives to use the measure; high utility for quality improvement

[1] See Appendix D.

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
General Organizational Index (GOI) http://www.mentalhealth.samhsa.gov/media/ken/pdf/toolkits/illness/14.IMR_GOI.pdf						
The General Organizational Index (GOI) measures a set of general operating characteristics of an organization hypothesized to be related to its overall capacity to implement and sustain any evidence-based practice. The items on the GOI were derived from clinical experience, although the research literature also supports the importance of many of these factors. The 6/26/02 draft version of this index contains 10 broad principles regarding elements such as program philosophy, training, supervision, and program monitoring. In future drafts, several items regarding cultural competency will be added. Whereas the fidelity scales are specific to each EBP, the GOI refers to operating characteristics that should be very similar across the EBPs.	Used in sites within states testing the first and second generations of the six EBP Toolkits and the related Evaluation and Training grants funded by SAMHSA's Center for Mental Health Services	Public sector organizational settings	Low			High cost to implement; low incentives to use the measure; high utility for quality improvement.

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Dartmouth Assertive Community Treatment Scale (DACTS) Protocol: http://ebp.networkofcare.org/uploads/ACT_Protocol_9942960.pdf Scale: http://ebp.networkofcare.org/uploads/ACT_Scale_3113827.pdf						
Fidelity of EBP implementation to Assertive Community Treatment	Medium use among organizations	Public sector treatment provider organizations and programs	High			High cost to implement; high incentives to use the relevant EBP; medium incentives to use the measure; medium utility for quality improvement
Supported Employment Fidelity Scale (formerly IPS Fidelity Scale) Questions: http://ebp.networkofcare.org/uploads/SE_Questions_4597221.pdf Scale: http://ebp.networkofcare.org/uploads/SE_Scale_3188692.pdf						
Fidelity of EBP implementation to the Supported Employment model	Medium use among organizations	Public sector provider organizations and programs	High			High cost to implement; high incentives to use the relevant EBP; high incentives to use the measure; high utility for quality improvement
Illness Management and Recovery (IMR) Fidelity Scale Protocol: http://ebp.networkofcare.org/uploads/IMR_Protocol_1535059.pdf Scale: http://ebp.networkofcare.org/uploads/IMR_Scale_4791812.pdf						

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Fidelity of EBP implementation to the Illness Management and Recovery model	Low use among organizations	Public sector treatment provider organizations and programs.	Low			High cost to implement; high incentives to use the relevant EBP; medium incentives to use the measure; medium utility for quality improvement

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Family Psychoeducation (FPE) Fidelity Scale Prococol: http://ebp.networkofcare.org/uploads/FPE_Protocol_2048176.pdf Scale: http://ebp.networkofcare.org/uploads/FPE_Scale_7223896.pdf						
Fidelity of EBP implementation to the Family Psychoeducation model	Low among organizations	Public sector treatment provider organizations and programs	Low			High cost to implement; high incentives to use the relevant EBP; medium incentives to use the measure; high utility for quality improvement
Integrated Dual Disorder Treatment (IDDT) Fidelity Scale Protocol: http://ebp.networkofcare.org/uploads/IDDT_Protocol_9179137.pdf Scale: http://ebp.networkofcare.org/uploads/IDDT_Scale_8599136.pdf						
	Low use among organizations	Public sector treatment provider organizations and programs	Low among organizations			High cost to implement; high incentives to use the relevant EBP; medium incentives to use the measure; medium utility for quality improvement
Medication Management According to Protocol (MedMAP) Fidelity Scale Instructions: http://ebp.networkofcare.org/uploads/MMAP_Instruction_4816613.pdf Chart Review: http://ebp.networkofcare.org/uploads/MMAP_Chart_4890237.pdf Interview: http://ebp.networkofcare.org/uploads/						

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Fidelity of EBP implementation to the Medication Management According to Protocol model	Low use among organizations	Treatment provider organizations, particularly in public but also private sectors	Low			High cost to implement; high incentives to use the relevant EBP; medium incentives to use the measure; medium utility for quality improvement

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Fidelity Assessment Common Ingredients Tool (FACIT) http://www.cstprogram.org/consumer%20op/Multi-Site%20Activities/FACIT%20Protocol/ Facit_Protocol%20Page.htm						
Consumer-operated service programs and traditional mental health service programs when information on the "consumer-friendliness" is sought.	Among individual providers: 8 consumer programs and 8 traditional programs which participated in the COSP multisite study.	To be used as part of any evaluation of a consumer-operated program where service outcomes are to be assessed, and to determine the "consumer-friendliness" of traditional mental health service programs	High	This is the only measure of its kind to successfully identify the critical ingredients of consumer-operated programs and to correlate ingredients to outcomes to provide key information about the nature and effectiveness of the programs. It has both a theoretical and scientific base. It was developed collaboratively with a broad sample of consumer providers adding to its generalizability.		Low cost to implement; medium incentives to use the relevant EBP; high utility for quality improvement

Table 2. Summary of Descriptive Information Regarding Measures of EBP Implementation

Aspects Measured	Current Use	Settings and Users	Psychometric Foundation	Strengths	Limitations	Factors Affecting Use
Inventory of Seclusion and Restraint Reduction Interventions (ISRRI)[2]						
Reduction and elimination of seclusion and restraint	Developed as one component in the evaluation of seclusion and restraint reduction initiatives conducted by eight state mental health agencies, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion (SM-04-007), the ISRRI will be used in 48 inpatient facilities and residential programs across the 8 sites through a web-based data collection system. It will be used a second time for the same facilities in approximately one year.	Public and private inpatient psychiatric facilities, and perhaps community residential programs.	Unknown	Development incorporated extensive expert opinion, related to both the intervention and measure development generally. It applies to an important area (seclusion and restraint), and will fill an important gap as there is nothing similar in the field now.	It has not yet been tested. Supporting material such as a manual needs to be developed.	Medium cost to implement; high incentives to use the relevant EBP; high incentives to use the measure

[2] See Appendix E.

Table 3. Uniform Report System (URS) #16-18

URL	www.nri-inc.org/SDICC/SDICC05/05devel.xls
Aspect(s) measured	Extent of implementation of selected EBPs within a state mental health system of care
Current use	Across most state mental health systems of care
Settings and users	Implemented throughout most states
Psychometric foundation	Unknown
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	Unknown

Table 4. State Mental Health Agency Profiling System, Services Component

URL	www.nri-inc.org/Profiles/Profiles05/Services05.pdf
Aspect(s) measured	For state systems of care, types of EBPs being implemented, for which age groups and types of conditions, and within what number of treatment programs. Also, extent and methods of measuring fidelity to the EBPs being implemented, funding sources for EBPs being implemented, extent of staff training for each EBP, barriers to EBP implementation, and initiatives to promote EBP implementation.
Current use	Across most state mental health systems of care
Settings and users	State systems of care
Psychometric foundation	Unknown
Strengths	Enables benchmarking of EBP implementation across states to support policy development, funding and quality improvement both nationally and for states.
Weaknesses	The language in the items is geared more for researchers than state administrators. The measure is most easily and reliably used by independent evaluators. Some state administrators will want to use it themselves for system self-assessment and find it somewhat difficult to do so.
Factors affecting potential for widespread use	High cost Medium incentives to use applicable EBP High incentives to use measure High utility for quality improvement

Table 5. State Health Authority Yardstick (SHAY)

URL	See appendix A
Aspect(s) measured	How state-wide systems of care and other large systems of care with authority over multiple treatment programs use levers to promote EBP implementation.
Current use	Fairly widespread including Japan and about 15 state systems within the United States
Settings and users	State systems and other large systems of care
Psychometric foundation	High validity
Strengths	The empirical research used to develop the measure was sound. It predicts successful implementation of EBPs. Since states are being asked to invest considerable resources in EBP implementation, this measure is very useful to them in planning strategies for EBP implementation, measuring the results of those strategies, and using those results for quality improvement. It is also useful as a guide to consultants working with states on EBP implementation strategies.
Weaknesses	The language in the items is geared more for researchers than state administrators. The measure is most easily and reliably used by independent evaluators. Some state administrators will want to use it themselves for system self-assessment and find it somewhat difficult to do so.
Factors affecting potential for widespread use	Low cost High incentives to use applicable EBP Medium incentives to use measure High utility for quality improvement

Table 6. General Organizational Index (GOI)

URL	http://www.mentalhealth.samhsa.gov/media/ken/pdf/toolkits/illness/14.IM R_GOI.pdf
Aspect(s) measured	The General Organizational Index (GOI) measures a set of general operating characteristics of an organization hypothesized to be related to its overall capacity to implement and sustain any evidence-based practice. The items on the GOI were derived from clinical experience, although the research literature also supports the importance of many of these factors. The 6/26/02 draft version of this index contains 10 broad principles regarding elements such as program philosophy, training, supervision, and program monitoring. In future drafts, several items regarding cultural competency will be added. Whereas the fidelity scales are specific to each EBP, the GOI refers to operating characteristics that should be very similar across the EBPs.
Current use	Used in sites within states testing the first and second generations of the six EBP Toolkits and the related Evaluation and Training grants funded by SAMHSA's Center for Mental Health Services
Settings and users	Public sector organizational settings
Psychometric foundation	Unknown
Strengths	Useful for quality improvement
Weaknesses	Expensive to implement
Factors affecting potential for widespread use	Medium cost Low incentives to use measure High utility for quality improvement

Table 7. Dartmouth Assertive Community Treatment Scale (DACTS)

URL	Protocol: http://ebp.networkofcare.org/uploads/ACT_Protocol_9942960.pdf Scale: http://ebp.networkofcare.org/uploads/ACT_Scale_3113827.pdf
Aspect(s) measured	Fidelity of EBP implementation to Assertive Community Treatment
Current use	Organizations
Settings and users	Public sector treatment provider organizations and programs
Psychometric foundation	Well studied High reliability & validity
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP Medium incentives to use measure Medium utility for quality improvement

Table 8. Supported Employment (SE) Fidelity Scale

URL	Questions: http://ebp.networkofcare.org/uploads/SE_Questions_4597221.pdf Scale: http://ebp.networkofcare.org/uploads/SE_Scale_3188692.pdf
Aspect(s) measured	Fidelity of EBP implementation to the Supported Employment model
Current use	Organizations
Settings and users	Public sector provider organizations and programs
Psychometric foundation	Well studied High reliability & utility
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP High incentives to use measure High utility for quality improvement

Table 9. Illness Management and Recovery (IMR) Fidelity Scale

URL	Protocol: http://ebp.networkofcare.org/uploads/IMR_Protocol_1535059.pdf Scale: http://ebp.networkofcare.org/uploads/IMR_Scale_4791812.pdf
Aspect(s) measured	Fidelity of EBP implementation to the Illness Management and Recovery model
Current use	Medium
Settings and users	Public sector treatment provider organizations and programs.
Psychometric foundation	Unknown
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP Medium incentives to use measure Medium utility for quality improvement

Table 10. Family Psychoeducation (FPE) Fidelity Scale

URL	Protocol: http://ebp.networkofcare.org/uploads/FPE_Protocol_2048176.pdf Scale: http://ebp.networkofcare.org/uploads/FPE_Scale_7223896.pdf
Aspect(s) measured	Fidelity of EBP implementation to the family psychoeducation model
Current use	Organizations
Settings and users	Public sector treatment provider organizations and programs.
Psychometric foundation	Unknown
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP Medium incentives to use measure Medium utility for quality improvement

Table 11. Integrated Dual Disorder Treatment (IDDT) Fidelity Scale

URL	Protocol: http://ebp.networkofcare.org/uploads/IDDT_Protocol_9179137.pdf Scale: http://ebp.networkofcare.org/uploads/IDDT_Scale_8599136.pdf
Aspect(s) measured	Fidelity to the integrated dual disorder treatment protocol
Current use	Organizations
Settings and users	Public sector treatment provider organizations and programs.
Psychometric foundation	Unknown
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP Medium incentives to use measure Medium utility for quality improvement

Table 12. Medication Management According to Protocol (MedMAP) Fidelity Scale

URL	Instructions: http://ebp.networkofcare.org/uploads/MMAP_Instruction_4816613.pdf Chart Review: http://ebp.networkofcare.org/uploads/MMAP_Chart_4890237.pdf Interview: http://ebp.networkofcare.org/uploads/MMAP_Interview_5048872.pdf Scale: http://ebp.networkofcare.org/uploads/MMAP_Scale_3892799.pdf
Aspect(s) measured	Fidelity of EBP implementation to the medication management according to protocol model
Current use	Organizations
Settings and users	Treatment provider organizations, particularly in public but also private sectors
Psychometric foundation	Unknown
Strengths	Unknown
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP Medium incentives to use measure Medium utility for quality improvement

Table 13. Fidelity Assessment Common Ingredients Tool (FACIT)

URL	http://www.cstprogram.org/consumer%20op/Multi-Site%20Activities/FACIT%20Protocol/Facit_Protocol%20Page.htm
Aspect(s) measured	Consumer-operated service programs and traditional mental health service programs when information on the "consumer-friendliness" is sought.
Current use	8 consumer programs and 8 traditional programs which participated in the COSP multisite study.
Settings and users	To be used as part of any evaluation of a consumer-operated program (e.g., drop-in center, education/advocacy program, mutual support program) where service outcomes are to be assessed, and to determine the "consumer-friendliness" of traditional mental health service programs.
Psychometric foundation	Well studied High reliability & validity
Strengths	This is the only measure of its kind to successfully identify the critical ingredients of consumer-operated programs and to correlate ingredients to outcomes to provide key information about the nature and effectiveness of the programs. It has both a theoretical and scientific base. It was developed collaboratively with a broad sample of consumer providers adding to its generalizability.
Weaknesses	Unknown
Factors affecting potential for widespread use	High cost High incentives to use applicable EBP Medium incentives to use measure Medium utility for quality improvement

Table 14. Inventory of Seclusion and Restraint Reduction Interventions (ISRRI)

URL	See Appendix B.
Aspect(s) measured	Reduction and elimination of seclusion and restraint
Current use	Developed as one component in the evaluation of seclusion and restraint reduction initiatives conducted by eight state mental health agencies, funded by SAMHSA State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion (SM-04-007). It will be used in 48 inpatient facilities and residential programs across the 8 sites. In March, 2006 data were collected through a web-based data collection system and will be collected again.
Settings and users	Public and private inpatient psychiatric facilities, and perhaps community residential programs.
Psychometric foundation	Unknown
Strengths	Development incorporated extensive expert opinion, related to both the intervention and measure development generally. It applies to an important area (seclusion and restraint) and will fill a significant gap as there is nothing similar in the field now.
Weaknesses	It has not yet been tested. Supporting material such as a manual needs to be developed.
Factors affecting potential for widespread use	Medium cost High incentives to use applicable EBP High incentives to use measure