

Appendix A. Workgroup Members

Technical Experts

Jean Campbell, Ph.D.

Research Associate Professor
Missouri Institute of Mental Health

Crystal Blyler, Ph.D.

Social Science Analyst
Community Support Program Branch
Center for Mental Health Services

Vijay Ganju, Ph.D.

NASMHPD Research Institute, Inc.

Frank A. Ghinassi, Ph.D.

Chief, Adult Services
Western Psychiatric Institute and Clinic of
The UPMC Health System

Nancy Lane, Ph.D.

CEO
Massachusetts Behavioral Health
Partnership

Steve Leff

Senior Vice President
Human Services Research Institute (HSRI)

Dennis Morrison, Ph.D.

CEO
Center for Behavioral Health

Betsy McDonel Herr, Ph.D.

Social Science Analyst
Center for Mental Health Services

Peter E. Nathan, PhD

Professor
Department of Psychology
University of Iowa

Robert Rosenheck, M.D.

Director, VA Northeast Program Evaluation
Professor of Psychiatry, Public Health &
Child Study Center
Yale School of Medicine

DS2000+ Team

Jim Kretz

Survey and Analysis Branch
Division of State and Community Systems
Development
Center for Mental Health Services

Ronald Manderscheid, Ph.D.

Chief, Survey and Analysis Branch
Division of State and Community Systems
Development
SAMHSA Center for Mental Health Services

Hugh McDonough, Ed.M.

Project Director
Decision Support 2000+
Abt Associates Inc.

Sarah Minden, M.D.

Principal Investigator
Abt Associates Inc.

Tom Trabin, Ph.D.

Consultant Lead
DS2000+ EBP Component



Appendix B. Questionnaire: Descriptive Information Regarding Measures of EBP Implementation

1. What is the name of the EBP implementation measure?
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
3. What aspect(s) of EBP implementation is this instrument intended to measure?
4. How widespread is its current use among:
 - a. systems of care (if applicable)
 - b. organizations (if applicable):
 - c. individual providers (if applicable)
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable):
 - b. Types of individual providers (if applicable)
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high ___
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high ___
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium ___ high ___
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high ___
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low ___ medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available ___
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available ___
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.1. Uniform Report System (URS) Developmental Tables

1. What is the name of the EBP implementation measure?
Uniform Reporting System (URS) Developmental Tables #16-#18
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed? www.nri-inc.org/SDICC/SDICC05/05devel.xls
3. What aspect(s) of EBP implementation is this instrument intended to measure? Extent of implementation of selected EBPs within a state mental health system of care
4. How widespread is its current use among:
 - a. systems of care (if applicable): implemented throughout most states
 - b. organizations (if applicable): n/a
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): state systems of care
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high ___ n/a
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium ___ high
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low ___ medium ___ high ___ n/a
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.2. State Mental Health Agency Profiling System, Services Component

1. What is the name of the EBP implementation measure? 2005 State Mental Health Agency Profiling System, Section V: Services Component
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed? www.nri-inc.org/Profiles/Profiles05/Services05.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure?
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.
4. How widespread is its current use among:
 - a. systems of care (if applicable): across most state mental health systems of care
 - b. organizations (if applicable): n/a
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): state systems of care
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium high ___
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium ___ high
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none low ___ medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available

8. Overall evaluation of this measure:
 - a. Strengths, advantages: Enables benchmarking of EBP implementation across states to support policy development, funding and quality improvement both nationally and for states
 - b. Weaknesses: Methods of data collection vary by state

Appendix C.3. State Health Authority Yardstick (SHAY)

1. What is the name of the EBP implementation measure?
State Health Authority Yardstick (SHAY)
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed? See Appendix A
3. What aspect(s) of EBP implementation is this instrument intended to measure?
How state-wide systems of care and other large systems of care with authority over multiple treatment programs use levers to promote EBP implementation.
4. How widespread is its current use among:
 - a. systems of care (if applicable): fairly widespread including Japan and about 15 state systems within the United States.
 - b. organizations (if applicable): n/a
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): state systems and other large systems of care
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low medium high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low medium high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low medium high
 - d. the utility of the measure for quality improvement is:
low medium high
 - e. other reasons (please explain): measure results are strongly correlated with and predictive of high levels of fidelity to implementation of EBPs across the system of care
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none low medium high
 - b. According to the research, how reliable is the measure?
low medium high no information available
 - c. According to the research, how valid is the measure?
low medium high no information available

8. Overall evaluation of this measure:
 - a. Strengths, advantages: 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.
 - b. 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.
9. Other comments:

Appendix C.4. General Organizational Index (GOI)

1. What is the name of the EBP implementation measure? General Organizational Index (GOI)
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
http://www.mentalhealth.samhsa.gov/media/ken/pdf/toolkits/illness/14.IMR_GOI.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure?
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.
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): 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.
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): public sector organizational settings
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium high ___
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high ___ n/a
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low medium ___ high ___ (could increase to medium)
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high
 - e. other reasons (please explain)

7. What is the psychometric foundation for this measure?
- a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low x medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available x
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available x
8. Overall evaluation of this measure:
- a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.5. Dartmouth Assertive Community Treatment Scale (DACTS)

1. What is the name of the EBP implementation measure? Dartmouth Assertive Community Treatment Scale (DACTS)
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
Protocol: http://ebp.networkofcare.org/uploads/ACT_Protocol_9942960.pdf
Scale: http://ebp.networkofcare.org/uploads/ACT_Scale_3113827.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure? Fidelity of EBP implementation to Assertive Community Treatment
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): medium
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): public sector treatment provider organizations and programs
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium high ___ (low now, higher soon)
 - d. the utility of the measure for quality improvement is:
low ___ medium high ___
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low ___ medium ___ high
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high no information available ___
 - c. According to the research, how valid is the measure?
low ___ medium ___ high no information available ___
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.6. Supported Employment (SE) Fidelity Scale

1. What is the name of the EBP implementation measure? Supported Employment Fidelity Scale (formerly IPS Fidelity Scale)
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
Questions: http://ebp.networkofcare.org/uploads/SE_Questions_4597221.pdf
Scale: http://ebp.networkofcare.org/uploads/SE_Scale_3188692.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure? Fidelity of EBP implementation to the Supported Employment model.
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): medium
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): public sector provider organizations and programs
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium ___ high
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low ___ medium ___ high
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high no information available ___
 - c. According to the research, how valid is the measure?
low ___ medium ___ high no information available ___
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.7. Illness Management and Recovery (IMR) Fidelity Scale

1. What is the name of the EBP implementation measure? Illness Management and Recovery (IMR) Fidelity Scale
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
Protocol: http://ebp.networkofcare.org/uploads/IMR_Protocol_1535059.pdf
Scale: http://ebp.networkofcare.org/uploads/IMR_Scale_4791812.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure? Fidelity of EBP implementation to the Illness Management and Recovery model
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): medium
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): public sector treatment provider organizations and programs.
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium high ___ (low now, higher likely later)
 - d. the utility of the measure for quality improvement is:
low ___ medium high ___ (low now, higher likely later)
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.8. Family Psychoeducation (FPE) Fidelity Scale

1. What is the name of the EBP implementation measure? Family Psychoeducation (FPE) Fidelity Scale
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
Protocol:http://ebp.networkofcare.org/uploads/FPE_Protocol_2048176.pdf
Scale: http://ebp.networkofcare.org/uploads/FPE_Scale_7223896.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure? Fidelity of EBP implementation to the Family Psychoeducation model
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): low
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): public sector treatment provider organizations and programs
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium high ___ (low now, higher likely later)
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high (low now, higher likely later)
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:
9. Other comments:

Appendix C.9. Integrated Dual Disorder Treatment (IDDT) Fidelity Scale

1. What is the name of the EBP implementation measure? Integrated Dual Disorder Treatment (IDDT) Fidelity Scale.
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
Protocol: http://ebp.networkofcare.org/uploads/IDDT_Protocol_9179137.pdf
Scale: http://ebp.networkofcare.org/uploads/IDDT_Scale_8599136.pdf
3. What aspect(s) of EBP implementation is this instrument intended to measure?
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): low
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): public sector treatment provider organizations and programs
 - b. Types of individual providers (if applicable)
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium high ___ (low now, higher likely later)
 - d. the utility of the measure for quality improvement is:
low ___ medium high ___ (low now, higher later)
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses
9. Other comments:

Appendix C.10. Medication Management According to Protocol (MedMAP) Fidelity Scale

1. What is the name of the EBP implementation measure? Medication Management According to Protocol (MedMAP) Fidelity Scale
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed?
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
3. What aspect(s) of EBP implementation is this instrument intended to measure? Fidelity of EBP implementation to the Medication Management According to Protocol model
4. How widespread is its current use among:
 - a. systems of care (if applicable): n/a
 - b. organizations (if applicable): low
 - c. individual providers (if applicable): n/a
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable): treatment provider organizations, particularly in public but also private sectors
 - b. Types of individual providers (if applicable): n/a
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium ___ high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium high ___ (low now, higher likely later)
 - d. the utility of the measure for quality improvement is:
low ___ medium high ___ (low now, higher likely later)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none ___ low medium ___ high ___
 - b. According to the research, how reliable is the measure?
low ___ medium ___ high ___ no information available
 - c. According to the research, how valid is the measure?
low ___ medium ___ high ___ no information available
8. Overall evaluation of this measure:
 - a. Strengths, advantages:
 - b. Weaknesses:

Appendix C.11. Fidelity Assessment Common Ingredients Tool (FACIT)

1. What is the name of the EBP implementation measure?
Fidelity Assessment Common Ingredients Tool (FACIT)
2. What is its electronic linkage address?
http://www.cstprogram.org/consumer%20op/Multi-Site%20Activities/FACIT%20Protocol/Facit_Protocol%20Page.htm
If an electronic link does not exist, how else might we be able to post it electronically for our viewers?
3. What aspect(s) of EBP implementation is this instrument intended to measure?
Consumer-operated service programs and traditional mental health service programs when information on the “consumer-friendliness” is sought.
4. How widespread is its current use among:
 - a. systems of care (if applicable)
 - b. organizations (if applicable):
 - c. individual providers (if applicable): 8 consumer programs and 8 traditional programs which participated in the COSP multisite study.
5. What do you anticipate will be the settings and users for its increased use in the future?
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
 - a. Types of organizational settings and systems of care (if applicable):
 - b. Types of individual providers (if applicable): Consumer-operated service programs (e.g., drop-in centers, education/advocacy programs, mutual support programs)
6. The measure has actual or potential for widespread use, compared to fidelity measures for other EBPs, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low medium high
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low medium high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low medium high
 - d. the utility of the measure for quality improvement is:
low medium high
 - e. other reasons (please explain)
7. What is the psychometric foundation for this measure?
 - a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none low medium high

- b. According to the research, how reliable is the measure?
low ___ medium ___ high X no information available ___
 - c. According to the research, how valid is the measure?
low ___ medium ___ high X no information available ___
8. Overall evaluation of this measure:
- a. Strengths, advantages: 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.
 - b. Weaknesses:
9. Other comments:

Appendix C.12. Inventory of Seclusion and Restraint Reduction Interventions (ISRRI)

1. What is the name of the EBP implementation measure?
Inventory of Seclusion and Restraint Reduction Interventions (ISRRI)
2. What is its electronic linkage address? If an electronic link does not exist, how else can it be easily accessed? See Appendix B.
3. What aspect(s) of EBP implementation is this instrument intended to measure?
Reduction and elimination of seclusion and restraint
4. How widespread is its current use among:
 - a. systems of care (if applicable):
It was 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). It will be used in 48 inpatient facilities and residential programs across the 8 sites.
It is just now (March, 2006) being implemented for the first time through a web-based data collection system. It will be used a second time for the same facilities in approximately one year.
 - b. organizations (if applicable): 8 state mental health agencies
 - c. individual providers (if applicable): N/A
5. What do you anticipate will be the settings and users for its increased use in the future?
 - a. Types of organizational settings and systems of care (if applicable):
Public and private inpatient psychiatric facilities, and perhaps community residential programs.
 - b. Types of individual providers (if applicable) (N/A)
6. The measure has actual or potential for widespread use, compared to other measures of EBP implementation, because (check all that may apply):
 - a. the combined cost to implement the measure in funds, human resources, and equipment is:
low ___ medium high ___
 - b. upcoming public and/or private reimbursement and other policy incentives to use the EBP for which this measure is intended are likely to be:
low ___ medium ___ high
 - c. public and/or private reimbursement and other policy incentives to use this particular measure are likely to be:
low ___ medium ___ high
 - d. the utility of the measure for quality improvement is:
low ___ medium ___ high ___
 - e. other reasons (please explain)

7. What is the psychometric foundation for this measure?
- a. How extensive is the psychometric research substantiating the reliability and validity of the measure?
none low medium high
 - b. According to the research, how reliable is the measure?
low medium high no information available
 - c. According to the research, how valid is the measure?
low medium high no information available
8. What is your overall evaluation of this measure:
- a. What do you like about it?
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.
 - b. What do you not like about it?
It has not yet been tested, supporting material such as a manual needs to be developed.
9. **Other comments:** This fidelity measure is only now being promulgated and tested, therefore perhaps not ready for inclusion in the Module, depending on criteria. By the end of the SAMHSA grant project (October, 2007) however, it should be ready for use in the field, i.e. fully tested and supporting materials available.

Appendix D. State Health Authority Yardstick (SHAY)

State *H*ealth *A*uthority *Y*ardstick

The SHAY Rating Scale

- a. Rater: _____
- b. EBP (separate SHAY must be completed for each EBP): _____
- c. State: _____
- d. Number of outpatient programs implementing this EBP model statewide:

- e. Total number of outpatient MH programs statewide: _____
- f. Penetration: calculate EBP sites/total outpatient MH programs = _____
- g. Today's Date: _____
- h. Date the state committed to implementation of this EBP (e.g. state "kick off", initiation of state campaign): _____
- i. Date the first site initiated implementation of the EBP (e.g. began training in the EBP):

Instructions:

Ideally the SHAY should be completed by two raters, who make independent ratings, then discuss their scores, and come to a final consensus score for each item. Raters may need to interview one or more state staff in order to rate items (e.g. the commissioner, EBP point person, operations staff, budget staff) as well as site staff (e.g. EBP program leader). When there are differences across EBP sites, rate the typical program.

1. EBP Plan

The SMHA has an EBP plan to address the following:

(Use boxes to identify which components are included in the plan)

Note: The plan does not have to be a written document, or if written, does not have to be distinct document, but could be part of the state's overall strategic plan. However if not written the plan must be common knowledge among state employees, e.g. if several different staff are asked, they are able to communicate the plan clearly and consistently.

- | | |
|--------------------------|---|
| <input type="checkbox"/> | 1) A defined scope for initial and future implementation efforts, |
| <input type="checkbox"/> | 2) Strategy for outreach, education, and consensus building among providers and other stakeholders, |
| <input type="checkbox"/> | 3) Identification of partners and community champions, |
| <input type="checkbox"/> | 4) Sources of funding, |
| <input type="checkbox"/> | 5) Training resources, |
| <input type="checkbox"/> | 6) Identification of policy and regulatory levers to support EBP, |
| <input type="checkbox"/> | 7) Role of other state agencies in supporting and/or implementing the EBP, |
| <input type="checkbox"/> | 8) Defines how EBP interfaces with other SMHA priorities and supports SMHA mission |
| <input type="checkbox"/> | 9) Evaluation for implementation and outcomes of the EBP |
| <input type="checkbox"/> | 10) The plan is a written document, endorsed by the SMHA |

Section 1.01 Score

- | | |
|--------------------------|---------------------------------|
| <input type="checkbox"/> | 1. No planning activities |
| <input type="checkbox"/> | 2. 1 – 3 components of planning |
| <input type="checkbox"/> | 3. 4 – 6 components of planning |
| <input type="checkbox"/> | 4. 7 – 9 components |
| <input type="checkbox"/> | 5. 10 components |

Evidence Used to Justify Rating

2. Financing: Adequacy

Is the funding model for the EBP adequate to cover costs, including direct service, supervision, and reasonable overhead? Are all EBP sites funded at the same level? Do sites have adequate funding so that practice pays for itself?

Note: Consider all sources of funding for the EBP that apply (Medicaid fee-for-service, Medicaid waiver, insurance, special grant funds, vocational rehabilitation funds, department of education funds, etc.)

Adequate funding (score of 4 or 5) would mean that the practice pays for itself; all components of the practice financed adequately, or funding of covered components is sufficient to compensate for non-covered components (e.g. Medicaid reimbursement for covered supported employment services compensates for non-covered on inadequately covered services, e.g. job development in absence of consumer). Sources: state operations and budget, site program managers. If financing is variable among sites, estimate average.

Score:

1. No components of services are reimbursable
2. Some costs are covered
3. Most costs are covered
4. Services pays for itself (e.g. all costs covered adequately, or finding of covered components compensates for non-covered components)
5. Service pays for itself and reimbursement rates attractive relative to competing non-EBP services.

Evidence Used to Justify Rating

3. Financing: Start-up & Conversion Costs

Are costs of start up and or conversion covered, including: 1) Lost productivity for staff training, 2) hiring staff before clients enrolled (e.g. ACT), 3) any costs associated with agency planning and meetings, 4) changing medical records if necessary, 5) computer hardware and/or software if necessary, etc. *Note: If overall fiscal model is adequate to cover start-up costs then can rate 5. If financing is variable among sites, estimate average. Important to verify with community EBP program leaders/ site program managers.*

Article II. Score:

1. No costs of start-up are covered
2. Few costs are covered
3. Some costs are covered
4. Majority of costs are covered
5. Programs are fully compensated for costs of conversion

Evidence Used to Justify Rating

4. Training: Ongoing consultation and technical support

Is there ongoing training, supervision and consultation for the program leader and clinical staff to support implementation of the EBP and clinical skills:

(Use boxes to indicate criteria met.)

Note: If there is variability among sites, then calculate/estimate the average visits per site..

	1) Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)
	2) Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)
	3) Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)
	4) On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).
	5) Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)

Score

	1. 0-1 components
	2. 2 components
	3. 3 components
	4. 4 components
	5. 5 components

Evidence Used to Justify Rating

5. Training: Quality

Is a high quality training delivered to each site? High quality training should include the following:

(Use boxes to indicate which components are in place.

Note: If there is variation among sites calculate/estimate the average number of components of training across sites.)

<input type="checkbox"/>	1) credible and expert trainer,
<input type="checkbox"/>	2) active learning strategies (e.g. role play, group work, feedback,
<input type="checkbox"/>	3) good quality manual, e.g. SAMHSA Toolkit,
<input type="checkbox"/>	4) comprehensively addresses all elements of the EBP,
<input type="checkbox"/>	5) modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,
<input type="checkbox"/>	6) high quality teaching aides/materials including workbooks/work sheets, slides, videos, handouts, etc, e.g. SAMHSA Toolkit/ West Institute.

Score:

<input type="checkbox"/>	1. 0 components
<input type="checkbox"/>	2. 1 - 2 components
<input type="checkbox"/>	3. 3 - 4 components
<input type="checkbox"/>	4. 5 components
<input type="checkbox"/>	5. all 6 components of a high quality training

Evidence Used to Justify Rating:

6. Training: Infrastructure / Sustainability

Has the state established a mechanism to allow for continuation and expansion of training activities related to this EBP, for example relationship with a university training and research center, establishing a center for excellence, establishing a learning network or learning collaborative. This mechanism should include the following components:

(Use boxes to indicate which components are in place)

	offers skills training in the EBP,
	offers ongoing supervision and consultation to clinicians to support implementation in new sites,
	offer ongoing consultation and training for program EBP leaders to support their role as clinical supervisors and leaders of the EBP,
	build site capacity to train and supervise their own staff in the EBP,
	offers technical assistance and booster trainings in existing EBP sites as needed,
	expansion plan beyond currently identified EBP sites,
	one or more identified model programs with documented high fidelity that offer shadowing opportunities for new programs,
	SMHA commitment to sustain mechanism (e.g. center of excellence, university contracts) for foreseeable future, and a method for funding has been identified.

Score:

	1. No mechanism
	2. 1 - 2 components
	3. 3 - 4 components
	4. 5 - 6 components
	5. 7 - 8 components

Evidence Used to Justify Rating:

7. Training: Penetration

What percent of sites have been provided high quality training (score of 3 or better on question #5, see note below), and ongoing training (score of 3 or better on question #4, see note below).

Note: *If both criteria are not met, does not count for penetration. Refers to designated EBP sites only.*

High quality training should include 3 or more of the following components:

- 1) *credible and expert trainer,*
- 2) *active learning strategies (e.g. role play, group work, feedback,*
- 3) *good quality manual (e.g. SAMHSA toolkit),*
- 4) *comprehensively addresses all elements of the EBP,*
- 5) *modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered,*
- 6) *high quality teaching aids/ materials including workbooks/ work sheets, slides, videos, handouts, etc. e.g. SAMHSA toolkit/ West Institute.*

Ongoing training should include 3 or more of the following components:

- 1) *Initial didactic training in the EBP provided to clinicians (e.g. 1-5 days intensive training)*
- 2) *Initial agency consultation re. implementation strategies, policies and procedures, etc. (e.g. 1 - 3 meetings with leadership prior to implementation or during initial training)*
- 3) *Ongoing training for practitioners to reinforce application of EBP and address emergent practice difficulties until they are competent in the practice (minimum of 3 months, e.g. monthly x 12 months)*
- 4) *On site supervision for practitioners, including observation of trainees clinical work and routines in their work setting, and feedback on practice. Videoconferencing that includes clients can substitute for onsite work (minimum of 3 supervision meetings or sessions for each trainee, e.g. monthly x 12 months).*
- 5) *Ongoing administrative consultation for program administrators until the practice is incorporated into routine work flow, policies and procedures at the agency (minimum of 3 months, e.g. monthly X 12 months)*

Score:

1. 0-20%
2. 20-40%
3. 40-60%
4. 60-80%
5. 80-100%

Evidence Used to Justify Rating:

8. SMHA Leadership: Commissioner Level

Commissioner is perceived as a effective leader (influence, authority, persistence, knows how to get things done) concerning EBP implementation who has established EBPs among the top priorities of the SMHA as manifested by:

(Use boxes to indicate components in place.)

Note: Rate existing Commissioner, even if new to post.

<input type="checkbox"/>	1) EBP initiative is incorporated in the state plan, and or other state documents that establish SMHA priorities,
<input type="checkbox"/>	2) Allocating one or more staff to EBP, including identifying and delegating necessary authority to an EBP leader for the SMHA,
<input type="checkbox"/>	3) Allocation of non-personnel resources to EBP (e.g. money, IT resources, etc.),
<input type="checkbox"/>	4) Uses internal and external meetings, including meetings with stakeholders, to express support for, focus attention on, and move EBP agenda,
<input type="checkbox"/>	5) Can site successful examples of removing policy barriers or establishing new policy supports for EBP.

How long has the current Commissioner held the post? _____

How long has the current Commissioner worked in the agency? _____

Score:

<input type="checkbox"/>	1. 0 - 1 component
<input type="checkbox"/>	2. 2 components
<input type="checkbox"/>	3. 3 components
<input type="checkbox"/>	4. 4 components
<input type="checkbox"/>	5. all 5 components

Evidence Used to Justify Rating:

9. SMHA Leadership: Central Office EBP Leader

There is an identified EBP leader (or coordinating team) that is characterized by the following:
(Use boxes to indicate which components in place.)

Note: Rate current EBP leader, even if new to post.

<input type="checkbox"/>	1) EBP leader has adequate dedicated time for EBP implementation (min 10%), and time is protected from distractions, conflicting priorities, and crises,
<input type="checkbox"/>	2) There is evidence that the EBP leader has necessary authority to run the implementation,
<input type="checkbox"/>	3) There is evidence that EBP leader has good relationships with community programs,
<input type="checkbox"/>	4) Is viewed as an effective leader (influence, authority, persistence, knows how to get things done) for the EBP, and can site examples of overcoming implementation barriers or establishing new EBP supports.

How long has the current EBP leader held the post? _____

How long has the current EBP leader worked in the agency? _____

Score:

<input type="checkbox"/>	1. No EBP leader
<input type="checkbox"/>	2. 1 component
<input type="checkbox"/>	3. 2 components
<input type="checkbox"/>	4. 3 components
<input type="checkbox"/>	5. All 4 components

Evidence Used to Justify Rating

10. Policy and Regulations: Non SMHA State Agencies

The SMHA has developed effective interagency relations (other state agencies, counties, governors office, state legislature) to support and promote the EBP as necessary/appropriate, identifying and removing or mitigating any barriers to EBP implementation, and has introduced new key facilitating regulations as necessary to support the EBP.

Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way? Note: give most weight to policies that impact funding.

Examples of supporting policies:

- Medicaid agency provides reimbursement for the EBP (If Medicaid not under the SMHA)
- The state's vocational rehabilitation agency pays for supported employment programs
- The state's substance abuse agency pays for integrated treatment for dual disorders
- Department of Professional Licensing requires EBP training for MH professionals

Examples of policies that create barriers:

- Medicaid agency excludes EBP, or critical component, e.g. disallows any services delivered in the community (If Medicaid agency not under the SMHA)
- State substance abuse agency prohibits integrated treatment, or will not reimburse for integrated treatment
- State substance abuse agency and state mental health authority are divided, and create obstacles for programs attempting to develop integrated service programs
- State vocational rehabilitation agency does not allow all clients looking for work access to services, or prohibits delivery of other aspects of the supported employment model
- Department of Corrections policies that create barriers to implementation of EBPs

Score:

1. Virtually all policies and regulations impacting the EBP act as barriers
2. On balance, policies that create barriers outweigh policies that support/promote the EBP
3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers
4. On balance, policies that support/promote the EBP outweigh policies that create barriers
5. Virtually all policies and regulations impacting the EBP support/promote the EBP

Evidence Used to Justify Rating:

11. Policies and Regulations: SMHA

The SMHA has reviewed its own regulations, policies and procedures to identify and remove or mitigate any barriers to EBP implementation, and has introduced new key regulations as necessary to support and promote the EBP.

Ask SMHA staff and site leadership: What regulations or policies support the EBP implementation? What regulations or policies get in the way?

Examples of supporting policies:

- *SMHA ties EBP delivery to contracts*
- *SMHA ties EBP to licensing/ certification/ regulation*
- *SMHA develops EBP standards consistent with the EBP model*
- *SMHA develops clinical guidelines or fiscal model designed to support model EBP implementation*

Examples of policies that create barriers:

- *SMHA develops a fiscal model or clinical guidelines that directly conflict with EBP model, e.g. ACT staffing model with 1:20 ratio*
- *SMHA licensing/ certification/ regulations directly interfere with programs ability to implement EBP*

Score:

1. Virtually all policies and regulations impacting the EBP act as barriers
2. On balance, policies that create barriers outweigh policies that support/promote the EBP
3. Policies that are support/promote the EBP are approximately equally balanced by policies that create barriers
4. On balance, policies that support/promote the EBP outweigh policies that create barriers
5. Virtually all policies and regulations impacting the EBP support/promote the EBP

Evidence Used to Justify Rating:

12. Policies and Regulations: SMHA EBP Program Standards

The SMHA has developed and implemented EBP standards consistent with the EBP model with the following components:

(Use boxes to identify which criteria have been met)

	1) Explicit EBP program standards and expectations, consonant with all EBP principles and fidelity components, for delivery of EBP services. <i>(Note: fidelity scale may be considered EBP program standards, e.g. contract requires fidelity assessment with performance expectation)</i>
	2) SMHA has incorporated EBP standards into contracts, criteria for grant awards, licensing, certification, accreditation processes and/or other mechanisms
	3) Monitors whether EBP standards have been met,
	4) Defines explicit consequences if EBP standards not met (e.g. contracts require delivery of model supported employment services, and contract penalties or non-renewal if standards not met; or licensing/accreditation standards if not met result in consequences for program license.)

Score:

	1. No components (e.g. no standards and not using available mechanisms at this time)
	2. 1 component
	3. 2 components
	4. 3 components
	5. 4 components

Evidence Used to Justify Rating:

13. Quality Improvement: Fidelity Assessment

There is a system in place for conducting ongoing fidelity reviews by trained reviewers characterized by the following components:

(Use boxes to indicate criteria met.)

Note: If fidelity is measured in some but not all sites, answer for the typical site.

<input type="checkbox"/>	1) EBP fidelity (or functional equivalent designed to assess adherence to all critical components of the EBP model) is measured at defined intervals
<input type="checkbox"/>	2) GOI fidelity (or functional equivalent designed to assess adherence to all critical components required to implement and sustain delivery of EBP) is measured at defined intervals.
<input type="checkbox"/>	3) Fidelity assessment is measured independent – i.e. not assessed by program itself, but by SMHA or contracted agency
<input type="checkbox"/>	4) Fidelity is measured a minimum of annually
<input type="checkbox"/>	5) Fidelity performance data is given to programs and used for purposes of quality improvement
<input type="checkbox"/>	6) Fidelity performance data is reviewed by the SMHA +/- local MHA
<input type="checkbox"/>	7) The SMHA routinely uses fidelity performance data for purposes of quality improvement, to identify and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).
<input type="checkbox"/>	8) The fidelity performance data is made public (e.g. website, published in newspaper, etc.)

Score:

<input type="checkbox"/>	1. 0 – 1 components
<input type="checkbox"/>	2. 2 – 3 components
<input type="checkbox"/>	3. 4 – 5 components
<input type="checkbox"/>	4. 6 – 7 components
<input type="checkbox"/>	5. All 8 components

Evidence Used to Justify Rating

14. Quality Improvement: Client Outcomes

A mechanism is in place for collecting and using client outcome data characterized by the following:

(Use boxes to indicate criteria met.)

Note: Client outcomes must be appropriate for the EBP, e.g. Supported employment outcome is persons in competitive employment, and excludes prevoc work, transitional employment, and shelter workshops. If outcome measurement is variable among sites, consider typical site.

	1) Outcome measures, or indicators are standardized statewide, AND the outcome measures have documented reliability/validity, or indicators are nationally developed/recognized
	2) Client outcomes are measured every 6 months at a minimum
	3) Client outcome data is used routinely to develop reports on agency performance
	4) Client specific outcome data are given to programs and practitioners to support clinical decision making and treatment planning
	5) Agency performance data are given to programs and used for purposes of quality improvement
	6) Agency performance data are reviewed by the SMHA +/- local MHA
	7) The SMHA routinely uses agency performance data for purposes of quality improvement; performance data trigger state action. Client outcome data is used as a mechanism for identification and response to high and low performers (e.g. recognition of high performers, or for low performers develop corrective action plan, training & consultation, or financial consequences, etc.).
	8) The agency performance data is made public (e.g. website, published in newspaper, etc.)

Scores:

	1. 0 components
	2. 1 – 2 components
	3. 3 – 5 components
	4. 6 – 7 components
	5. All 8 components

Evidence Used to Justify Rating

15. Stakeholders

The degree to which consumers, families, and providers are opposed or supportive of EBP implementation.

Note: Ask - Did stakeholders initially have concerns about or oppose EBPs? Why? What steps were taken to reassure/engage/partner with stakeholders. Were these efforts successful? To what extent are stakeholders currently supportive this EBP? Opposed? In what ways are stakeholders currently supporting/ advocating against this EBP? Rate only current opposition/support.

Scores:

1. Active, ongoing opposition to the EBP
2. Opposition outweighs support, or opinion is evenly split, but no active campaigning against EBP
3. Stakeholder is generally indifferent
4. Generally supportive, but no partnerships, or active proponents.
5. Stakeholder advocacy organization leadership/opinion leaders currently offer active, ongoing support for the EBP. Evidence of partnering on initiative.

- | | |
|--------------------------|--|
| <input type="checkbox"/> | 15. Summary Stakeholder Score: (Average of 3 scores below) |
| <input type="checkbox"/> | 15.a Consumers Stakeholders Score |
| <input type="checkbox"/> | 15.b Family Stakeholders Score |
| <input type="checkbox"/> | 15.c Providers Stakeholders Score |

Evidence to Justify Ratings:

Summary of Scores

1. EBP Plan _____
2. Financing: Adequacy _____
3. Financing: Start-up and Conversion Costs _____
4. Training: Ongoing Consultation & Technical Support _____
5. Training: Quality _____
6. Training: Infrastructure / Sustainability _____
7. Training: Penetration _____
8. SMHA Leadership: Commissioner Level _____
9. SMHA Leadership: EBP Leader _____
10. Policy and Regulations: Non-SMHA _____
11. Policy and Regulations: SMHA _____
12. Policy and Regulations: SMHA EBP Program Standards _____
13. Quality Improvement: Fidelity Assessment _____
14. Quality Improvement: Client Outcome _____
15. Stakeholders: Aver. Score (Consumer, Family, Provider) _____

Stakeholders: individual scores

15.a Consumers: 15.b Families: 15.c Providers:

OVERALL SHAY SCORE = SUM TOTAL _____ ÷ 15 = _____



Appendix E. Restraint and Seclusion Fidelity Measure

.Form Approved

OMB NO: 0930-0271
Exp. Date 11/30/08
See burden statement on last page

Inventory of Seclusion and Restraint Reduction Interventions (ISRR) Worksheets

Cover Sheet

Facility ID: _____

Name of Facility/Program: _____

State: _____

Start-up Date (mm/dd/yyyy): ___/___/___

Reviewer Name: _____

Title/Position: _____

Role:

- External Evaluator
- Internal Evaluator (e.g., QI)
- Staff external to the facility S/R program
- Staff part of the facility S/R program
- NTAC Consultant
- Other Consultant
- Other (specify): _____

Phone: () - _____

Date Completed (mm/dd/yyyy): ___/___/___



Worksheet 1: Leadership

LEADERSHIP 1: STATE POLICY			
<i>State DMH Office or relevant state level office directs or supports the reduction of seclusion and restraint in all state run and provider facilities</i>			
<i>Description:</i> A developed and communicated statewide mission statement, vision statement, and/or action plan that clearly articulates the goal of the reduction of seclusion, restraint, or other coercive measures; the development of systems of care that are trauma informed; and a commitment to the principles of recovery including consumer partnerships, assuring safe environments for staff and consumers, peer services and supports, the provision of hope through individualized treatment and full participation in own care; and the promulgation of rules directing or regulating the use of seclusion and restraint that restrict use for safety only.			
L.1	Leadership: State Policy		
The state has written policies and procedures that include (check if yes):			
<input type="checkbox"/>	1. A Philosophy Statement (vision statement, action plan, etc.) that specifically identifies goal of reducing seclusion/restraint		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. A policy providing for a program of trauma-informed care		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. A policy providing for consumer partnerships, peer services and supports		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. A policy for ensuring a safe environment for consumers (e.g., a violence prevention program)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. A policy providing for comprehensive individualized treatment planning process that includes the full participation of consumers in their own care		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	6. A policy restricting the use of S/R to emergencies that reach the level of imminent risk of harm to staff or other consumers only		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

LEADERSHIP 2: FACILITY POLICY

Description: The facility has policies that explicitly identify S/R reduction as a goal, are congruent with principles of recovery, build a trauma informed system of care, create violence free and coercion free environments, and assure safe environments for staff and consumers.

L.2 Leadership: Facility Policy

The facility has written policies and procedures that include (check if yes):

<input type="checkbox"/>	1. A policy identifying S/R reduction as a goal (may be a position or policy statement, vision statement, or action plan)
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. A policy supporting the adoption of principles of recovery
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. A policy supporting a trauma-informed system of care (e.g., including universal trauma assessment upon admission, use of crisis/safety plans, staff training in trauma, availability of EAP services)
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. A policy providing for creation of violence- and coercion-free environments
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. A policy providing for safe environments for staff through a violence prevention approach
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	6. A policy providing for safe environments for consumers through a violence prevention approach
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year

Comment:



LEADERSHIP 3: FACILITY ACTION PLAN

Description: 1) Stand-alone plan for reduction, with specific goals, objectives and action steps, assigned responsibility and due dates). 2) Process for regular review and revision. 3) Indication of senior executive oversight and review.

L.3 Leadership: Facility Action Plan

The facility has (check if yes):

<input type="checkbox"/>	1a. A stand-alone action plan for reduction				
	Source of information:				
	Start Date: / /	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
	1b. The stand alone action plan includes (check all that apply):				
	<input type="checkbox"/> Policy statement	<input type="checkbox"/> Recovery oriented programming	<input type="checkbox"/> Trauma informed care principles		
	<input type="checkbox"/> Violence and coercion free programming	<input type="checkbox"/> Violence prevention	<input type="checkbox"/> Goals, objectives		
	<input type="checkbox"/> S/R Reduction Team				
<input type="checkbox"/>	2. A process for regular review and revision of the action plan				
	Source of information:				
	Start Date: / /	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Number of times S/R reduction team has met to date: _____ (do not check the box at left if no meeting were held)				
	Source of information:				
	Start Date: / /	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Indications of senior executive oversight and review of the action plan				
	Source of information:				
	Start Date: / /	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year

Comment:



LEADERSHIP 4: LEADERSHIP FOR RECOVERY ORIENTED AND TRAUMA INFORMED CARE

Description: A program that seeks to prevent environmental or staff related triggers for conflict and that follows the principles of a system of care that is Recovery Oriented and Trauma Informed.

L.4A Leadership: Recovery Oriented Care

The program documentation includes (check if yes):

<input type="checkbox"/>	1. Consumer inclusion in their plan of care, consisting of the following (check all that apply, check box on left if any are present):		
	<input type="checkbox"/> Training on consumer roles	<input type="checkbox"/> Training on how to participate in their plan of care	
	<input type="checkbox"/> Pre-treatment planning meeting with consumer	<input type="checkbox"/> Consumer signature in progress notes	
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Informed consent, consisting of the following (check all that apply, check box on left if any are present):		
	<input type="checkbox"/> Communication of risks, benefits, side effects, adverse effects, alternative treatments (all included)	<input type="checkbox"/> Provided in coercion-free, private setting	
	<input type="checkbox"/> Presented in user-friendly, easy to read (non-technical) language	<input type="checkbox"/> Questions/discussions encouraged	
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Allowance for choices (e.g. Activities of Daily Living and treatment activities)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Avoidance of uniform rules and regulations that do not respect individual needs and preferences (e.g., enforced wake-up, eating or visiting times, mandatory participation in treatment activities)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. Predominant use of person first language by staff (e.g., using "persons with psychiatric disabilities" instead of "the mentally ill")		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	6. Predominant use of common courtesies in staff-to-consumer communication		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	7. Clear expectation that all people can self-manage illness (e.g., understand illness, monitor symptoms and avoid crises, understand medications and how to manage side effects)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year

Comment:



LEADERSHIP 4: LEADERSHIP FOR RECOVERY ORIENTED AND TRAUMA INFORMED CARE			
<i>Description:</i> A program that seeks to prevent environmental or staff related triggers for conflict and that follows the principles of a system of care that is Recovery Oriented and Trauma Informed.			
L.4B	Leadership: Trauma Informed Care		
The program includes (check if yes):			
<input type="checkbox"/>	1. Training for staff in the prevalence and incidence of traumatic experiences in persons served		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Use of universal trauma assessment upon admission		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Integration of trauma assessment findings in treatment plans		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Efforts to encourage staff attitudes, interventions, and practices that promote empowerment and inclusion and that do not re-traumatize		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. Access to trauma specific services when needed for persons who demonstrate trauma related symptoms		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	6. Access to expert consultation when needed for persons who demonstrate trauma related symptoms		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

LEADERSHIP 5: CEO	
<i>CEO/Administrator participation is active, routine, observable</i>	
<i>Description:</i> The CEO/Administrator directs the S/R reduction initiative by: 1) Participating in S/R Reduction Team meetings; 2) Being perceived by staff as playing a central role at a “kickoff” event for the rollout of the initiative; and 3) Reviewing progress by means of a standing agenda item for management meetings.	
L.5	Leadership: CEO
The CEO or designated leader (check if yes):	
<input type="checkbox"/>	1. Number of S/R Reduction Team meeting attended by the CEO or designated leader to date: _____ (Do not check if no team formed)
	Source of information:
<input type="checkbox"/>	2. Was perceived by staff as playing a central role at “kickoff” event for the rollout of the initiative
	Source of information:
<input type="checkbox"/>	3. Reviewed progress by means of a standing agenda item for management meeting
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:	



LEADERSHIP 6: MEDICAL DIRECTOR

Description: The Medical Director is present at S/R meetings, central role at kickoff event, reviews incidents and data at least weekly, attends formal debriefings, and supervises staff usage.

L.6 Leadership: Medical Director

Medical Director (check if yes):

1. Number of S/R Reduction Team meeting attended by the Medical Director to date: _____ (Do not check if no team formed)

Source of information:

2. Was perceived by staff as playing a central role at "kickoff" event for the rollout of the initiative

Source of information:

3. Participated in S/R data reviews and analysis at least weekly

Source of information:

Start Date: / / or: Within 6 months 6-12 months more than 1 year

4. Attended at least one formal debriefing

Source of information:

Start Date: / / or: Within 6 months 6-12 months more than 1 year

5. Supervised individual physician usage of S/R on at least a monthly basis

Source of information:

Start Date: / / or: Within 6 months 6-12 months more than 1 year

Comment:



LEADERSHIP 7: NON-COERCIVE ENVIRONMENT

Description: Highly visible and well-publicized statements promoting non-coercive environments.

L.7 Leadership: Non-Coercive Environment

Statements supporting non-coercion issued in the past year by means of (check if yes):

<input type="checkbox"/>	1. Staff meetings
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Newsletters
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Posters
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Other: (specify)
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year

Comment:



LEADERSHIP 8: KICKOFF CELEBRATION			
<i>Description:</i> A highly visible, well-publicized public event dedicated exclusively to promoting the reduction initiative, open to and attended by a majority of the facility staff at all levels.			
L.8	Leadership: Kickoff Celebration		
<input type="checkbox"/>	1. A kick-off celebration has been held (check if yes)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Percent of facility staff attended: ___ (Do not check box, if kickoff has not been held)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

LEADERSHIP 9: STAFF RECOGNITION PROGRAM			
<i>Description:</i> A formal program for regular (monthly or weekly) public acknowledgment of the achievements or contributions of individual staff to S/R reduction or related goals such as promotion of recovery or non-coercive treatment environment.			
L.9	Leadership: Staff Recognition		
<input type="checkbox"/>	1. Individual contributions to S/R reduction, recovery, non-coercive treatment publicly acknowledged _____ times (do not check box at left if zero)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

Worksheet 2: Debriefing

DEBRIEFING 1: IMMEDIATE POST-EVENT DEBRIEFING

Description: An immediate post-event debriefing that is done onsite after each event and is led by the senior on-site supervisor who immediately responds to the unit or area. The goals of the post-event debriefing are: to assure that everyone is safe; to ensure that documentation is sufficient to be helpful in later analysis; to briefly check in with involved staff, consumers, and witnesses to the event to gather information; to try and return the milieu to pre-event status; to identify potential needs for policy and procedure revisions; and to assure that the consumer in restraint is safe and being monitored appropriately.

Method: Review a minimum of five reports randomly selected from measurement month. If less than five, review all for the month and indicate number in comment section. Using the Debriefing Review Tool, count the number of debriefings that contain each item. Items ask for whether a particular aspect of the debriefing was addressed in the report.

Review #1 Measurement month: Month at of the beginning of the grant cycle (October 2004, or within 3 months of October 2004)

Review #2 Measurement month: Month at of the beginning of year 2 of the grant cycle (October 2005, or within 3 months of October 2005)

D.1 Debriefing: Immediate Post-Event

Review #1	Review #2	Number of immediate post event debriefings in measurement month that addressed the following (i.e. indicated whether or not it occurred):
<input type="checkbox"/>	<input type="checkbox"/>	1. Designated mid or senior level clinical staff responded no later than one hour
<input type="checkbox"/>	<input type="checkbox"/>	2. Immediate Post-Event analyses were held within one hour
<input type="checkbox"/>	<input type="checkbox"/>	3. Post-Event analysis included direct or indirect input or documented refusal by consumer affected
<input type="checkbox"/>	<input type="checkbox"/>	4. Post-Event analysis included all staff witnessing or participating
<input type="checkbox"/>	<input type="checkbox"/>	5. Post event response included attention to returning milieu to pre-crisis state
<input type="checkbox"/>	<input type="checkbox"/>	6. Post-Event response included assessment and management of potential physical or emotional injury or trauma to consumers or staff
<input type="checkbox"/>	<input type="checkbox"/>	7. Post-Event response includes documentation staff and/or consumer reports of antecedents to event (such as conflict triggers)
<input type="checkbox"/>	<input type="checkbox"/>	Number of reports reviewed
		Review #1: Month and year of reviewed reports(If other than recommended month, explain why below)
		Review #2: Month and year of reviewed reports(If other than recommended month, explain why below)
Comment:		

DEBRIEFING 2: FORMAL DEBRIEFING REVIEW

Description: A formal debriefing that occurs within 48 hours of the event or next business day and includes a rigorous analysis (e.g., root cause analysis) or rigorous problem solving procedure to identify what went wrong, what knowledge was unknown or missed, what could have been done differently, and how to avoid it in the future. The formal debriefing includes attendance by the involved staff, the treatment team, the consumer and/or proxy, surrogate or advocate representative, and other agency staff as appropriate.

Method: Review five reports randomly selected from measurement month. If less than five review all for the month and indicate number in comment section.

Review #1 Measurement month: Month at of the beginning of the grant cycle (October 2004, or within 3 months of October 2004)

Review #2 Measurement month: Month at of the beginning of year 2 of the grant cycle (October 2005, or within 3 months of October 2005)

D.2		Debriefing: Formal Review
Review #1	Review #2	Number of formal debriefing reports in measurement month that addressed the following (i.e. indicated whether or not it occurred) : (Leave unchecked if no formal debriefings held,
<input type="checkbox"/>	<input type="checkbox"/>	1. Formal debriefing held within 48 hours or next business day (if 48 hour period falls within weekend or holiday)
<input type="checkbox"/>	<input type="checkbox"/>	2. Led by credentialed facilitator not involved in event
<input type="checkbox"/>	<input type="checkbox"/>	3. Review of assessment and treatment activities with revisions made and/or additional training or supervision provided
<input type="checkbox"/>	<input type="checkbox"/>	4. Conflict trigger/antecedents noted
<input type="checkbox"/>	<input type="checkbox"/>	5. Timely response demonstrated
<input type="checkbox"/>	<input type="checkbox"/>	6. Individual safety/crisis plan or other similar individualized options utilized
<input type="checkbox"/>	<input type="checkbox"/>	7. Imminent danger threshold reached
<input type="checkbox"/>	<input type="checkbox"/>	8. Restraint or seclusion applied safely
<input type="checkbox"/>	<input type="checkbox"/>	9. Continuously monitored, face to face for restraint
<input type="checkbox"/>	<input type="checkbox"/>	10. ASAP release
<input type="checkbox"/>	<input type="checkbox"/>	11. Release criteria reasonable with burden on staff, not person
<input type="checkbox"/>	<input type="checkbox"/>	12. Immediate post debriefing activities carried out
<input type="checkbox"/>	<input type="checkbox"/>	13. Learning occurred and is documented
<input type="checkbox"/>	<input type="checkbox"/>	14. Follow-up recommendations made
<input type="checkbox"/>	<input type="checkbox"/>	15. Recommended changes planned for, implemented, and assessed
		Number of formal debriefings measurement month that included the following staff:
<input type="checkbox"/>	<input type="checkbox"/>	1. Staff involved in event
<input type="checkbox"/>	<input type="checkbox"/>	2. Treatment team of consumer involved in event
<input type="checkbox"/>	<input type="checkbox"/>	3. Administration representative
<input type="checkbox"/>	<input type="checkbox"/>	4. Attending physician
<input type="checkbox"/>	<input type="checkbox"/>	Number of reports reviewed
		Review #1: Month and year of reviewed reports (If other than recommended month, explain why below)
		Review #2: Month and year of reviewed reports (If other than recommended month, explain why below)
Comment:		

Worksheet 3: Use of Data

USE OF DATA 1: DATA COLLECTED							
<i>Description:</i> Standard reports on S/R events that include specified data elements.							
U.1 Use of Data: Data Collected							
1. Standard reports include the following items (check if included):							
<input type="checkbox"/>	a. Number of S/R events						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	b. Hours in S/R						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	c. Time of day						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	d. Day of week						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	e. Type of restraint						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	f. Consumer injuries						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	g. Staff injuries						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	h. Use of involuntary medication						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	i. Uses of PRN (voluntary, non-routine) medications either prior to or during event						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	j. Avoidances/near misses						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
2. Consumer Demographics:							
<input type="checkbox"/>	a. Race						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	b. Gender						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	c. Age						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	d. Diagnosis						
	Start Date:	/	/	or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
Comment:							

USE OF DATA 2: GOAL SETTING			
<i>Description:</i> Using data in an empirical, non-punitive manner by identifying facility baseline, setting improving goals and comparatively monitoring use over time.			
U.2	Use of Data: Goal Setting		
<input type="checkbox"/>	1. Goals and current S/R rates were communicated to staff (e.g., posted, newsletters, etc.)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Benchmarking against self (e.g., baseline) was collected and graphed		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Benchmarking against like or risk-adjusted others was collected and graphed		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

Worksheet 4: Workforce Development

WORKFORCE DEVELOPMENT 1: STRUCTURE			
<p><i>Description:</i> The appointment of a committee and chair to address workforce development agenda and lead organizational changes in safe S/R application training, and inclusion of technical and attitudinal competencies in job descriptions and performance evaluations.</p>			
W.1	Workforce Development: Structure		
<input type="checkbox"/>	1. Formed S/R Workforce Committee (or Taskforce)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Number of times S/R Workforce Committee (or Taskforce) has met to date: _____ (Do not check if no committee formed)		
	Source of information:		
<input type="checkbox"/>	3. Evidence of inclusion of technical and attitudinal competencies regarding S/R reduction initiative in activities of human resources department (e.g., during new hire interviews, new hire orientations, and in job descriptions)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

WORKFORCE DEVELOPMENT 2: TRAINING PROGRAM

Description: A formal program of training specifically in S/R reduction concepts and techniques, provided at least annually.

W.2 Workforce Development: Training

<input type="checkbox"/>	1. Training program in alternatives to S/R exists (check if yes)		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Training program in alternatives to S/R includes (do not check box at left if no training occurred):		
	<input type="checkbox"/> Principles of recovery/resilience/strength based treatment		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	<input type="checkbox"/> Core therapeutic skills/relationship building		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	<input type="checkbox"/> Principles of trauma-informed care		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	<input type="checkbox"/> Cultural competence		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	<input type="checkbox"/> Myths and assumptions regarding S/R		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	<input type="checkbox"/> Involvement of consumer as full time or part time staff members		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	<input type="checkbox"/> Role of peer support		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
	Source of information:		

Comment:



WORKFORCE DEVELOPMENT 3: SUPERVISION AND PERFORMANCE REVIEW

Description: 1) On-going supervision that supports training philosophy and skill development; 2) Performance reviews that included staff competencies in S/R prevention; 3) Competency demonstrations; 4) Re-training for staff demonstrating lack of competence; and 5) Mechanisms for holding staff accountable for performance (e.g., employment counseling, performance improvement reviews, and/or termination for ongoing resistance to change).

W.3 Workforce Development: Supervision and Performance Review

The facility has established processes for the following (check if yes):

<input type="checkbox"/>	1. Ongoing supervision that supports training philosophy and skill development			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Performance Reviews that include staff competencies in S/R prevention			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Competency demonstrations			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Re-training for staff demonstrating lack of competence			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. Mechanisms for holding staff accountable for performance (for example, employment counseling, performance improvement reviews, and/or termination for ongoing resistance to change)			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year

Comment:



WORKFORCE DEVELOPMENT 4: STAFF EMPOWERMENT

Description: The empowerment of staff includes: 1) Formal opportunity to input on rules, policies, and procedures; 2) Satisfaction surveys; 3) Formal process for administration follow-up on survey findings, 4) Process for public recognition of achievements; 5) Individualized scheduling (such as opportunities for mental health days, training days, etc.); and 6) Confidential access to EAP or comparable assistance with job-related stress.

W.4 Workforce Development: Staff Empowerment

The facility provides for the following (check if yes):

<input type="checkbox"/>	1. Formal opportunity for staff input on rules, policies, procedures
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Staff satisfaction surveys
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Formal process for administration follow-up on survey findings
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Process for public recognition of staff achievements
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. Individualized scheduling (such as opportunities for mental health days, training days, etc.)
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	6. Confidential access to EAP or comparable assistance with job-related stress
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year

Comment:



Worksheet 5: Tools for Reduction

TOOLS FOR REDUCTION 1: IMPLEMENTATION			
<p><i>Description:</i> The use of the following tools for the reduction of S/R: 1) Assessment of risk factors for aggression/violence; 2) Assessment of medical/physical risks for death or injury; 3) De-escalation/safety plans/crisis plans; and 4) Behavioral scale that assists in determining appropriate staff interventions that match level of behavior observed.</p>			
T.1 Tools for Reduction: Implementation			
The facility utilizes the following tools (check if yes):			
<input type="checkbox"/>	1. Assessment of risk factors for aggression/violence		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Assessment of medical/physical risks for death or injury		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. De-escalation/safety plans/crisis plans		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Behavioral scale that assists in determining appropriate staff interventions that match level of behavior observed		
	Source of information:		
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
Comment:			

TOOLS FOR REDUCTION 2: EMERGENCY INTERVENTION

Description: Policies and procedures for emergency intervention including: 1) Safe restraint procedures that include restrictions on prone use; and 2) Safe monitoring that includes continuous observation.

T.2 Tools for Reduction: Emergency Intervention

Policies and procedures for emergency intervention include the following (check if yes):

<input type="checkbox"/>	1. Safe restraint procedures that include restrictions on prone use in policy
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Safe monitoring that includes continuous observation
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year

Comment:

TOOLS FOR REDUCTION 3: ENVIRONMENT

Description: Environment of care changes implemented by facilities including: 1) Sensory/comfort rooms; 2) Avoidance of signs of coercion in posters or other signs; 3) Evidence of signs promoting violence prevention and safe environment of care; 4) Avoidance of overcrowding (e.g., extra beds, insufficient seating in common areas, etc.); 5) Avoidance of unnecessary noise (e.g., overhead announcements, bells or buzzers, phones ringing, staffing raising voices unnecessarily, etc.); and 6) Process where direct care staff and consumers have opportunity to review institutional rules on routine basis to assure need and effect with evidence of review and resultant change.

T.3 Tools for Reduction: Environment

The facility is characterized by the following (check if yes):

<input type="checkbox"/>	1. Sensory/comfort room
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Avoidance of signs of coercion in posters or other signs
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Evidence of signs promoting violence prevention and safe environment of care
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Avoidance of overcrowding (e.g., extra beds, insufficient seating in common areas)
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. Avoidance of unnecessary noise (e.g., overhead announcements, bells or buzzers, phones ringing, staff raising voices unnecessarily)
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year
<input type="checkbox"/>	6. Process where direct care staff and consumers have opportunity to review institutional rules on routine basis to assure need and effect with evidence of review and resultant changes
	Source of information:
	Start Date: / / or: <input type="checkbox"/> Within 6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> more than 1 year

Comment:



Worksheet 6: Inclusion

INCLUSION 1: CONSUMER ROLES				
<p><i>Description:</i> The full and formal inclusion of consumers in a variety of roles in the organization including: 1) In key executive committees; 2) In paid staff roles with formal supervision; 3) Satisfaction surveys; and 4) Formal follow-up on satisfaction surveys.</p>				
I.1 Inclusion: Consumer Roles				
The facility provides the following mechanisms for consumer input (check if yes):				
<input type="checkbox"/>	1. Consumers on key executive committees (e.g. leadership team, safety/risk-management, pharmacy, CQI)			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Consumers in paid staff roles are provided formal supervision			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Consumer satisfaction surveys conducted			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Process exists for formal follow-up on satisfaction surveys			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
Comment:				

INCLUSION 2: FAMILY ROLES*

** This subdomain is only applicable to Child/Adolescent facilities/programs—skip if completing Inventory for an Adult facility/program.*

Description: The full and formal inclusion of family members in a variety of roles in the organization including: 1) Key executive committees; 2) Paid staff roles with formal supervision; 3) Participating in treatment planning meetings; 4) Satisfaction surveys; and 5) Formal follow-up on satisfaction surveys.

I.2 Inclusion: Family Roles

The facility utilizes family members in the following ways (check if yes):

<input type="checkbox"/>	1. Family members on key executive committees			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Family members in paid staff roles are provided formal supervision			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Family members are encouraged to attend treatment planning meetings			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Family satisfaction surveys conducted			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	5. Process exists for formal follow up on satisfaction surveys			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year

Comment:

INCLUSION 3: ADVOCATE ROLES

Description: The full and formal inclusion of advocates in a variety of roles in the organization including: 1) Key executive committees; 2) Paid staff roles with formal supervision; 3) Satisfaction surveys; and 4) Formal follow-up on satisfaction surveys.

I.3 Inclusion: Advocate Roles

The facility utilizes advocates in the following ways (check if yes):

<input type="checkbox"/>	1. Advocates on key executive committees			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	2. Advocates in paid staff positions are provided formal supervision			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	3. Advocate satisfaction surveys conducted			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year
<input type="checkbox"/>	4. Process exists for formal follow-up on satisfaction surveys			
	Source of information:			
	Start Date: / / or:	<input type="checkbox"/> Within 6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> more than 1 year

Comment:

Worksheet 7: Oversight/Witnessing

OVERSIGHT/WITNESSING: ELEVATING OVERSIGHT		
<p><i>Description:</i> The leadership ensures oversight accountability by watching and elevating the visibility of every event 24 hours a day/7 days per week by assigning specific duties and responsibilities to multiple levels of staff including: 1) On-call observer competent in S/R policies and procedures and familiar with daily operations; 2) On-call supervisor; and 3) Senior staff responding to event.</p> <p><i>Review #1 Measurement month:</i> Month at of the beginning of the grant cycle (October 2004, or within 3 months of October 2004)</p> <p><i>Review #2 Measurement month:</i> Month at of the beginning of year 2 of the grant cycle (October 2005, or within 3 months of October 2005)</p>		
O.1 Oversight/Witnessing: Elevating Oversight		
Review #1	Review #2	During the measurement month the following occurred (check if yes):
<input type="checkbox"/>	<input type="checkbox"/>	1. Formal Executive oversight available on a 24 hour/7 day a week basis was available
<input type="checkbox"/>	<input type="checkbox"/>	2. On-call observer competent in S/R policies and procedures and familiar with usual and daily operations of facility/units was available (Denotes use of senior administrator, nursing director, facility manager, clinical director, physician)
<input type="checkbox"/>	<input type="checkbox"/>	3. Formally designated on-call supervisor was identified and communicated to staff
<input type="checkbox"/>	<input type="checkbox"/>	4. Senior staff responding to events notified executive on call
		Month and year of reviewed reports (If other than recommended month, explain why below)
		Review #2: Month and year of reviewed reports (If other than recommended month, explain why below)
Comment:		

Public reporting burden for this collection of information is estimated to average 4 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 7-1044, One Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0271.

