EBP Evidence-Based Practice

Saginaw County Community Mental Health Authority

EVIDENCE-BASED PRACTICES

and

SYSTEM TRANSFORMATION

Update Report On Fidelity

Improving Practices at SCCMHA

March 2014

Introduction

SCCMHA issued an initial five year EBP report in March 2011, as well as a brief update in June 2012 and are available from SCCMHA.

The purpose of this March 2014 report is twofold: 1) to provide an update on overall EBP progress within the SCCMHA system including inclusion of foundational EBP content and the introduction of any new practices; and 2) to specifically highlight current **fidelity** measurement status in the various practices which SCCMHA endorses. Practice areas in this report are organized by service population groups. The methodology of determining fidelity varies by practice area and SCCMHA has varied implementation depth of fidelity measurement across all practices in the network at this time.

Fidelity

Fidelity is the extent to which each of the principle components of a given practice are adhered. Research has shown that fidelity is critical to achieving beneficial outcomes. Many evidence-based practices have fidelity review tools that may be used to periodically review adherence to the specific model. Fidelity reviews may be conducted by external entities to provide for a more neutral review. Fidelity is not the same as measuring consumer outcomes or satisfaction. For most practices it is not the same thing as a certification process. To put it simply, a fidelity review involves a formal objective review, preferably external to assist with objectivity conducted by a knowledgeable source, who looks at each component of the model or practice and identifies the extent of adherence of each, with recommendations for improvement where there is not full alignment in any given area. There are times where local variations may be tolerated, but those should be declared and accepted in keeping with consumer needs, and not be a variation that impacts positive outcomes or the core elements of the practice model. All fidelity reviews are an opportunity to re-embrace parameters of a model, and to implement quality improvements where needed, to help ensure desired and expected positive consumer outcomes.

Although it is the intent of SCCMHA to ensure widespread fidelity review occurs in the future, it should be noted that fidelity reviews at this time have not been officially conducted for all practices being provided throughout the SCCMHA network. There has been a mix of external and internal reviews as well for those that have been conducted to date, and quite a bit of variation of the evolving level of support for fidelity reviews of models from the Michigan Department of Community Health (MDCH). Ongoing informal fidelity responsibility does rest with specific practice trained and involved service program staff/network members and their supervisors, however SCCMHA does have an obligation to provide centralized oversight and support to ensure fidelity across system endorsed practices. Where formal fidelity reviews have occurred, either SCCMHA orchestrated or through external parties, this is so noted in the practice summary content. Fidelity reviews are 'point-in-time-measures', and especially in practices where services are provided by a team, many variables can impact fidelity outcomes, including but not limited to staff turnover, inattentive drift away from any element or element of the model, lack of supervisory supports, other demands on the team's attention, or other barriers or issues which affect successful sustainability. It should be noted, where MDCH has veered from official fidelity tools, SCCMHA has maintained use of established national methods if they exist.

Where fidelity has been measured in some manner, the practice title is highlighted with an asterisk (*) in this report. Fidelity scales for 8 key practice areas are included in an Appendix.

All Populations

There are core evidence-based trainings in which SCCMHA requires individual competency of service program staff across the network. While there are no current methods of reviewing fidelity or ongoing demonstration of individual practice in place at this time in these specific areas, SCCMHA may look to future means to help ensure fidelity to these foundational evidence-based elements of services and supports for all persons served.

Motivational Interviewing

This is a foundational evidence-based model of working with individuals to assist them in identifying and changing behaviors that may place them at risk, prevent optimal management of a chronic condition, or interfere with personal goals progress. SCCMHA expects that all practitioners in service programs will have skills to target interventions to each person's stage of change and use basic principles of motivational interviewing, including expressing empathy, avoiding challenging a consumer's hesitation to change, assisting consumers to identify their behaviors which do not reflect their values, and supporting self-confidence in the ability to change behaviors. Heidi Wale, MA, LLP, represents Saginaw in a Michigan coalition of certified MI trainers.

Trauma Informed Practice

Providers of care and supports are expected to be sensitive to the potential for any type of trauma history for persons served. Elements include screening and assessment of trauma history or risk, and treatment planning in a safe, nurturing and empowering environment that supports consumer choice and control and avoids re-traumatization. Robert White, LMSW, is certified in Trauma Focused CBT with MDCH. SCCMHA has invested significant training and resources in various aspects of trauma, sensitive to the impact of violence on persons served and their families. SCCMHA is currently in the process of assessing the organization as a trauma informed organization (TIO) working with resources from Western Michigan University. SCCMHA has also hosted community training for more than 50 local practitioners in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) with monthly fidelity/supervisory support events this year. SCCMHA has also sponsored parents to become trained as Resource Parents (a component of MDCH's Trauma Focused CBT training) to advocate and function as community trainers in trauma impact.

Positive Behavioral Supports

Increasingly program service staff members are expected to have a basic understanding of core behavior treatment principles, and to be able to offer positive feedback, support and redirection when indicated to assist consumers with their life goals. Positive behavior support is a form of applied behavioral analysis. (ABA) SCCMHA has also developed behavior champions to help teams support consumers in areas that do not require a behavioral treatment plan or formal behavioral treatment team involvement. Positive behavioral support is a systemic part of trauma reduction strategies, since its use is the antithesis of re-traumatization.

Adults with Serious Mental Illness

For all adult practices, there is an emphasis on the core principles of the concept of recovery. Four key practice areas have received some form of fidelity review for services for adults with serious mental illness.

*****ASSERTIVE COMMUNITY TREATMENT (ACT)

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Assertive Community Treatment	***Adults With Serious Mental Illness***	***Team Level***	***Training & Treatment Innovations, ACT Team: Tommie Orange, Supervisor***

ACT is one of the longest implemented EBPs in the SCCMHA (and other CMHSP) systems, although official fidelity review is somewhat recent. MDCH Medicaid Review protocols include most of the fidelity elements for ACT, based on the DACTS (Dartmouth Assertive Community Treatment Scale) fidelity scale, so statewide ACT programs have had annual reviews of fidelity elements to some extent historically through that process, however, these audits end effective FY 2014. MDCH also conducted a special field guide site visit for state ACT programs in 2008, a project funded by the Flinn Foundation. SCCMHA has conducted five (5) fidelity reviews of the local ACT program, between 2006 and 2012. Scores from those reviews were: 102-104/140 (baseline), 105/140, 111/140, 112/140. One review was not final scored due to changes in service team size in progress. Historically, the availability of psychiatry has often impacted the ACT fidelity score. In Saginaw, as well as elsewhere in Michigan CMHSP programs, many ACT programs are also IDDT certified, and subject to that practice fidelity review separately. ACT fidelity components include: small/team caseload, frequent meetings, direct service supervisor, staff continuity and capacity, team psychiatrist and nurse, SUD and vocational specialists, program size, explicit admission criteria, low admission rate, full service/crisis responsibility, hospital admit involvement, time unlimited services, community-based services, no dropout policy, assertive consumer engagement, intense/frequent services, informal support systems, individualized SUD treatment and co-occurring groups, dual disorder model, and consumer role on team. ACT teams must also be MDCH certified programs. ACT serves adults who exhibit the most serious symptoms of mental illness and need intensive support to be safe in their community.

*****DIALECTICAL BEHAVIOR THERAPY (DBT)

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Dialectical Behavior Therapy	***Adults With Serious Mental Illness – Borderline Personality Disorder***	***Team Level***	***SCCMHA Community Support Services: Adult Case Management Team Steve Gonzalez, Supervisor***

SCCMHA has been providing and sustaining this therapeutic practice for persons with specific mental health disorders since 2006. The CSS adult case management team has hosted DBT graduations for individual consumers who complete the requirements of participation. Since 2006 there have been six (6) consumer small group graduation events, the most recent in February 2014. Also that month, SCCMHA participated in a pilot, on-site external DBT fidelity review sponsored by MDCH; the program was reviewed against the key elements of DBT programs, including five modes of treatment – individual therapy and group skills training, telephone contact and weekly consult group, and ancillary treatments, such as medication, and other evidence-based practices. Final fidelity rating/report is still pending at this time. Some of the reviewers anticipated recommendations include assessment of all referred adults for DBT appropriateness, emphasis on measurement of consumer outcomes, and establishment of a mission for the treatment practice. The SCCMHA adult case management team has a DBT certification from MDCH.

FAMILY PSYCHOEDUCATION (FPE)

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Family Psychoeducation	***Adults With Serious Mental Illness***	***Team Level***	***Adult Case Management Team Supervisors – SCCMHA - Robert Thrash, TTI - Kevin Steinbauer, and SPSI - Kris Curtis Wheeler and John Burages, Mental Health Therapist & Regional Certified Trainer***

This practice was initiated in three adult case management teams beginning in 2007-2008. John Burages, LMSW, is a certified regional trainer for this practice. While no formal fidelity review has been conducted, the three provider programs met with the statewide FPE coordinator during 2009 and 2010 for an external supervision review and the feedback received was positive. Supervision of the provision of clinical services via the video taping of sessions was provided by an external reviewer/supervisor at the implementation stage of the practice. The statewide FPE workgroup, which has created a statewide certification process, is in the process of establishing a fidelity review structure. SCCMHA has not done so to date, but will likely pursue using the SAMHSA provided fidelity tool in the near future to conduct a local FPE review.

***Integrated Dual Disorder Treatment (IDDT)

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Integrated Dual Disorder Services	***Adults With Serious Mental Illness and Substance Use Disorders***	***Team Level***	***Adult Case Management Team Supervisors: SCCMHA CSS -Steve Gonzalez, SPSI - Kris Curtis Wheeler, TTI - Kevin Steinbauer, and Tommie Orange (ACT)***

The 14 elements of IDDT fidelity include: multi-disciplinary team, integrated substance use disorder specialist, stage-wise interventions, access to comprehensive dual disorder services, long-term services, outreach, motivational interventions, substance use disorder counseling, group dual disorder treatment, family dual disorder treatment, self-help liaison, pharmacological treatment, interventions to reduce negative consequences, and secondary interventions for on-responders. For this practice, all four adult case management teams, including ACT, have routine, periodic external fidelity reviews by a MDCH sponsored MiFAST (Michigan Fidelity Assessment Service Team) team. The SCCMHA Adult Case Management Teams identify persons to be served through the identification of any substance use disorder diagnosis and the EMR then automatically requires an assessment and plan for dual disordered treatment. Fidelity review is conducted using a standardized format, and a report is issued. Fidelity reviews occur every 1-2 years, as scheduled by each team, and MDCH considers this a quality improvement activity for IDDT teams. Although this dual disorder enhanced (DDE) status is an adult practice, dual disorder capability (DDC) is an expectation across the SCCMHA network since co-occurring substance use disorders are common, and this practice has applicability for older youth and any individual with multiple diagnoses. IDDT teams have to be certified by MDCH. MiFAST reviewers also use the GOI, General Organizational Index, to assess 12 administrative and overall supports for this practice, including program philosophy, eligibility/client identification, penetration, assessment, treatment plan, treatment, training, supervision, process monitoring, outcome monitoring, quality improvement and consumer choice. Given that the adult teams serve over 900 adults at any given time, and approximately half have substance use disorders, this practice has a wide impact on consumer supports in the SCCMHA system.

There are now four IDDT certified adult case management programs in the SCCMHA network and all have had fidelity reviews by the MDCH sponsored MiFAST teams. SPSI has had four external fidelity reviews (2007, 2009, 2010, and 2011), CSS has had four reviews (2008, 2009, 2011, and 2013), ACT has had three reviews (2008, 2010, and 2013) and the TTI Adult Case Management Team experienced a first review in 2013 and was then issued their IDDT certification status shortly thereafter. The MiFAST reviews offer improvement and feedback consultation to the IDDT teams, and written reports are issued post the site reviews. Most recent review scores, on a scale of 1-5 were: CSC – 3.75; SPSI – 4.57; TTI ACT – 3.57 and TTI Adult Case Management (baseline) – 3.07. All programs scored in the fair implementation range, except for TTI case management which was not yet evidence-based as the program was in the process of being implemented; MDCH did issue an IDDT certification for this program in June 2013.

*****SUPPORTED EMPLOYMENT

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Supported Employment	***Adults With Serious Mental Illness***	***Team Level***	***SCCMHA Supported Employment Unit: Todd Dixon, Supervisor & Supported Employment Specialists***

SCCMHA was an early adopter of the supported employment model within the MDCH service system. While this practice was designed for persons with mental health disorders, it is applicable and was implemented by SCCMHA for adults with developmental disabilities as well. Since the implementation in 2005, there have been four supervisor changes in oversight of the practice. SCCMHA has conducted seven (7) fidelity reviews, using the SAMHSA fidelity tool. MDCH offered a revised tool which SCCMHA did not adopt; the SAMHSA tool was modified by SAMHSA several years ago. Fidelity reviews conducted 2006 – 2014, resulted in scores of 57/75 (baseline measure), 69/75, 70/75, 70/75, 68/75, and for the adjusted tool most recently, 68/90 and 61/90. Fidelity reviews have included discussion and planning in several areas for improvement. In addition to supervisory changes, turnover in supported employment specialists have also impacted the fidelity scores over time for this practice. MDCH is now hosting an external fidelity review option, and the SCCMHA program plans to schedule this in the future.
The Supported Employment fidelity areas include: caseload size, dedicated/generalist staff, integration with mental health treatment, distinct vocational unit, zero exclusion criteria, work-based focus, rapid/individualized job search, diversity of job development, job permanence, jobs as transition, follow along supports, community based services and active engagement.

PEER SUPPORT SERVICES

SCCMHA developed a unique Peer Support Services fidelity tool several years ago, as none is known to exist nationally; however, SCCMHA has yet to use it to review fidelity. At the current time SCCMHA engages approximately 20 individuals who provide certified peer support services to adults with serious and persistent mental illness and conducts regular administrative meetings with the peer group; most but not all have certification as a PSS. The February 2014 opening of the new consumer run Drop In program, Friends for Recovery Center (FFRC) - with a wellness program focus - will expand the scope of peer services in the SCCMHA network.

TRAUMA – M TREM & W TREM

SCCMHA offers both men's and women's trauma support groups, referred to as M TREM and W TREM; TREM is the Trauma Recovery & Empowerment Model. There is no fidelity tool to measure this practice; the model is being used inside the adult case management service

programs to support both men and women in small groups. This practice continues to be very well received by consumers. For example, the M TREM program has been in practice at SCCMHA for over 4 years and has supported over 40 male consumers.

VARIOUS COGNITIVE BEHAVIOR THERAPIES

This is a broad practice area of various cognitive practice models, in which individual clinicians become proficient in specific individual or family therapy methods of treatment. Therapists and other clinical staff are expected to be proficient in at least one area - Cognitive Behavioral Therapy, Brief Solution Focused Therapy, Functional Family Therapy, and/or a similar evidence-based practice area where applicable to meet consumer needs. No fidelity review has occurred in these areas at this time but this is on the work plan for the future along with centralized privileging of individual clinicians in various relevant CBT EBPs for their job roles.

Children & Families

Two key children's evidence-based practice areas have received fidelity reviews to date.

*****PMTO

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Parent Management Training – Oregon Model	***Parents with children preschool to adolescence who display behavioral problems***	***Individual Level***	***SCCMHA FSU: Matt Linkowski, Family Intervention Specialist***

This practice involves initial training, as well as both initial and ongoing direct supervision, through the review of videos and monthly coaching of the practitioner's correct use of the model's core elements, by a certified coach. Practitioners are rated and must receive an acceptable score level among all the dimensions to become certified and maintain certification, using the PMTO – Oregon Model, Fidelity of Implementation Rating System. (FIMP) Recertification is completed annually. Skill training in core effective parenting practices include encouragement, limit setting, monitoring and supervision, family problem solving, and positive parental involvement. SCCMHA currently has one certified "FIMPer" (there are only 6 in Michigan), Matt Linkowski, MA, LPC, who is also the current regional coordinator; a second SCCMHA practitioner is expected to become certified soon. Statewide there are about 60 certified PMTO therapists. To date, 24 parents have received PMTO interventions and supports to become more effective in their parental functioning through SCCMHA, since this practice was initiated in 2008. PMTO certification/fidelity elements include: understanding of core supporting parenting practices, flow/pacing/transitions/summing up structures, verbal and active teaching and use of role play, process skills and overall development.

TRAUMA – G TREM & TF CBT

SCCMHA has trained staff and can offer G TREM (Girls – Trauma Recovery & Empowerment Model) – since 2009. There is no current fidelity tool for this practice. SCCMHA also has practitioners trained in Trauma Focused Cognitive Behavioral Therapy.

DIALECTICAL BEHAVIOR THERAPY (DBT-A)

The family services unit of SCCMHA has DBT trained staff members as part of a team providing DBT services for youth. Staff are not yet certified in this practice area. An adolescent group

(ages 12 – 17) was initiated most recently in April. Now meeting in two groups (ages 12-14 and 15-17), these groups meet weekly, and a graduation of approximately 5 youth completing the DBT program is expected in July.

COMMUNITIES THAT CARE (CTC)

This is a community practice introduced by the Saginaw Public Health Department in 2013 as part of a Saginaw community multi-year SAMHSA grant. It is a systems prevention approach to reduction of youth risk factors through a coalition building model. The goal of CTC is to reduce substance abuse, teen pregnancy, school dropout, delinquency, violence and depression and anxiety. SCCMHA administration and Saginaw Max System of Care representatives are participating in this local effort.

PARENTING WISELY (PW)

Implemented at SCCMHA in 2008, this practice has been expanded to include many local community venues through system of care efforts. Services are provided to parents of children generally ages 3 to 18 who display mild to moderate aggressive and disruptive behaviors. While this practice is available through the SCCMHA Family Services Unit, this computerized curriculum is offered to all new parents/families entering service anywhere at SCCMHA, though not all elect to participate or finish the program it its entirety. Participation is voluntary unless there is a court order stipulating the inclusion of this program as a condition for family mental health treatment. There has not been an official external fidelity review, and there is no formal fidelity tool. However, involved staff report that they adhere closely to the curriculum. SCCMHA has modified this practice to strengthen the fidelity, including the use of weekly survey questions to ascertain progress and has also offered it in group settings to parents. This practice is also available and very effective with teen parents. Most recently 11 additional teen parents successfully completed the 11 week session.

***WRAPAROUND**

Practice:	Population Type/Scope:	Fidelity	Champion(s):
Wraparound	***Families with children involved in multiple service systems***	***Team Level***	***SCCMHA Wraparound Supervisor: Dawna Westbrook***

Local wraparound program fidelity was assessed for the first time by MDCH as part of an SED children's services waiver review in August 2012. A report was issued with feedback in various areas for improvement, but no score was issued. Wraparound is integral to the local system of care effort, and SCCMHA intends to work with SOC grant evaluators to conduct subsequent fidelity reviews using the national wraparound fidelity tool. There are 27 specific elements of wraparound fidelity measured, including the areas of culture, plan of service, choice, identification and use of supports, team meetings, mission, needs assessment, action plan, outcomes, budget, flexible funds, safety risk identification and crisis plan, roles, contacts, connection to community, and graduation.

SYSTEM OF CARE (SOC)

SCCMHA's multi-year, federally funded grant, which supports the local system of care development, implementation and sustainability effort, now known as Saginaw Max System of Care, has undergone onsite reviews by SAMHSA officials as part of the grant oversight during

the past two years. Required elements of system care could be included in future fidelity reviews to be conducted on a regular basis by SCCMHA post federal grant oversight. A strong element of the local system of care development has been an emphasis on cultural responsiveness. Wardene Talley, Project Director, and Dalia Smith, Cultural Linguistic and Competence Coordinator, have certification for the California Brief Multicultural Competence Scale (CBMCS).

SEVEN CHALLENGES

Practice: ***Seven Challenges***	Population Type/Scope: ***Adolescents with Substance Use Disorders***	Fidelity ***Individual***	**Champion(s):** ***SCCMHA FSU: Lori Denter, Westland, Erin Nostrandt, and SPSI, Fran Erwin***

A practice support and informal initial fidelity consult was conducted by Seven Challenges, LLC in August 2013. Three children's teams are involved in this practice. SCCMHA as a system has struggled to implement this practice given insufficient volume of appropriate consumers to participate in a facilitated group at trained program sites based on the model of practice. This practice is designed specifically for adolescents with drug programs, to motivate a decision and commitment to change and to support success in implementing desired changes.

MOBILE URGENT TREATMENT TEAM (MUTT) (also known as Children's Mobile Crisis Response)

This practice was initiated in 2010 by the SCCMHA FSU unit, and was recently expanded for hours of service with a dedicated supervisor to support implementation in school settings. Crisis response support is provided in children's homes or school settings on an immediate basis. There is no current fidelity process for this practice model at this time.

MULTI-DIMENSIONAL TREATMENT FOSTER CARE (MTFC)

This is a model of service SCCMHA has been exploring to develop locally to better meet the needs of some children. SCCMHA has been gaining expertise and plans to purchase this service from a provider to support children in the future. This practice is appropriate for children and adolescents who have a history of delinquency, emotional disturbance and who display ongoing antisocial behavior.

FAMILY ADVOCACY & TRAINING

This is a service provided by the Association for Children's Mental Health in Michigan, to support interested parents of severely emotionally disabled children while in receiving mental health services. Services are provided by trained parent peers who assist parents served in all aspects of support based on individual need.

VARIOUS COGNITIVE BEHAVIOR THERAPIES

This is a broad practice area of various cognitive practice models, in which individual clinicians become proficient in specific individual or family therapy methods of treatment. Therapists and other clinical staff are expected to be proficient in at least one area - Cognitive Behavioral Therapy, Brief Solution Focused Therapy, Functional Family Therapy, and/or a similar evidence-based practice area where applicable to meet consumer needs. No fidelity review has occurred in these areas at this time but this is on the work plan for the future along with centralized privileging of individual clinicians in various relevant EBPs for their job roles. Some SCCMHA practitioners have been trained in AF-CBT, Alternative for Families – Cognitive Behavior Therapy. This practice is designed to improve the relationships between children and

parents or caregivers in families involved in physical coercion and/or force and chronic conflict or hostility.

Persons With Substance Use Disorders

The Saginaw substance use disorder network has implemented a number of evidence-based and best practices throughout both treatment service delivery and prevention activities in the community, under the oversight of Saginaw County Substance Abuse Treatment & Prevention Services. A few examples of current treatment practices for adults and youth include: Seeking Safety (for persons with PSTD), Brief Solution Focused Therapy (BSFT), Cognitive Behavior Therapy (CBT),Thinking for a Change (T4C), Motivational Interviewing (MI), Seven Challenges, and Functional Family Therapy (FFT). SUD treatment programs have also been held to expectations of Dual Disorder Capable (DDC) practices, given the common occurrence of both substance use and mental health disorders. SUD programs statewide have implemented a Recovery Oriented System of Care (ROSC) and employ recovery coaches to support treatment services. Prevention programs also have a variety of best practice models in use, with which SCCMHA is less familiar at this time. SCCMHA has not been involved in any review of any specific practices being used to date, but anticipates full incorporation of SUD EBP in an annual fidelity review plan in the near future, as part of the integration transition plan at the local CMHSP and regional PIHP level. As with mental health provider programs, SCCMHA will need to seek to communicate and support 'endorsed' evidence-based practices and impact use of any non- evidence-based practices being used in the SUD panel provider network, as well as assure ongoing model fidelity.

Individuals With Intellectual Disabilities

PICTURE EXCHANGE COMMUNICATION SYSTEM (PECS)

SCCMHA has supported the training of key staff in the use of this communication method with persons who cannot fully express their needs and wants verbally. SCCMHA has recently expanded this training to additional service delivery staff members, although no fidelity review has been conducted of this practice to date. PECS is a modified applied behavioral analysis program, and an augmentative/alternative communication technique using picture cards for individuals with limited verbal abilities.

APPLIED BEHAVIOR ANALYSIS (ABA)

The provision of services to persons with Autism Spectrum Disorders (ASD) is associated with this element of behavioral modification in the evidence-based practice area. A specific autism-focused team has been developed to address assessment and treatment needs of individual consumers. ABA is not a treatment per se, but rather a well-grounded approach to working with individuals who display maladaptive or problematic behaviors. ASD services are provided for children as part of their team treatment plans to support their individualized needs with intensive, in-home services provided, with detailed treatment planning and data collection under the supervision of a licensed psychologist.

Summary & Future Planning

SCCMHA remains committed to the provision of a variety of evidence-based practices across the service array, to appropriately address individual consumer needs and to routinely review those practices for fidelity integrity. Within the SCCMHA network workforce there is now a

strong culture of enthusiasm for evidence-based practices, including the involvement of peer staff. While SCCMHA has made efforts to measure and/or facilitate external fidelity reviews, more consistent attention to fidelity reviews for all practices and follow-up is needed. For some practices where fidelity tools do not exist, SCCMHA will explore creation of tools to utilize for fidelity review purposes. SCCMHA has historically developed policies for endorsed practices, and in the near future will ensure that SCCMHA policy exists for all endorsed areas given recent practice area expansion, which include procedures to guide staff and network practitioners on an ongoing basis.

SCCMHA intends to develop resources in order to more consistently conduct and/or ensure review of fidelity for the evidence-practices endorsed in the local mental health service array of programs and supports. A new Evidence-Based Practice Coordinator position will provide dedicated coordination, not only for fidelity review and related follow-up, but also assurance of proper privileging of key staff for each practice area as needed. As SCCMHA works with TAPS in further integration, a focus on SUD practices will ensue. It is also likely that additional practices will arise as a part of targeted planning with various community partners in local priority areas.

Increasingly, measures of consumer outcomes reviewed with the provision of services by practice type will be needed. This has been conducted on a very rudimentary basis in the past using the existing assessment tools, Child and Adolescent Functional Assessment Scale (CAFAS) and Devereux Early Childhood Assessment (DECA) as outcome measurements for children. It is expected that now for adults, the Adult Needs and Strengths Assessment (ANSA) implemented by SCCMHA in the past year, will provide this option for all adults served as well. SCCMHA also needs to work to ensure integrity of the EBP data collected by practice, as well as weed out any remaining use of non-evidence-based practices in the system, replacing such with appropriate evidence-based models for staff and consumers. Finally, in addition to new research on existing practices, the increasing integration of physical and behavioral healthcare, service expansion and participation in a larger PIHP region, each may lead to new models of SCCMHA evidence-based practice involvement.

Appendices

EVIDENCE-BASED PRACTICES FIDELITY TOOLS/SCALES

Assertive Community Treatment (ACT) – DACT - page 12

Dialectical Behavior Therapy (DBT) – MDCH - page 16

Family Psychoeducation (FPE) – SAMHSA – page 23

[i]Integrated Treatment Fidelity Scale (IDDT) – SAMHSA – page 26

Parent Management Training-Oregon (PMTO) – FIMP – page 31

Peer Support Services Fidelity Scale (PSS) – SCCMHA – page 32

Supported Employment Scale (SE) – SAMHSA – page 36

Wraparound – MDCH – page 39

ACT Fidelity Scale

Human resources: Structure and composition

Criterion		Ratings / Anchors 1	2	3	4	5
H1	**Small caseload:** Consumer/ provider ratio = 10:1	50 consumers/team member or more	35–49	21–34	11–20	10 consumers/team member or fewer
H2	**Team approach:** Provider group functions as team rather than as individual ACT team members; ACT team members know and work with all consumers	Less than 10% consumers with multiple team face-to-face contacts in reporting 2-week period	10–36%	37–63%	64–89%	90% or more consumers have face-to-face contact with >1 staff member in 2 weeks
H3	**Program meeting:** Meets often to plan and review services for each consumer	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/ week	Meets at least 4 days/ week and reviews each consumer each time, even if only briefly
H4	**Practicing ACT leader:** Supervisor of Frontline ACT team members provides direct services	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	Supervisor provides services at least 50% time
H5	**Continuity of staffing:** Keeps same staffing over time	Greater than 80% turnover in 2 years	60–80% turnover in 2 years	40–59% turnover in 2 years	20–39% turnover in 2 years	Less than 20% turnover in 2 years
H6	**Staff capacity:** Operates at full staffing	Operated at less than 50% staffing in past 12 months	50–64%	65–79%	80–94%	Operated at 95% or more of full staffing in past 12 months
H7	**Psychiatrist on team:** At least 1 full-time psychiatrist for 100 consumers works with program	Less than .10 FTE regular psychiatrist for 100 consumers	.10–.39 FTE for 100 consumers	.40–.69 FTE for 100 consumers	.70–.99 FTE for 100 consumers	At least 1 full-time psychiatrist assigned directly to 100-consumer program
H8	**Nurse on team:** At least 2 full-time nurses assigned for a 100-consumer program	Less than .20 FTE regular nurse for 100 consumers	.20–.79 FTE for 100 consumers	.80–1.39 FTE for 100 consumers	1.40–1.99 FTE for 100 consumers	2 full-time nurses or more are members for 100-consumer program
H9	**Substance abuse specialist on team:** A 100-consumer program with at least 2 staff members with 1 year of training or clinical experience in substance abuse treatment	Less than .20 FTE S/A expertise for 100 consumers	.20–.79 FTE for 100 consumers	.80–1.39 FTE for 100 consumers	1.40–1.99 FTE for 100 consumers	2 FTEs or more with 1 year S/A training or supervised S/A experience
H10	**Vocational specialist on team:** At least 2 team members with 1 year training/experience in vocational rehabilitation and support	Less than .20 FTE vocational expertise for 100 consumers	.20–.79 FTE for 100 consumers	.80–1.39 FTE for 100 consumers	1.40–1.99 FTE for 100 consumers	2 FTEs or more with 1 year voc. rehab. training or supervised VR experience
H11	**Program size:** Of sufficient absolute size to consistently provide necessary staffing diversity and coverage	Less than 2.5 FTE staff	2.5–4.9 FTE	5.0–7.4 FTE	7.5–9.9	At least 10 FTE staff

Organizational boundaries

Criterion		Ratings / Anchors 1	2	3	4	5
O1	**Explicit admission criteria:** Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Has no set criteria and takes all types of cases as determined outside the program	Has a generally defined mission but admission process dominated by organizational convenience	Tries to seek and select a defined set of consumers but accepts most referrals	Typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure	Actively recruits a defined population and all cases comply with explicit admission criteria
O2	**Intake rate:** Takes consumers in at a low rate to maintain a stable service environment	Highest monthly intake rate in the last 6 months = greater than 15 consumers/month	13–15	10–12	7–9	Highest monthly intake rate in the last 6 months no greater than 6 consumers/month
O3	**Full responsibility for treatment services:** In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance abuse treatment, employment and rehabilitative services	Provides no more than case management services	Provides 1 of 5 additional services and refers externally for others	Provides 2 of 5 additional services and refers externally for others	Provides 3 or 4 of 5 additional services and refers externally for others	Provides all 5 services to consumers
O4	**Responsibility for crisis services:** Has 24-hour responsibility for covering psychiatric crises	Has no responsibility for handling crises after hours	Emergency service has program-generated protocol for program consumers	Is available by phone, mostly in consulting role	Provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement	Provides 24-hour coverage
O5	**Responsibility for hospital admissions:** Is involved in hospital admissions	Is involved in fewer than 5% decisions to hospitalize	ACT team is involved in 5%–34% of admissions	ACT team is involved in 35%–64% of admissions	ACT team is involved in 65%–94% of admissions	ACT team is involved in 95% or more admissions
O6	**Responsibility for hospital discharge planning:** Is involved in planning for hospital discharges	Is involved in fewer than 5% of hospital discharges	5%–34% of program consumer discharges planned jointly with program	35%–64% of program consumer discharges planned jointly with program	65–94% of program consumer discharges planned jointly with program	95% or more discharges planned jointly with program
O7	**Time-unlimited services (graduation rate):** Rarely closes cases but remains the point of contact for all consumers as needed	More than 90% of consumers are expected to be discharged within 1 year	From 38–90% of consumers expected to be discharged within 1 year	From 18–37% of consumers expected to be discharged within 1 year	From 5–17% of consumers expected to be discharged within 1 year	All consumers served on a time-unlimited basis, with fewer than 5% expected to graduate annually

Nature of services

Criterion		Ratings / Anchors 1	2	3	4	5
S1	**Community-based services:** Works to monitor status, develop community living skills in community rather than in office	Less than 20% of face-to-face contacts in community	20–39%	40–59%	60–79%	80% of total face-to-face contacts in community
S2	**No dropout policy:** Retains high percentage of consumers	Less than 50% of caseload retained over 12-month period	50–64%	65–79%	80–94%	95% or more of caseload is retained over a 12-month period
S3	**Assertive engagement mechanisms:** As part of ensuring engagement, uses street outreach and legal mechanisms (probation/parole, OP commitment) as indicated and as available	Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	Makes initial attempts to engage but generally focuses on most motivated consumers	Tries outreach and uses legal mechanisms only as convenient	Usually has plan for engagement and uses most mechanisms available	Demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate
S4	**Intensity of service:** High total amount of service time, as needed	Average 15 minutes/week or less of face-to-face contact for each consumer	15–49 minutes/week	50–84 minutes/week	85–119 minutes/week	Average 2 hours/week or more of face-to-face contact for each consumer
S5	**Frequency of contact:** High number of service contacts, as needed	Average less than 1 face-to-face contact/week or fewer for each consumer	1–2x/week	2–3x/week	3–4x/week	Average 4 or more face-to-face contacts/week for each consumer
S6	**Work with informal support system:** With or without consumer present, provides support and skills for consumer's support network: family, landlords, employers	Less than .5 contact/month for each consumer with support system	.5–1 contact/month for each consumer with support system in the community	1–2 contact/month for each consumer with support system in the community	2–3 contacts/month for consumer with support system in the community	4 or more contacts/month for each consumer with support system in the community
S7	**Individualized substance abuse treatment:** 1 or more team members provides direct treatment and substance abuse treatment for consumers with substance-use disorders	No direct, individualized substance abuse treatment provided	Team variably addresses SA concerns with consumers; provides no formal, individualized SA treatment	While team integrates some substance abuse treatment into regular consumer contact, no formal, individualized SA treatment	Some formal individualized SA treatment offered; consumers with substance-use disorders spend less than 24 minutes/week in such treatment	Consumers with substance-use disorders average 24 minutes/week or more in formal substance abuse treatment
S8	**Co-Occurring disorder treatment groups:** Uses group modalities as treatment strategy for consumers with substance-use disorders	Fewer than 5% of consumers with substance-use disorders attend at least 1 substance abuse treatment group meeting a month	5–19%	20–34%	35–49%	50% or more of consumers with substance-use disorders attend at least 1 substance abuse treatment group meeting/month
S9	**Dual Disorders (DD) Model:** Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence	Fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehab; recognizes need to persuade consumers in denial or who don't fit AA	Uses mixed model: e.g., DD principles in treatment plans; refers consumers to persuasion groups; uses hospitalization for rehab.; refers to AA, NA	Uses primarily DD model: e.g., DD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some SA treatment	Fully based in DD treatment principles, with treatment provided by ACT staff members
S10	**Role of consumers on team:** Consumers involved as team members providing direct services	Consumers not involved in providing service	Consumers fill consumer-specific service roles (e.g., self-help)	Consumers work part-time in case-management roles with reduced responsibilities	Consumers work full-time in case management roles with reduced responsibilities	Consumers employed full-time as ACT team members (e.g., case managers) with full professional status

ACT Fidelity Score Sheet

Date of visit: _____ / _____/ _____

Agency name: _____

Assessors' names: _____ _____

		Assessor 1	Assessor 2	Consensus
H1	Small caseload			
H2	Team approach			
H3	Program meeting			
H4	Practicing ACT leader			
H5	Continuity of staffing			
H6	Staff capacity			
H7	Psychiatrist on team			
H8	Nurse on team			
H9	Substance abuse specialist on team			
H10	Vocational specialist on team			
H11	Program size			
O1	Explicit admission criteria			
O2	Intake rate			
O3	Full responsibility for treatment services			
O4	Responsibility for crisis services			
O5	Responsibility for hospital admissions			
O6	Responsibility for hospital discharge planning			
O7	Time-unlimited services			
S1	In vivo services			
S2	No drop-out policy			
S3	Assertive engagement mechanisms			
S4	Intensity of service			
S5	Frequency of contact			
S6	Work with support system			
S7	Individualized substance abuse treatment			
S8	Co-Occurring disorder treatment groups			
S9	Co-Occurring disorders (Dual Disorders) model			
S10	Role of consumers on treatment team			
	Total mean score			

Attachment 2: On-Site Program Description Manual

In order to become an approved DBT program, the affiliation must:

Present a manual that will show that their DBT program adheres to the fidelity of DBT and that the PIHP/CMH is consistent with meeting the standards of a fully implemented DBT provider. This manual will be kept on-site and will contain information related to the DBT program's policies and procedures which guide how DBT is delivered and how fidelity is maintained regardless of staff turnover.

The manual will consist of the following information (in this order):

I. Name of team leader and team members along with DBT start date
II. Credentials and training description of each team member
III. Description of the PIHP/CMH and the clientele it serves
IV. Reason(s) for DBT and Mission Statement of the DBT Program
V. Criteria used to determine inclusion vs. exclusion into the DBT Program
VI. Protocol for treating and moving clients through Stages of Treatment
VII. Referral process and how clients are assigned therapists
VIII. Detailed description of roles of contracted/employed therapists, case managers and peer support specialists and services they provide that are related to the delivery of DBT
IX. How each mode is structured and delivered to serve its function (if modes have been adapted from the evidenced-based model of DBT, please explain in detail why the adaptation(s) was made and how you are monitoring whether or not the adapted mode is serving the function)
X. Orientation and commitment procedures for new staff to join DBT team, staff training procedures, procedures for supervision
XI. Vacation, termination and transfer protocol
XII. Process and Outcome evaluation procedures
XIII. Suicide and risk assessment protocol
XIV. DBT requires that skills coaching is provided by a trained DBT staff member and is available 24 hours a day, 7 days a week, 365 days a year. Describe how the team provides twenty-four/seven-365 skills coaching. What is the process for a DBT client to access contact with someone from the DBT team or someone who has training in DBT skills coaching and crisis/suicide management after normal business hours?
XV. Attachments:
    a. Individual therapy progress note
    b. Diary Card
    c. Skills training progress notes
    d. Any adapted skills training handouts
    e. DBT contract
    f. Emergency contact form
    g. Consultation agenda/template used to structure meetings

Attachment 4: Dialectical Behavior Therapy (DBT)
Program Evaluation Questionnaire
Michigan Department of Community Health

Date: _____ Team: _____

Team Leader: _____ Number of people on Team: _____

Address: _____

_____

Phone Number: _____

Consultant/Coach: _____

Why was this questionnaire designed?
The purpose of developing this questionnaire was to help programs within Michigan's Community Mental Health provider network to assess their readiness for approval status as a DBT provider, thus being able to utilize the DBT billing codes. It was structured around the programmatic implementation and service delivery of DBT.

Directions:
The DBT Team Leader will be in charge of filling out this questionnaire. Please write down the appropriate number in the box (0-10) for each numbered question. The answer to each question should reflect the CURRENT status of your DBT program. After the Team Leader fills out the questionnaire, they should review it with their team and administration in order to make sure that the CURRENT policies and principles are aligned with DBT and that the answers to the questions are as accurate as possible.

Stages of implementation and your program's current status:
There are typically four stages of program implementation in DBT.

1) *Exploration*: Program and staff are starting to explore the possibilities of implementing DBT within their system. They assess whether or not they are equipped to support the development of DBT, have consumers who can benefit from DBT, current policies/principles/values are aligned with DBT, have funding for training, can structure their program around DBT, etc.
2) *Early Implementation*: Staff are currently being trained in DBT. Some modes of DBT are up and running, but not all. This is typically the stage where programs are "DBT-Informed" (less comprehensive/less adherent DBT).
3) *Full Implementation*: Staff are completely trained in DBT. All modes and functions (as well as form) are concurrently up and running.
4) *Sustainability*: The DBT program has been in existence for quite some time (typically 2-4 years of being fully implemented). The program has survived staff turnover and a training program is typically in place to train new staff who are interested in joining the team. Process and outcome evaluations are a major focus in this stage of implementation in order to make sure the program is running at optimal levels.

If you believe your DBT program is either a fully implemented or sustained DBT program, it is recommended you apply for approval status. If you believe your program is in the early implementation or exploration stage of implementation, you may need more time to develop your program before applying. You can use this program evaluation as a tool to help guide where your program still needs to improve and work on.

DBT Program Evaluation

1. Does your agency currently have a DBT Program? (If YES, please fill out the rest of this evaluation; If NO, please stop here and mail this form in)	YES	NO

KEY (Use the key and select the appropriate number to answer each question)

NO	In the process	Some	YES
0 1 2	3 4 5	6 7 8	9 10

PROGRAM ELEMENTS SPECIFIC TO DBT	#
2. Agency uses DBT as the primary treatment to treat suicidal/parasuicidal clients with Borderline Personality Disorder.	
3. The theoretical orientation of the language used by team members is aligned with CBT (Specifically, behavioral principles and learning theory are at the core of consultation).	
4. Inclusion on the DBT team only occurs on a strict voluntary basis.	
5. People who are not directly involved in delivering DBT do not attend DBT consultation meetings.	
6. The team allows perspective clinicians who are looking to join the team the opportunity to sit in and observe consultation before committing.	
7. The agency allows the DBT individual therapist to coordinate and organize the client's modes of treatment and modify it when necessary.	
8. In relationship to the client's DBT treatment, all clinical interventions that might impact the treatment plan/outcomes for this client are referred directly to the individual therapist.	
9. The program offers weekly DBT skills training for service recipients.	
10. The program offers 24/7 telephonic skills coaching for service recipients.	
11. The program makes sure that DBT crisis intervention/protocols are utilized and made available to clients outside scheduled sessions.	
12. Outreach/Support is made available to care providers when appropriate (i.e. adolescents, vulnerable clients, high risk, etc.) and the support is aligned with the principles of DBT.	
13. The DBT individual therapist is available to their clients during office hours to provide skills coaching with clients in crisis and to repair the therapeutic relationship (when necessary, a back-up is available).	
14. The DBT individual therapist is available to their clients after business hours to provide skills coaching with clients in crisis and to repair the therapeutic relationship (when necessary, a back is available).	

15. Adaptations made to the standard evidenced-based model of DBT are documented, stays within the principles of DBT and are designed to fulfill the function of the mode.	
16. The DBT program has a process in place to recruit new team members and is able to assess whether or not this new recruit has the necessary knowledge/skill/ability to deliver competent DBT.	
17. The DBT program has a system in place to maintain and enhance team member morale, motivation, cohesiveness, knowledge and skill while providing DBT.	
18. The agency provides a description (including modes of treatment and expectations) of their DBT program to the public (i.e. stakeholders, policy makers, clients, client's loved ones, etc.).	
19. The length of treatment a client receives in DBT matches the functions and goals of the DBT program.	
20. The DBT program has clear inclusion and exclusion criteria.	

PROGRAM CONSULTATION TEAM	
21. Weekly DBT consultation team meetings occur at the agency.	
22. It is a requirement that all DBT therapists attend DBT consultation team meetings.	
23. The DBT program has a team leader who is in charge of the DBT program and team.	
24. The DBT consultation team is designed to treat and monitor the behaviors of the DBT team members.	
25. The DBT team elicits a commitment from potential team members for a specified length of time using DBT commitment strategies before they become a member of the team.	
26. A sufficient amount of time and opportunity is given to each team member to get consultation on cases, ask for validation or praise, or talk about team functioning.	
27. The agency makes it easy for DBT providers to get consultation from other team members outside of consultation meetings.	
28. There are clear contingencies in place if DBT team members are failing to work towards or gain knowledge and skill in DBT, if they miss consultation, or continue to engage in team interfering behaviors,etc.	

CLIENT TREATMENT AND SUPPORT	
29. Team members are able to get in touch with and use emergency services close to the client's residence.	
30. The DBT program provides treatment at times and settings clients can reasonably access (clients can access the agency, appointment times are available for those who work during the day, etc.).	
31. Program has enough DBT service providers to facilitate groups (2 per group), conduct individual sessions, provide skills coaching backup and form a consultation team.	
32. Scheduling contact with DBT clients is conducted in a way that is aligned with the principles of DBT (24-hour rule, 4 miss rule).	
33. The length of treatment for each DBT client is based on severity of the disorder and stage of treatment and whether or not DBT is or continues to be an effective treatment for the client.	
34. The frequency and length of sessions (individual and group) are designed to fulfill the function of the mode AND to match the intensity of the client's needs.	
35. The DBT program decides whether or not a client continues in DBT beyond the initial contracted time of treatment. This decision is based on reasoned evaluation (is client in Stage 1 or 2, is client benefiting from DBT, is the client still motivated to be in treatment, is the clinician still motivated to work with the client).	
36. DBT program offers support to controlled ancillary providers (offers in-services on DBT, teaches learning theory to others in the system, skills are generalized within the agency, etc.).	
DBT PROGRAM TRACKING AND CLIENT OUTCOMES	
37. DBT program tracks client outcomes.	
38. DBT program has a system in place to show the team client and family members' satisfaction/dissatisfaction with the DBT treatment.	
39. Outcome measures are of specific interest to the DBT community (major target behaviors, retention, post-treatment follow-up, decrease in hospitalizations and ER visits, decrease in cost, etc.).	

40. The DBT team leader reviews and monitors outcome data on a regular basis.	
41. The DBT team leader periodically reviews and assesses team member adherence and competence in DBT.	
42. DBT team members periodically checks and treats team members' motivation and engagement in the process of delivering adherent DBT.	
43. The DBT program monitors team member attendance at consultation, takes notes during consultation and keeps these notes in a place for DBT team members to see.	
44. The DBT program conducts assessments on the adherence to DBT (formative evaluation).	
45. The DBT program tracks data on clients in DBT (summative evaluation) and the data collected is of importance to the DBT community.	
DOCUMENTATION OF TREATMENT	
46. DBT client contact information is readily available to each DBT team member during and after business hours.	
47. Assessment/diagnostic/medication information is readily available to each DBT team member during and after business hours.	
48. Individual, skills training, and telephone consultation progress notes are designed to document that the session followed the form and structure of DBT.	
49. Consultation team notes support DBT assessment and treatment recommendations that maintain adherent DBT for each client consulted on.	
TRAINING AND SUSTAINABILITY	
50. In-house DBT training curriculum is aligned with evidenced-based DBT.	

51. In-house DBT training covers all aspects of DBT.	

52. In-house DBT training uses the latest advances, publications and research in DBT.	

ADMINISTRATION SUPPORT	
53. Agency administration provides on-going financial support for team leaders to obtain supervision/consultation and training in DBT.	
54. Agency administration provides access to Marsha Linehan's *Skills Training Manual for Treating Borderline Personality Disorder* and *Cognitive Behavioral Treatment for BPD* for all team members.	
55. Agency administration allows team members time for learning and training in DBT (not above and beyond what team members are already expected to do).	
56. Outside DBT supervision/coaching is available and designed to fit the team's level of implementation and skill.	
57. DBT supervisors/coaches demonstrate mastery and competence in DBT.	
58. When collected, formative and summative data are given to team members, administration, stake holders, and policy makers for the purpose of continued support and to improve the delivery of DBT.	

Total Score ____ / 570

Family Psychoeducation Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
1.	**Family intervention coordinator:** Designated clinical administrator who performs the following tasks: ■ Establishes, monitors, and automates family intake and engagement procedures ■ Assigns potential FPE consumers to FPE practitioners ■ Monitors and adjusts FPE practitioner caseloads ■ Arranges for training new FPE practitioners and continuing education of existing FPE staff ■ Supervises FPE staff	Agency does not have a designated staff member OR Cannot rate due to no fit.	Agency has a designated staff member who performs 1 or 2 of the tasks.	Agency has a designated staff member who performs 3 of the tasks.	Agency has a designated staff member who performs 4 of the tasks.	Agency has a designated staff member who performs all tasks.
2.	**Session frequency:** Families and consumers participate biweekly in FPE sessions.	< Every 3 months OR Cannot rate due to no fit.	Every 3 months	Every 2 months	Monthly	At least twice a month
3.	**Long-term FPE:** Families and consumers are provided with long-term FPE; specifically, at least one family member per consumer participates in FPE sessions for at least 9 months.	Most families and consumers receive less than 6 months of FPE sessions OR Cannot rate due to no fit.	Most families and consumers receive 6–7 months of FPE sessions.	Most families and consumers receive 7–8 months of FPE sessions.	Most families and consumers receive 8–9 months of FPE sessions.	More than 90% of families and consumers receive at least 9 months of FPE sessions.
4.	**Quality of practitioner-consumer-family alliance** FPE practitioners engage family members and consumers with warmth, empathy, acceptance, and attention to each individual's needs and desires.	High dropout rate OR Cannot rate due to no fit.	Sources indicate that alliance is often poor, leading to high dropout rate.	MSources indicate alliance is inconsistent or barely adequate, leading to moderate dropout rate, OR Information is inconsistent	Sources indicate a fairly strong alliance.	Sources consistently indicate a strong alliance.
5.	**Detailed family reaction:** FPE practitioners identify and specify the family's reaction to their relative's mental illnesses.	There is consistent evidence for less than 33% of involved families.	There is consistent evidence for 33–49% of involved families.	There is consistent evidence for 50–64% of involved families.	There is consistent evidence for 65–79% of involved families.	There is consistent evidence for 80% or more of involved families.
6.	**Precipitating factors:** FPE practitioners, consumers, and families identify and specify precipitating factors for the consumers' mental illnesses.	There is consistent evidence for less than 33% of involved families and consumers.	There is consistent evidence for 33-49% of involved families and consumers.	There is consistent evidence for 50–64% of involved families and consumers.	There is consistent evidence for 65–79% of involved families and consumers.	There is consistent evidence for 80% or more of involved families and consumers.
7.	**Prodromal signs and symptoms:** FPE practitioners, consumers, and families identify and specify prodromal signs and symptoms of the consumer's mental illnesses.	There is consistent evidence for less than 33% of involved families and consumers.	There is consistent evidence for 33–49% of involved families and consumers.	There is consistent evidence for 50–64% of involved families and consumers.	There is consistent evidence for 65–79% of involved families and consumers.	There is consistent evidence for 80% or more of involved families and consumers.

Family Psychoeducation Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
8.	**Coping strategies:** FPE practitioners identify, describe, clarify, and teach coping strategies.	There is consistent evidence for less than 33% of involved families and consumers.	There is consistent evidence for 33–49% of involved families and consumers.	There is consistent evidence for 50–64% of involved families and consumers.	There is consistent evidence for 65–79% of involved families and consumers.	There is consistent evidence for 80% or more of involved families and consumers.
9.	**Educational curriculum:** FPE practitioners use a standardized curriculum to teach families about mental illnesses. The curriculum covers six topics: ■ Psychobiology of the specific mental illness; ■ Diagnosis; ■ Treatment and rehabilitation; ■ Impact of mental illness on the family; ■ Relapse prevention; and ■ Family guidelines.	Less than 33% of involved families receive a standardized educational curriculum, no standardized educational curriculum exists, OR Only 1–2 topics are covered	33–49% of involved families receive a standardized educational curriculum covering all 6 topics OR Only 3 topics are covered.	50–64% of involved families receive a standardized educational curriculum covering all 6 topics OR Only 4–5 topics are covered.	65–79% of involved families receive a standardized educational curriculum covering all 6 topics.	80% or more of involved families receive a standardized educational curriculum covering all 6 topics.
10.	**Multimedia education:** Consumers and family members are given educational materials about mental illnesses in several formats (for example, paper, video, and Web sites).	Less than 33% of families and consumers receive educational materials OR Cannot rate due to no fit.	33–49% of families and consumers receive educational materials OR Materials are given in only 1 format.	50–64% of families and consumers receive educational materials OR Materials are given in only 2 formats.	65–79% of families and consumers receive educational materials in all 3 formats.	80% or more of families and consumers receive educational materials in all 3 formats.
11	**Structured group sessions:** FPE practitioners follow a structured procedure that includes the following: ■ Beginning socialization; ■ Review progress from last session's action plan; ■ Go-round; ■ Selection of a single problem; ■ Structured problem solving; and ■ Ending with socialization.	Groups include 2 or fewer components.	Groups include 3 of the 6 components.	Groups include 4 of the 6 components.	Groups include 5 of the 6 components.	Groups include all 6 components.

Family Psychoeducation Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
12.	**Structured problem–solving:** FPE practitioners use a standardized approach to help consumers and families with problem solving, which includes the following: ■ Define the problem; ■ Generate solutions; ■ Discuss the advantages and disadvantages of each solution; ■ Choose the best solution; ■ Form an action plan; and ■ Review the action plan.	No more than 2 of 6 components of the structured problem-solving are used.	3 of 6 components of the structured problem-solving are used.	4 of 6 components of the structured problem-solving are used.	5 of 6 components of the structured problem-solving are used.	All 6 components of the structured problem-solving are used.
13.	**Stage-wise provision of services:** FPE services are provided in the following: ■ Engagement; ■ 3 or more joining sessions; ■ Educational workshop; and ■ Multifamily group.	Families and consumers begin multifamily groups with minimal or no engagement, no joining sessions, or no education.	Engagement is minimal and only 1 joining session is completed before entry into the multifamily group. Education is delayed or absent.	Engagement and 2 joining sessions are completed before entry into the multifamily group. Education is delayed or absent.	Most steps are done in order; however, families enter multifamily groups before 3 joining sessions are completed or education is provided.	Engagement, all 3 joining sessions, and education are completed before entry into the multifamily group.
14.	**Assertive engagement and outreach:** FPE practitioners assertively engage all potential consumers and family members by phone, by mail, or in person (in the agency or in the community) on an ongoing basis.	FPE practitioners do not engage potential consumers and family members.	FPE practitioners engage potential consumers and family members only once as part of initial engagement.	FPE practitioners engage potential consumers and family members 2 times as part of initial engagement.	FPE practitioners assertively engage some potential consumers and family members using all necessary means on a time-limited basis.	FPE practitioners assertively engage all potential consumers and family members using all necessary contact means on an ongoing basis. FPE practitioners demonstrate tolerance of different levels of readiness using gentle encouragement.

Integrated Treatment Fidelity Scale

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

Integrated Treatment Fidelity Scale

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

Integrated Treatment Fidelity Scale

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

Integrated Treatment Fidelity Scale

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

Score Sheet: Integrated Treatment Fidelity Scale

Date of visit ____/____/____

Agency name _____

Assessors' names _____ _____

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

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

FIMP Categories Rating Form

Knutson, Forgatch, Rains, & Sigmarsdóttir, 2009

Interventionist_____Family#____Session#____Session Date_____Rater_____Content_____Phase_____Date Coded_____

Time(s) Coded: ___:___:___:-___:___:___-____:___:____-____:___:____-___:___:___-____:___:___

	Good Work	Acceptable	Needs Work
PMTO Knowledge	***9 8 7***	***6 5 4***	***3 2 1***
• Applies principles and model - Understands core/supporting parenting practices • Uses correct technical details/procedures • Integrates PMTO tools as relevant			
Structure	***9 8 7***	***6 5 4***	***3 2 1***
• Follows an agenda • Includes appropriate sections • Manages orderly flow • Appropriate attention to relevant dimensions • Responsive to family • Maintains leadership • Leads without dominating • Good transitions • Sensitive pacing • Good timing • Sums up			
Teaching	***9 8 7***	***6 5 4***	***3 2 1***
Verbal Teaching • Gives information/instructions • Provides rationales • Good PMTO raps • Pinpoints • Provides sufficient information **Active Teaching** • Uses variety of activities • Balances verbal Teaching/active Teaching • Elicits goal behavior • Engages family • Integrates/weaves information • Guides review of material • Assesses skills and fills in gaps • Pre-corrects • Breaks into teachable units • Balances encouragement/correction • Predicts problems • Leads parents to pinpoint • Adjusts PMTO tools to family • Punctuates **Use of Role Play** • Capitalizes on opportunities • Conducts sufficient number/range <u>Sets Up:</u> • Models/demonstrates • Provides enough information • Directs what to do <u>Conducts/Coaches</u> • Engages family • Models/prompts/coaches • Breaks into appropriate steps/chunks • Theatrical/Uses movement <u>Debriefs:</u> • Balances encouragement/correction • Weaves instructional material • Differentiates			
Process Skills	***9 8 7***	***6 5 4***	***3 2 1***
• Uses questioning Process • Prevents/manages resistance • Prevents/manages conflict • Maintains balance • Promotes unified approach • Encourages/supports • Connects with storyline • Uses variety of tools • Normalizes • Interpret/reframes • Metaphors • Mirrors/matches • Strategic warning • Takes responsibility • Paraphrases/summarizes • Humor • Paradox • Reflects • Supportive interrupts • Keeps contact • Movement			
Overall Development	***9 8 7***	***6 5 4***	***3 2 1***
• Application of PMTO/SIL model • Adjusts for context/situation/needs • Apparent relationship with therapist • Family making progress • Likelihood family will use • Likelihood family will come back • Family's satisfaction • Difficulty of family/situation • Growth occurred			

Evidence-Based Practice

SCCMHA Peer Support Services Fidelity Scale

Program_____ Date_____

Respondent(s) _____ Interviewer(s)_____

Criterion		Ratings / Anchors				
	Organizational Structure	(1)	(2)	(3)	(4)	(5)
OS1	The organization promotes and supports a vibrant peer culture in recognition of the experience of consumers of mental health and substance use disorder treatment services as an important component of effective service and support delivery	0 peer services are offered	Policies reflect peer services but no PSS are on staff	Less than 25% of programs/services have PSS staff	More than 50% of programs/services have PSS staff	All programs have at least 1 PSS staff
OS2	Peer Support Specialists are present or past consumers of mental health services	0% of PSS staff are current/former consumers	25% of PSS staff are current/former consumers	50% of PSS staff are current/former consumers	75% of PSS staff are current/former consumers	100% of PSS staff are current/former consumers
OS3	Peer Support Specialists report they participate as full-fledged members of treatment teams/departments/units.	0 PSS staff report participation as full-fledged members	25% of PSS staff report participation as full-fledged members	50% of PSS staff report participation as full-fledged members	75% of PSS staff report participation as full-fledged members	100% of PSS staff report participation as full-fledged members
OS4	Peer Support Specialists' services are offered to all consumers	PSS services are not offered	PSS services are offered to 25% of consumers	PSS services are offered to 50% of consumers	PSS services are offered to 75% of consumers	PSS services are offered to all consumers (100%)
OS5	Peer Support Specialists work with consumers in a range of settings, including treatment offices, consumers' homes, hospitals, and community settings	PSS staff do not work in any settings	PSS staff work in 1 setting	PSS staff work in more than setting	PSS staff work in most settings	PSS staff work in all settings
OS6	Each SCCMHA-funded adult case management team has at least one PSS position.	CM teams do not include PSS staff	20% of CM teams include PSS staff	50% of CM teams include PSS staff	75% or more CM teams include PSS staff	More than 1 PSS staff is included in CM teams

OS7	Peer Support Specialists provide a wide range of peer support services to consumers to assist them in regaining control over their lives, the recovery process, and attain personal goals of community membership, independence, and productivity.	0 services provided	1 services is provided	2-3 services are provided	4 services are provided	More than 5 services are provided
OS8	Consumers are given a choice, where possible, of Peer Support Specialists with whom they work.	No choice is given	Choice of more than 1 PSS staff on average	Choice of 2 or more PSS staff is given on average	Choice of 3 or more PSS staff is given on average	Choice of more than 4 PSS staff is given on average
OS9	Peer Support Specialists are provided with individual supervision by qualified mental health professionals.	No individual supervision is provided	Individual supervision is provided by unqualified staff	Supervision is provided in group format by unqualified staff	Group supervision is provided by qualified staff	All PSS staff are individually supervised by qualified staff
SERVICES		(1)	(2)	(3)	(4)	(5)
S1	Peer Support Specialists model and teach effective communication, recovery-oriented living, effective coping/problem-solving skills, and self-help strategies to consumers.	0% of consumers receive coping skills training	25% of consumers receive coping skills training	50% of consumers receive coping skills training	75% of consumers receive coping skills training	100% of consumers receive coping skills training
S2	Peer Support Specialists assisting consumers in identifying their personal recovery goals, setting objectives for each goal, and determining interventions to be used based on consumers' recovery/life goals.	0% of consumers receive help with goals	25% of consumers receive help with goals	50% of consumers receive help with goals	75% of consumers receive help with goals	100% of consumers receive help with goals
S3	Peer Support Specialists are actively involved in consumers' person-centered recovery plans.	0 involvement	25% of consumers have active PSS involvement	50% of consumers have active PSS involvement	75% of consumers have active PSS involvement	100% of consumers have active PSS involvement
S4	Peer Support Staff orient new consumers to SCCMHA-funded services and supports.	0% of new consumers receive orientation	25% of new consumers receive orientation	50% of new consumers receive orientation	75% of new consumers receive orientation	100% of new consumers receive orientation
S5	Peer Support Specialist function as liaisons to community resources, and assisting consumers in accessing and using such resources.	0% of consumers receiving peer support receive liaison activity	25% of consumers receiving peer support receive liaison activity	50% of consumers receiving peer support receive liaison activity	75% of consumers receiving peer support receive liaison activity	100% of consumers receiving peer support receive liaison activity
S6	Peer Support Specialists advocate for the full	0% of	25% of	50% of	75% of consumers	100% of consumers

	integration of individuals into communities of their choice and promoting the inherent value of those individuals to those communities.	consumers receive advocacy	consumers receive advocacy	consumers receive advocacy	receive advocacy	receive advocacy
S7	Peer Support Staff provide input during staff and person-centered planning meetings.	0 input	25% of meetings have documented input	50% of meetings have documented input	75% of meetings have documented input	100% of meetings have documented input
TRAINING		(1)	(2)	(3)	(4)	(5)
T1	Peer Support Specialists receive standardized, accredited training (and are eligible for certification).	0% of PSS staff receive training	25% of PSS staff receive training	50% of PSS staff receive training	75% of PSS staff receive training	100% of PSS staff receive training
T2	All non peer staff members receive an orientation to peer support services.	0% of non-consumer staff receive orientation	25% of non-consumer staff receive orientation	50% of non-consumer staff receive orientation	75% of non-consumer staff receive orientation	100% of non-consumer staff receive orientation
T3	Peer Support Specialists have opportunities provide in-service training to agency staff.	0% of PSS staff have opportunities to provide trainings	25% of PSS staff have opportunities to provide trainings	50% of PSS staff have opportunities to provide trainings	75% of PSS staff have opportunities to provide trainings	100% of PSS staff have opportunities to provide trainings
T4	Peer Support Specialists attend relevant seminars, meetings, and in-service training.	0% of PSS staff participate in ongoing training	25% of PSS staff participate in ongoing training	50% of PSS staff participate in ongoing training	75% of PSS staff participate in ongoing training	100% of PSS staff participate in ongoing training

Data Sources:

- Management Information System
- Document review: clinical records, agency policy and procedures
- Interviews with consumers, staff, and families
- Observation (e.g., team meetings, shadowing peer support staff)
- Individual Service/Support Plans
- Training database

80 – 85	= Exemplary Fidelity
75 - 84	= Good Fidelity
65 – 74	= Fair Fidelity
73 and below	= Poor Fidelity

SCCMHA Peer Support Services Fidelity Scale Score Sheet

Organization		Score	Comments
1.	The organization promotes and supports a vibrant peer culture in recognition of the experience of consumers of mental health and substance use disorder treatment services as an important component of effective service and support delivery.	Score:	
2.	Peer Support Specialists are present or past consumers of mental health services.	Score:	
3.	Peer Support Specialists report they participate as full-fledged members of treatment teams/units/departments.	Score:	
4.	Peer Support Specialists' services are offered to all consumers.	Score:	
5.	Peer Support Specialists work with consumers in a range of settings, including treatment offices, consumers' homes, hospitals, and community settings.	Score:	
6.	Each SCCMHA-funded adult case management team has at least one PSS position.	Score:	
7.	Peer Support Specialists provide a wide range of peer support services to consumers to assist them in regaining control over their lives and recovery process, and attain personal goals of community membership, independence, and productivity.	Score:	
8.	Consumers are given a choice, where possible, of peer support specialists with whom they work.	Score:	
9.	Peer Support Specialists are provided with individual supervision by qualified mental health professionals.	Score:	
Services – PSS Self-Report Meaures			
1.	Peer Support Specialists model and teach effective communication, recovery-oriented living, effective coping/problem-solving skills, and self-help strategies.	Score:	
2.	Peer Support Specialists assist consumers in identifying their personal recovery goals, setting objectives for each goal, and determining interventions to be used based on consumer's recovery/life goals.	Score:	
3.	Peer Support Specialists are actively involved in consumers' person-centered recovery plans.	Score:	
4.	Peer Support Specialists orient new consumers to SCCMHA-delivered services and supports.	Score:	
5.	Peer Support Specialists function as liaisons to community resources and assist consumers in accessing and using such resources.		
6.	Peer Support Specialists advocate for the full integration of individuals into communities of their choice and promote the inherent value of those individuals to those communities.	Score:	
7.	Peer Support Specialists provide input to colleagues during staff and person-centered planning meetings.	Score:	
Training			
1.	Peer Support Specialists receive standardized and accredited training and are eligible for certification.	Score:	
2.	All non-peer staff members receive an orientation to peer support services.	Score:	
3.	Peer Support Specialists have opportunities to provide in-service training to agency staff.	Score:	
4.	Peer Support Specialists attend relevant seminars, meetings, and in-service training.	Score:	
Scoring	**Total:**		

Supported Employment Fidelity Scale

	Criteria	Ratings / Anchors 1	2	3	4	5
Staffing						
1.	**Caseload:** Employment specialists manage caseloads of up to 25 consumers.	A ratio of 81 or more consumers per employment specialist, or Cannot rate due to no fit	A ratio of 61 to 80 consumers per employment specialist	A ratio of 41 to 60 consumers per employment specialist	A ratio of 26 to 40 consumers per employment specialist	A ratio of 25 or fewer consumers per employment specialist
2.	**Vocational services staff:** Employment specialists provide only vocational services.	Employment specialists provide nonvocational services such as case management 80% or more of the time, or Cannot rate due to no fit	Employment specialists provide nonvocational services such as case management about 60% of the time	Employment specialists provide nonvocational services such as case management about 40% of the time	Employment specialists provide nonvocational services such as case management about 20% of the time	Employment specialists provide only vocational services
3.	**Vocational generalists:** Each employment specialist carries out all phases of vocational service including engagement, assessment, job development, job placement, job coaching, and follow-along supports.	Employment specialists provide only vocational referrals to other vendors or programs, or Cannot rate due to no fit	Employment specialists maintain caseloads but refer consumers to other programs for vocational service	Employment specialists provide 1 aspect of the vocational service	Employment specialists provide 2 or more phases of vocational service but not the entire service	Employment specialists carry out all phases of vocational service
Organization						
1.	**Integration of rehabilitation with mental health treatment:** Employment specialists are part of the mental health treatment teams with shared decisionmaking. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.	Employment specialists are part of a vocational program, separate from the mental health treatment. No regular direct contact with mental health staff, only telephone or 1 face-to-face contact per month, or Cannot rate due to no fit	Employment specialists attend treatment team meetings once per month	Employment specialists have several contacts with treatment team members each month and attend 1 treatment team meeting per month	Employment specialists are attached to 1 or more case management treatment teams with shared decisionmaking; attend weekly treatment team meetings	Employment specialists are attached to 1 or more case management treatment teams with shared decisionmaking; attend 1 or more treatment team meetings per week and have at least 3 consumer-related case manager contacts per week
2.	**Vocational unit:** Employment specialists function as a unit rather than a group of practitioners. They have group supervision, share information, and help each other with cases.	Employment specialists are not part of a vocational unit, or Cannot rate due to no fit	Employment specialists have the same supervisor but do not meet as a group	Employment specialists have the same supervisor and discuss cases between each other; they do not provide services for each other's cases	Employment specialists form a vocational unit and discuss cases between each other; they provide services for each other's cases	Employment specialists form a vocational unit with group supervision at least weekly; provide services for each other's cases and backup and support for each other

Supported Employment Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
3.	**Zero-exclusion criteria:** No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms	Consumers are screened out based on formal or informal eligibility requirements, or Case managers first screen referrals, or Cannot rate due to no fit	Some eligibility criteria, or Vocational staff who make consumer referrals to other vocational programs screen referrals	Some eligibility criteria, or Vocational staff who provide the vocational service screen referrals	All consumers are eligible and services are voluntary. Referral sources are limited	All consumers are encouraged to participate, and Several sources (self-referral, family members, self-help groups, etc.) solicit referrals
Services						
1.	**Ongoing, work-based vocational assessment:** Vocational assessment is an ongoing process based on work experiences in competitive jobs.	Vocational evaluation is conducted before job placement with emphasis on office-based assessments, standardized tests, intelligence tests, and work samples, or Cannot rate due to no fit	Consumer participates in a prevocational assessment at the program site (e.g. work units in a day program)	Assessment occurs in a sheltered setting where consumers carry out work for pay	Most of the assessment is based on brief, temporary job experiences in the community that are set up with the employer	Vocational assessment is ongoing and occurs in community jobs. Minimal testing may occur but not as a prerequisite to the job search. Aims at problem-solving using environmental assessments and considering reasonable accommodations
2.	**Rapid search for competitive jobs:** The search for competitive jobs occurs rapidly after program entry.	First contact with an employer about a competitive job is typically more than 1 year after program entry, or Cannot rate due to no fit	First contact with an employer about a competitive job is typically at more than 9 months and within 1 year after program entry	First contact with an employer about a competitive job is typically at more than 6 months and within 9 months after program entry	First contact with an employer about a competitive job is typically at more than 1 month and within 6 months after program entry	First contact with an employer about a competitive job is typically within 1 month after program entry
3.	**Individualized job search:** Employer contacts are based on consumers' job preferences (relating to what they enjoy and their personal goals) and needs (including experience, ability, how they affect a good job and setting match) rather than the job market (that is, what jobs are readily available).	Employer contacts are based on decisions made unilaterally by the employment specialist. These decisions are usually driven by the nature of the job market, or Cannot rate due to no fit	About 25% of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market	About 50% of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market	About 75% of employer contacts are based on job choices which reflect consumers' preferences and needs rather than the job market	Most employer contacts are based on job choices, which reflect consumers' preferences and needs rather than the job market
4.	**Diversity of jobs developed:** Employment specialists provide job options that are in different settings.	Employment specialists provide options for either the same types of jobs for most consumers, e.g., janitorial, or jobs at the same settings, or Cannot rate due to no fit	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, about 75% of the time	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, about 50% of the time	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, about 25% of the time	Employment specialists provide options for either the same types of jobs, e.g., janitorial, or jobs at the same work settings, less than 10% of the time

Supported Employment Fidelity Scale

Criteria		Ratings / Anchors 1	2	3	4	5
5.	**Permanence of jobs developed:** Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status.	Employment specialists usually do not provide options for permanent, competitive jobs, or Cannot rate due to no fit	Employment specialists provide options for permanent, competitive jobs about 25% of the time	Employment specialists provide options for permanent, competitive jobs about 50% of the time	Employment specialists provide options for permanent, competitive jobs about 75% of the time	Virtually all competitive jobs offered by employment specialists are permanent
6.	**Jobs as transitions:** All jobs are viewed as positive experiences on the path of vocational growth and development. Employment specialists help consumers end jobs when appropriate and then find new jobs.	Employment specialists prepare consumers for a single lasting job, and if it ends, will not necessarily help them find another one, or Cannot rate due to no fit	Employment specialists help consumers find another job 25% of the time	Employment specialists help consumers find another job 50% of the time	Employment specialists help consumers find another job 75% of the time	Employment specialists help consumers end jobs when appropriate and offer to help them all find another job
7.	**Follow-along supports:** Individualized, follow-along supports are provided to employer and consumer on a time-unlimited basis. Employer supports may include education and guidance. Consumer supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and supportive networks (friends and family).	Follow-along supports are nonexistent, or Cannot rate due to no fit	Follow-along supports are time-limited and provided to less than half of the working consumers	Follow-along supports are time-limited and provided to most working consumers	Follow-along supports are ongoing and provided to less than half the working consumers	Most working consumers are provided flexible, follow-along supports that are individualized and ongoing
8.	**Community-based services:** Vocational services such as engagement, job finding, and follow-along supports are provided in community settings.	Employment specialists spend 10% of time or less in the community, or Cannot rate due to no fit	Employment specialists spend 11–39% of time in community	Employment specialists spend 40–59% of time in community	Employment specialists spend 60–69% of time in community	Employment specialists spend 70% or more of time in community
9.	**Assertive engagement and outreach:** Assertive engagement and outreach (telephone, mail, community visits) are conducted as needed.	Employment specialists do not provide outreach to consumers as part of initial engagement or to those who stop attending the vocational service, or Cannot rate due to no fit	Employment specialists make 1 contact to consumers as part of initial engagement or to those who stop attending the vocational service	Employment specialists make 1 or 2 contacts as part of initial engagement or within 1 month when consumers stop attending the vocational service	Employment specialists make multiple contacts as part of initial engagement and at least every 2 months on a time-limited basis when consumers stop attending the vocational service	Employment specialists make multiple contacts as part of initial engagement and at least monthly on a time-unlimited basis when consumers stop attending the vocational service, and Employment specialists demonstrate tolerance of different levels of readiness using gentle encouragement

WRAPAROUND: FIDELITY TO THE MODEL

Indicator / Evidence	Degree to Which Standard is Met			Findings/Comment
	Full	Partial	Inadequate	
W-1 A Strength and Culture Discovery is completed for each member of the family, and for the family as a whole. (evidence: the Strength and Culture Discovery is completed and maintained in the record)				
W-2 The Strength and Culture Discovery is holistic and crosses life domain areas. (evidence: the Strength and Culture Discovery addresses skills, abilities, values, traditions, interests, preferences, etc; and life domains)				
W-3 Results of the Strength and Culture Discovery are incorporated in the Plan of Service (POS). (evidence: planned interventions and strategies incorporate individual / family strengths and culture)				
W-4 People that support the child and family across various areas of their lives are identified. (evidence: meeting minutes, notes of discussions, and/or POS/PCP documents identify family, friends, neighbors, professionals, school personnel, etc.)				
W-5 The child, youth or family choose who participates on the wraparound team. (evidence: POS/PCP paperwork; meeting minutes; case file notes)				
W-6 Wraparound team meetings and attendance at meetings are documented. (evidence: minutes document each meeting and attendance)				
W-7 Wraparound team meetings are held at least weekly initially and subsequently no less than twice monthly while enrolled in the SEDW unless otherwise documented in a transition plan. (evidence: minutes of meetings)				
W-8 A mission statement is developed / articulated for each wraparound team. (evidence: the POS; minutes)				
W-9 A needs assessment across life domain areas is completed. (evidence: assessment format includes all domains and the assessment is				

Indicator / Evidence	Degree to Which Standard is Met			Findings/Comment
	Full	Partial	Inadequate	
maintained in the record)				
W-10 Needs are prioritized by the family. (evidence: family priorities are clearly evident in minutes, notes, and/or POS)				
W-11 The wraparound team develops an action plan that identifies alternative strategies (various ways) to meet identified needs. (evidence: meeting minutes; alternative strategies are outlined in the plan)				
W-12 The Wraparound plan contains strategies or interventions that pertain to natural supports and other community resources, in addition to billable services. (evidence: the POS)				
W-13 Outcomes are measurable and method of measurement is identified for each outcome. (evidence: measurement format, meeting minutes and/or POS)				
W-14 Outcomes are monitored and evaluated at least monthly by the Child and Family Team, and by the Community Team at least every 6 months. (evidence: meeting minutes, outcome tool, Community Team 6-month Review format)				
W-15 The Community Team reviews the plan and budget on a regular basis. This means at least initially, every 6 months and at graduation; crisis and safety plans are reviewed more frequently – as appropriate to need. (evidence: signatures / dates on the budget and plan)				
W-16 The plan and budget are updated to reflect new interventions and services. (evidence: case notes, meeting minutes, budget reflects the plan)				
W-17 Flexible funds are used as a last resort and community outreach is done to meet some needs of the child and family. (evidence: Community Team authorization of budget; budget form identifies other community resources)				
W-18 The Child and Family Team identified and addressed safety risks. (evidence: the Safety Plan)				

Indicator / Evidence	Degree to Which Standard is Met			Findings/Comment
	Full	Partial	Inadequate	
W-19 Worries, concerns and potential crisis / safety areas are identified and planned. (evidence: the Crisis / Safety Support Plan)				
W-20 The crisis / safety plan identifies both proactive and reactive steps / interventions. (evidence: the Crisis / Safety Support Plan)				
W-21 The crisis / safety plan includes interventions that are culturally relevant and strength-based. (evidence: the crisis / safety plan is consistent with the results of the Strength and Culture Discovery)				
W-22 All team members have a defined role in implementing the crisis / safety plan. (evidence: roles of each team member are specified in the crisis / safety plan)				
W-23 All contacts are documented in the file. (evidence: case file notes; minutes)				
W-24 A transition plan is developed and it outlines how the family will continue to get their needs met after the child / youth is off the SEDW. (evidence: plan, outcomes measurement format and/or transition plan)				
W-25 A graduation summary identifies overall progress on outcomes and transition to other services / supports. (evidence: the graduation summary)				
W-26 The child / youth and his/her family have identifiable connection to the community. (evidence: included in the graduation summary)				
W-27 The Community Team agreed with / to the graduation plan. (evidence: signature of Community Team members on the graduation plan)				

[i] MDCH/MiFAST uses a combination of the SAMHSA fidelity scale as well as the GOI to conduct IDDT team reviews for fidelity. The GOI is included in all of the SAMHSA EBP toolkits as a part of fidelity monitoring.