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Examining the Interrater Reliability of the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS)

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by

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This dissertation is one step in the continuing development, evaluation, and validation of the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS). The CIMHRRS is an instrument to guide comprehensive assessment of programs that provide integrated services to people with serious mental illness (SMI). The CIMHRRS was developed for use in services research and program evaluation.

The purpose of the project described in this dissertation was to evaluate three key aspects of its performance in real world application: 1) its practical feasibility, 2) internal consistency and reliability, 3) its ability to distinguish between different programs. The project utilized a combination of principles and methods, associated with psychometric scale development, field methods, and program evaluation. Using a structured site review process, program evaluations were conducted at five SMI service programs that reflect the diversity found in mental health systems. The service programs represent points on a continuum of services for an adult SMI population. Programs varied by location (urban, rural), setting (inpatient, residential, community), security (maximum, medium), service provision, and estimated levels of psychiatric rehabilitation and recovery-oriented services. Investigators assessed program organization, policy and

procedures, fidelity to policies and procedures, and outcome. Data collected while on site was used to evaluate the CIMHRRS' practicability and its psychometric properties, and determine its capacity to differentiate qualitative aspects of the service programs.

Overall, the CIMHRRS demonstrated excellent internal consistency across all subjectively rated items (α=.98) and good to excellent internal consistency within each subjectively rated domains (α=.82 to α=.96). The CIMHRRS demonstrated excellent interrater agreement (97% - 100%) and interrater reliability (.99). It demonstrated an ability to differentiate qualitative dimensions of the various programs.

The results of this project indicate that the CIMHRRS is a practical, reliable instrument for program evaluation and services research. It is expected to be especially valuable for studying the characteristics of psychiatric rehabilitation, recovery and related approaches to determine their impact on clinical outcome.

Dedication

To my mother Patricia Didier and my Grandparents Blanche and Bob Freemole, while you are not here to share in the celebration of this milestone in my life, your spirit lives on and can be found in the pages of my life and work.

To my parents, Bill and Loretta Johnson, thank you for all your love and sharing the life lessons that have allowed me to accomplish this monumental task. Thank you for not only teaching but also demonstrating the true meaning of a hard day's work and the value of being true to oneself.

To my family and friends, to whom the completion of my Ph.D. is as significant for them as it is for me, I thank you for your unconditional support throughout this process. Through your support, I managed to stay balanced and humble.

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Time spent training in UNL's Clinical Psychology Training Program (CPTP) will always be a source of pride. I will always look back on my experiences there fondly. Special thanks are extended to Dr. Debra Hope for her guidance, supervision, and unwavering support in my development as a clinician and scientist.

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Chapter 1

Introduction

Examining the Interrater Reliability of the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS).

Over the past 3 decades, treatment and related services for people with serious mental illness (SMI) have undergone substantial evolution, a process that continues to accelerate today. Services are increasingly provided as comprehensive, multi-modal "packages" or programs, consisting of specific evidence-based components, integrated and coordinated by interdisciplinary treatment planning and related activities. The organizational characteristics of such packages, and the specific components they include, have become highly diverse. It is logical to expect that optimum cost-effectiveness will be determined by the specific components of programs and the theories and principles that guide their organization and delivery. However, there is currently no measure or instrument that can adequately characterize and contrast the diversity of existing programs, and so comparative outcome research remains focused on specific treatments and other program components. Consequently, program administrators and regulatory bodies have lacked an instrument to measure the comprehensive integration of these concepts into services settings. To take SMI outcome research to its next stage of evolution, a new instrument is necessary. The following discussion reviews the historical developments that set the stage for contemporary service program research, and identifies the required characteristics of a new methodological tool for characterizing and comparing comprehensive SMI service programs.

More recently, in the past ten years, there has been a distinct movement toward a comprehensive recovery-oriented philosophy for the treatment of people with serious mental illness (SMI) (Surgeon General's Report on Mental Health, 1999; President's New Freedom Commission on Mental Health 2003; Federal Action Agenda, 2005, Uniformed Mental Health Services Package, 2008). The principles set forth in these documents set in motion major policy reformation in the U.S. Substance Abuse & Mental Health Services Administration (SAMHSA), the Joint Commission on Accreditation of Healthcare Organizations (JCHAO), the Veterans Administration and various national healthcare professional organizations. Until recently, there were no comprehensive instruments that summarized the integration of recovery-oriented services across multiple service sites. The need for this type of instrument prompted the principal investigator to develop the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS).

The purpose of this project was the continued development, and evaluation of the CIMHRRS for comprehensive assessment of programs that provide integrated services to people with a serious mental illness (SMI). Because the CIMHRRS is a newly developed instrument, investigation of its utility was warranted. The specific objectives of this project were 1) ensure complete content validity through consultation with experts on specific evidence-based practice modalities, psychiatric rehabilitation, and recovery from SMI, 2) ensure that the feasibility and interrater reliability can be maintained as content validation proceeds, 3) test the instrument in a broad array of SMI service programs and settings, and 4) analyze the capacity of the CIMHRRS to differentiate qualitative aspects of service provision.

It was hypothesized that rater agreement would meet acceptable reliability criteria (90%) with an intraclass correlation coefficient of .70 or higher. Internal consistency of the instrument's putative subscales was expected to meet the appropriate alpha criterion (α=.60). Lastly, it is hypothesized that the CIMHRRS would have the capacity to identify qualitative differences in the integration of psychiatric rehabilitation and recovery-oriented services.

Chapter 2

Literature Review

The Evolution of Community Based Services

Public sector treatment for SMI has undergone major structural changes over the past half century. The Community Mental Health Centers Construction act of 1963 and the process of deinstitutionalization changed the focus of public sector mental health from an institution-based to a community-based system. This process of moving mental health services from institutions to community-based services continues and has brought into question the need for long-term inpatient services. As a result, numerous states have closed or are in the process of closing state hospitals and developing community based services. Unfortunately, some of these closures are premature, as development of community services has not always kept the pace, and there is often a lack of viable supports and planning to support the transition. Among the consequences have been increases in homelessness, a disproportionate presence of people with SMI in the correctional system and personal tragedies due to ill considered risk factors (Bachrach, 1983, 1999; Scalora, 1999).

The premature actions of the past have induced some circumspection in the scientific, professional and policy communities about how the reformation of SMI services should proceed. There is some consensus that specialized community-based services can be safe and effective for most, if not all, people with SMI. However, there is no consensus about the specific nature of such services, or even whether a single model or approach can effectively serve all consumers. There are doubtless a number of factors that contribute to this lack of consensus, including the diversity of the population, the

rapid development of new treatments and other clinical technologies, and changing theoretical and social perspectives on SMI itself. Future development of SMI services will depend on a greater understanding of these factors, and on research methods that address them in the process of service development. For the purposes of the proposed project, these factors can be usefully discussed in terms of: 1) the concepts of recovery and rehabilitation; 2) the relevance of evidence-based practice; and 3) the development of Assertive Community Treatment.

The Recovery and Rehabilitation Movement

Nationally, there is a distinct movement toward a comprehensive philosophy for the treatment of people with SMI. Although the key concepts in this philosophy date back at least to the late 1970's, they gained a national forum in the 1999 Surgeon General's Report on Mental Health (U.S.D.H., 1999), and more recently in the report of the President's New Freedom Commission on Mental Health (2003). The principles set forth in the latter document set in motion major policy reformation in the U.S. Substance Abuse & Mental Health Services Administration (SAMHSA), the Joint Commission on Accreditation of Healthcare Organizations (JCHAO), the Veterans Administration (probably the largest single healthcare organization in the world) and various national healthcare professional organizations. The conceptual lynchpin of this reformation process is the concept of recovery.

There is no unitary definition of recovery. A review of the literature suggests that the concept of recovery is dependent upon which group is seeking to define the term (Bellack, 2006; Davidson, 2005; Frese, 2001). However, the common elements include a primary value on gaining autonomy and independence, in contrast with the traditional

focus on controlling symptoms and preventing relapse or hospitalization. The recovery concept provides a sense of hopefulness to consumers, with the idea that their diagnosis is not a terminal condition but rather one of possibility. It posits that people are more than their diagnosis, auguring against stigmatization and the implication that they are somehow responsible for their diagnosis. The concept implies that people with serious mental illness must have a voice in their treatment, and a sense of responsibility, instead of being a passive recipient of services. This concept is outlined by the second principle of the President's New Freedom Commission on Mental Health (2003), regarding the transformation of the current mental health system. Although recovery is a philosophical concept, incorporating social values not necessarily subject to scientific scrutiny, it does have implications for the purposes and outcomes of services, and these are subject to empirical evaluation.

Psychiatric rehabilitation is a comprehensive approach to assessment and treatment of SMI. It is closely associated with the concept of recovery, and together they provide an integration of social values, scientific understanding of severe mental illness, effective clinical practices, domains of operational outcome measurement, and implications for service systems (President's New Freedom Commission, 2003, Goal 2.2). Psychiatric rehabilitation can be usefully understood as a technology for enhancing recovery. From its beginnings four decades ago (Anthony et al, 1972; Anthony & Liberman, 1992), psychiatric rehabilitation has evolved along with the specific technologies it incorporates toward an increasingly complex, but integrated approach (Wallace et al, 2001; Spaulding et al, 2003) . Although state-of-the-art psychiatric rehabilitation is not universally available, for over 20 years now it has been practiced in

many scattered venues, usually associated with academic research programs and/or academic/public sector collaborations.

While evidence tends to support the overall cost effectiveness of the psychiatric rehabilitation model for enhancing recovery, unresolved questions remain about individualization of treatment regimens, treatment interactions and related complexities (reviewed by Wallace et al, 2001). These questions are inspired primarily by the recovery concept, which implies that desirable outcomes are multidimensional, unique to individuals, and ultimately linked to one's perceived quality of life. Most relevant to this proposed project, it is clear that psychiatric rehabilitation will have to be a flexible collection of interrelated methods and approaches, adaptable to individual needs, yet cost-effective and accessible in the settings in which people with SMI are served.

The theoretical basis of psychiatric rehabilitation is inseparable from the concept of recovery. From the beginning, psychiatric rehabilitation eschewed "cure" as an end goal, and emphasized instead the importance of functional abilities for overcoming disabilities produced by illness. However, as the concept of recovery has itself evolved, it is increasingly clear that psychiatric rehabilitation will need a more sophisticated and holistic theoretical basis. The need for more complete theory is also stimulated by the rapid expansion of psychiatric rehabilitation technology, increasingly incorporating neurophysiological, neurocognitive, social-cognitive, behavioral and environmental principles. Expanded theoretical accounts of psychiatric rehabilitation have begun to appear (e.g. Spaulding et al 2003), and it is clear that an integrated theoretical basis will be important in its future development. Accordingly, research methods for studying SMI services, including psychiatric rehabilitation, should also be consistent with advanced

theoretical syntheses that incorporate multiple levels of organismic functioning and environmental factors.

The recovery concept also has implications for who should be involved in the evaluation of psychiatric rehabilitation. The subjective dimensions of well-being and quality of life indicate that purely objective criteria are ultimately insufficient, even functional criteria such as acquiring social competence or gainful employment. The importance of any objective criterion is determined, at least in part, by its subjective significance to the person pursuing the criterion. This means that the consumers of rehabilitation services must be intimately and systematically involved in design of research and analysis of its data. Logically, that also means that early involvement of consumers in service development research should more efficiently lead to services that meet all the goals mandated by the President's Commission report.

Evidence Based Practice

In recent years the concept of evidence based practice (EBP) has become a major focus of attention in healthcare, within and outside of mental health (e.g. Morrison, 2004; Drake, Rosenberg, Teague, Bartels, & Torrey, 2003; Essock, Goldman, Van Tosh et al., 2003; Hermann & Provost, 2003; Lehman, Buchanan, Dickerson, et al., 2003). This attention is having a pronounced impact on development, evaluation and dissemination of psychiatric rehabilitation. Although the idea that clinical practice should be informed by scientific research would strike many as not a new idea, there is widespread agreement that many, if not most, clinical practices do not reflect what has been scientifically established to be effective. There is not widespread agreement on exactly what the criteria of "evidence based" should be, or exactly what practices should be "evidence

based." Definitions in the discourse range from specific treatments tested in randomized controlled trials to broader combinations of tested treatments, rational assessment and decision making, and systematic consideration of consumer/patient values and desires (e.g. American Psychological Association Task Force on Evidence-based Practice, 2005). A broader definition is more consistent with the principles of rehabilitation, which recognize that decisions must be informed by holistic considerations and subjected to empirical validation on a case-by-case basis (Spaulding et al, 2003, chap. 3).

The recovery movement has brought further urgency to the need for evidence-based practice, and the President's Commission report (2005) calls for a national effort to strengthen the evidence base as well accelerate dissemination. However, the consumer activism that has propelled the recovery movement also generates concerns about conventional notions of evidence in the context of mental health services. Consumers are concerned that an overriding emphasis on evidence-based practices will limit the opportunity for funding innovative consumer based practices that support consumers' goals of self determination and recovery (Marzilli, 2002; Kanapaux, 2003; Miller & Thompson, 2004; New York State Consumers, Survivors and Ex-Patients, 2004). Consumers question traditional scientific standards and promote the value of the qualitative experiences of the individual narratives of people who have moved beyond the limitations of their diagnosis (Kanapaux, 2003). All aspects of research and evidence-based practice activities about people living with SMI have been vigorously criticized as lacking sufficient consumer input at all levels and stages (Prager, & Tanaka, 1979; Campbell & Schraiber, 1989; Campbell, Ralph & Glover, 1993; Scott, 1993; Fenton, Batavia & Roody; 1993; Ralph, 1994; Everett & Boydell, 1994; Campbell & Johnson, J.

1995; Campbell, 1996; Ralph, Lambric & Steele, 1996; Campbell, 1997; Campbell, 1999; Campbell & Zahira DuVall, 2001). These concerns have contributed to the increased representation of consumers in academic-based research groups, although it is unclear whether such representation has influenced development or dissemination of evidence based practice. As with psychiatric rehabilitation research in general, the research that supports evidence based practice would benefit from more systematic inclusion of consumers' perceptions and experiences in actual treatment or other services.

Closely related to concerns about holistic and subjective considerations in EBP is concern about the individualization of treatment (Frese et al., 2001). This concern is expressed in the current draft NIMH Strategic Plan (NIMH, 2007) as "personalization," one of the "4 'P's" of mental health treatment research, using knowledge of individuals and circumstances to tailor treatment. There is a pervasive tendency for mental health policy to adopt a "one size fits all" presumption about service needs. There is also concern that an overly narrow focus on specific empirically validated treatment modalities would exacerbate this tendency ("we'll provide the one treatment that benefits the largest proportion of the entire population, regardless of how big that proportion is or what individual differences might moderate treatment effects"). People with SMI are in fact not all the same. There is no disagreement within the scientific and consumer communities, that they have vastly diverse needs, making recovery an individual and dynamic process. Different services must be expected to be optimal at different times throughout a person's life, as recovery progresses (Frese et al, 2001; Bellack, 2006).

Another problem with EBP, of particular relevance to psychiatric rehabilitation, is that some "evidence based" criteria do not address the question of "active ingredients."

Simply adding a new component to a treatment with other components having known effectiveness does not test whether the new component is effective. As Lehman et al. (2003) have pointed out, treatment modalities for SMI are multitudinous but they have very large overlaps. Distinguishing among them is often problematic. Remarkably little is known about the critical active ingredients of many psychosocial treatments whose benefit is robust and widely accepted. It is unclear whether promotion of EBP in mental health policy will stimulate research on the active ingredients of inclusive packages of specific treatments and techniques. Nevertheless, if a better understanding of active ingredients is not achieved, mental health services could be burdened by use of "evidence based" practices that include a lot of inert (but still expensive) components. In the near future research methods will need the capability to identify the active ingredients of multi-modal service packages.

In mental health, EBP issues are compounded by the empirical finding that new, effective treatments are disseminated much more slowly than in other domains of healthcare (Lehman et al, 1998). A project supported by SAMSHA (2004) is an attempt to address both the evidence and the dissemination issues, by making available a collection of "toolkits" designed to facilitate development and provision of specific services. The toolkits include manuals, guidelines, fidelity instruments and other materials. They are to be used by local service providers to enhance services with such evidence-based practices as "collaborative psychopharmacology" and "integrated substance abuse treatment" and "supported employment." The toolkits are designed to emulate modalities that have been tested in controlled trials, but are also designed to be practical and "user-friendly" in ordinary application. It is too soon to assess whether this

resource is having an impact on local application of evidence-based practice, but not too soon to raise questions about the limitations of the "toolkit" approach or the haphazard use of toolkits in a system that has not systematically determined what services are or are not needed. The toolkits are not an exhaustive array of specific treatments having known effectiveness for SMI, and of course, as research proceeds the number of such treatments is expected to increase. The collection is inevitably arbitrary, however empirically representative it may be. If the "toolkit" approach is to be successful, it will have to keep up with a rapidly progressing treatment development effort and recovery-oriented services.

One of the evidence based practices touted by SAMSHA toolkits (and arguably others), "assertive community treatment" (ACT), is not actually a treatment but an approach to organizing and delivering services (SAMHSA: Workbook, 2005). As specific treatments proliferate, the optimal approach to organizing and delivering them will probably change. In fact, as will be discussed in more detail below, this has already become somewhat controversial within the ACT research community. It is already clear that psychiatric rehabilitation is destined to be a multi-modal approach, inevitably generating complexity in organization and delivery. Different individuals and populations will need different combinations of services, probably necessitating different organization and delivery systems. As evidence based treatment practices proliferate, evidence based organization and delivery practices will have to keep up. This logical inevitability is a key consideration in the proposed research project. In the near future, it will be important to have research tools that comprehensively characterize the particular evidence based practices available within a particular organization and delivery system.

It is noteworthy that while the version of ACT in the SAMSHA toolkit emulates tested versions, no version of ACT has been tested that contains a full, state-of-the-art array of evidence-based treatments and other specific services. Also, although consumers were involved at the design stage of the SAMSHA toolkits, neither they nor comparable modalities have been studied with respect to the subjective responses of people actually receiving the services. Therefore, the impact of ACT and other modalities on recovery remains unknown. There is no data on the individualized assessments and decisions unavoidably involved in provision of the toolkit services, across individuals or within individuals over the course of recovery. Finally, there is too little data on the critical active ingredients of ACT, and this is controversial even within the ACT research community. In light of the considerations discussed here, future research on and development of toolkits for psychiatric rehabilitation should incorporate all four of these features: 1) inclusion of state-of-the-art components; 2) attention to the subjective experience of service recipients; 3) attention to individual differences among recipients and tailoring capabilities of services; and 4) analysis of critical active ingredients within multi-modal treatment packages.

Evolution of Assertive Community Treatment

The ACT model evolved out of an inpatient research unit located at Mendota State Hospital in Madison, Wisconsin in the late 1960's. In 1972, the first ACT team began providing services after moving the staff and patients of a hospital ward into the community. The leaders of this project hypothesized that by creating a community based treatment team that emulated hospital ward staffing, the gains that people made in the hospital would be maintained during people's time in the community (Allness and

Knoedler, 1998). A large volume of ACT research supports its effectiveness at reducing re-hospitalization among people who are de-institutionalized and/or have SMI. However, the evidence that people continue to improve their personal and social functioning in ACT alone remains equivocal. In this sense, it is unclear how well ACT complements the values and principles of the recovery movement.

Variations of Assertive Community Treatment make it difficult to delineate a unitary definition. Heterogeneity develops across programs, even in those programs that are rigorous in their attempts to adhere the original model (Monroe-DeVita, 2001), thus making the label of Assertive Community Treatment unreliable. Assertive Community Treatment standards differ in the structure, population, and services that they provide. National organizations such as the National Alliance on Mental Illness (NAMI), Commission on Accreditation of Rehabilitation Facilities (CARF), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Veteran's Administration (VA) have all developed differing structural and operational criteria of what defines Assertive Community Treatment (Phillips, S.D., et al., 2001). Research has attempted to distinguish ACT from other approaches to organization of SMI services, e.g. "intensive case management" and "brokered services" (e.g. Salyers, Bond, Teague, et al, 2003). However, the results suggest there are meaningful differences even among services that conform to formal ACT criteria. There is even debate among supporters about the importance of strict adherence to the ACT model and the need for adaptation at the local level (McHugo, Drake, Teague & Xie, 1999). Due to this variability in ACT programs, it is difficult to delineate the components that make one ACT team more successful than the other.

Although ACT is widely considered an evidenced based practice (Philips et al., 2001), it is now unclear what that means. To recapitulate the previous discussion of evidence-based practice, ACT has become a collection of different but overlapping packages of philosophies, organizational characteristics and specific service components. Even identical versions of ACT may become very different when implemented in different venues (e.g. rural vs. urban) or when they serve different populations (e.g. people with differing levels of disabilities, risk, or legal status). There is little doubt that something about ACT benefits some people in some contexts, but little more than that can be generalized. Comparative trials pitting different versions of ACT against one another are unlikely to meaningfully improve this situation. Today it appears much more likely that ACT will provide general guiding principles, and perhaps organizational templates, for service programs that are tailored to particular venues, recipients and circumstances. The kind of research that will have the most impact will be that which identifies particular organizational characteristics, treatment components, etc. as beneficial for particular circumstances and recipient groups. The findings of this research will more usefully guide further development of integrated, recovery-oriented service programs, regardless of the degree to which those programs adhere to any particular version in the evolution of ACT and its successors. This arguably represents a reformulation of ACT research, but there are strong indications that a corresponding reformulation is already in progress across the psychiatric rehabilitation and mental health policy communities (e.g. Lehman et al, 2003).

Reformulation of ACT research and the DACTS

Reformulation of ACT research starts with reconsideration of its primary research instrument, the Dartmouth Assertive Community Treatment (DACTS). The DACTS is a 28-item, program-specific instrument used to measure the adequacy of implementation of ACT teams (SAMHSA: ACT Scale. 2005). Each item is rated on a 5-point Likert scale ranging from 1 ("Not implemented") to 5 ("Fully implemented"). The scale items fall into three categories: human resources (structure and composition); organizational boundaries; and nature of services.

Fidelity instruments, like many clinical tools, can assess a variety of domains. Treatment fidelity can have numerous connotations and be used to describe model adherence, degree of implementation of a specific modality or what behaviors are absent from a model (Freeman, 2005). The DACTS has become the most widely used fidelity scale for ACT services. The original use of the DACTS was to discriminate well-executed ACT teams from different types of case management programs (Bond & Salyers, 2004). Since that time, the use of the DACTS has changed from treatment differentiation to treatment integrity and clinical outcome prediction despite the fact that no papers have been published supporting its extensive use (Bond & Salyers, 2004).

A criticism of the DACTS is that it is too focused on the organizational and structural components of the model, to the point that it excludes clinical elements of treatment (Bond, & Saylers, 2004). Additionally, the DACTS fails to identify contextual differences in the treatment population, geography and of the individual person. The DACTS does not differentiate between potentially important variations of treatment provision (Protocol, 2005). It fails to rate teams on the use of specific evidence based

practices that could be integrated to address common difficulties among people with serious mental illness, such as social impairment.

These criticisms of the DACTS converge with the preceding discussion of the evidence based practice concept and with the historical ACT research. A contemporary instrument for characterizing multi-modal psychiatric rehabilitation service programs must do much more than assess the fidelity of the program to one or another ACT model. The convergence points fairly directly to the need of new specifications:

- The instrument must identify key structural and organizational characteristics that may vary in response to contextual or circumstantial factors. These include: 1) administrative and management structure; 2) the composition or membership of treatment teams; 3) the professional and/or functional roles of program staff and affiliated individuals (including service recipients, families, friends, employers, guardians, judges, etc.); 4) the procedures by which treatment teams assemble and implement a treatment plan; 5) the array of specific services provided by the program; 6) links to other services coordinated but not directly provided by the program (This would be anathema in some ACT models, where provision of all psychiatric services and sometimes even nonpsychiatric medical and social services must be provided by the ACT program. However, it is not uncommon or considered unorthodox for ACT programs to "outsource" categories of services, such as housing, supervised residential facilities, vocational rehabilitation, etc.).
- The instrument must be capable of assessing the degree to which the principles of recovery are represented in goals and desires of service

> recipients are incorporated in a program's procedures and processes. This includes the degree of involvement of service recipients in treatment planning and provision, and the degree to which increased autonomy, hope and quality of life are valued outcomes, beyond behavioral stability and an absence of hospitalization. The instrument must be capable of assessing these characteristics in terms of the program's policies and procedures, behavioral adherence to those policies and procedures, and the subjective perceptions and experiences of program staff and service recipients.

Availability of an instrument meeting these specifications could usher in a new era of research and program development in SMI services, achieving the needed reformulation of ACT research and providing service systems a tool in which to systematically measure what is or is not needed contextually. In the shorter term, it would immediately provide a superior method for evaluating existing programs, with respect to the correspondence between their stated missions (role in the larger mental health system, intended recipients, appropriateness of funding levels, etc.) and the actual structure and functioning of the program. A psychometrically valid component for assessing the perceptions and experiences of staff and service recipients would immediately provide a compelling measure of program evaluation. If appropriately constructed, the psychometric component would also immediately provide assessment of the subjective dimensions of rehabilitation and recovery. In the longer term, systematic research with such an instrument would ultimately identify the "active ingredients" of service programs necessary to optimally serve particular subpopulations under particular circumstances, with respect to what particular dimensions of outcome. In this sense,

evaluation of SMI services would fall into step with the larger scientific agenda associated with evidence-based practice, and with the social values of the rehabilitation and recovery movement.

The proposed project is an initial step toward the validation of a new instrument for comprehensive assessment of programs that provide integrated services to people with a serious mental illness. The instrument is envisioned as eventually meeting all the specifications described in the preceding discussion, and is therefore named the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS; pronounced "simmers"). Complete development of the CIMHRRS is envisioned as a longer-term program of research, continuing beyond the principal investigator's predoctoral studies. In that sense, the first step in the development task is to analyze the development process itself, in order to identify what activities best complement both instrument development. The preceding discussion provides the key elements for this analysis. The analysis sorts itself into two categories, the conceptual and philosophical basis for instrument development, and theoretical considerations.

The concepts and philosophical principles most pertinent to development of the CIMHRRS are those of psychiatric rehabilitation and recovery. The overall purpose of SMI services is to enhance the recovery of the service recipients. This means different things to different people. There are objective and subjective dimensions of recovery and neither is well understood. Objective dimensions are somewhat represented in previous research, such as symptom severity and relapse rate. Objective dimensions not associated with traditional medical models of mental illness, such as interpersonal functioning and independent living skills, are less represented. Objective dimensions related to recovery,

such as financial independence and involvement in social activities, are even less represented. Subjective dimensions such as a sense of participation in rehabilitation and hope for a better future are rarely represented. The envisioned CIMHRRS must be capable of assessing the degree to which programs address all these dimensions.

The DACTS is not capable of assessing the degree to which programs address subjective and objective dimensions, so there is no clear precedent or prototype for the purpose of further development. Arguably, a program's attention to the objective dimensions of recovery could be gauged by the presence of specific relevant services, (e.g. attention to financial independence is gauged by availability of personal budgeting education, staff budget coaches, etc.). However, this presumes that the array of evidence-based practices is more distinct and differentiated than it is. This attention to the objective dimensions relegates programs to a position of efficacy not ecological validity. Some modalities have clear and specific implications for specific aspects of recovery, (e.g. social skills training speaks directly to involvement in social activities). However, a period of increased influence of recovery values will be needed before the full evidence based practice array is developed to the point that it corresponds to the full range of objective dimensions of recovery. Therefore, this does not appear to be a measurement domain that is ready for incorporation into a new instrument at this time.

Evaluating subjective dimensions of recovery does not have much precedent either, but the methodological challenge is more straightforward. Independent of services research and program evaluation, there is a small but growing body of work on how recovery from mental illness is or should be subjectively experienced (e.g. Shahar et al, 2004; Sells et al, 2004; Davidson et al, 2001; Chinman et al, 1999). Related research

methods, for measuring consumer satisfaction, are quite well developed. Development of a useful measure would be sufficiently guided by conventional psychometric theory and methods. Key policy documents such as the President's Commission report (2003) provide substantial indications of what the content of the items should be, i.e. what perceptions and experiences are most consistent with recovery. The additional resources needed are access to people undergoing recovery in a variety of contexts, access to experts in psychometric instrument development, and collaboration with experienced SMI researchers and advocates.

A general problem with ACT research and with research on SMI services in general, has been that it is minimally driven by theory. Specific modalities as well as service provision models have been developed primarily in response to pragmatic considerations. However, psychiatric rehabilitation has acquired some theoretical integrity, first with incorporation of diathesis-stress models (e.g. Liberman et al, 1982), more recently with the principles of systems theory and cognitive and behavioral science (e.g. Spaulding et al, 2003). Science does not yet provide a complete theoretical account of psychiatric rehabilitation or of recovery from SMI, but there are some general principles that have direct implications for services and the instruments that measure them: 1) SMI is generally episodic, with periods of greater impairment interspersed with periods of better functioning; 2) there are impairments and vulnerabilities that persist between episodes, and these can be serious barriers to recovery, however recovery is defined; 3) impairments and vulnerabilities are distributed across the entire range of the persons physiological, cognitive, behavioral and social functioning; 4) these impairments are independent enough that successfully treating any one of them does not ensure that

others will improve. The implications are: 1) services must emphasize prevention of episodes ("relapses") but must also accommodate the reality that episodes will occur; 2) services must address the full spectrum of impairments and vulnerabilities that compromise recovery, with methods of established effectiveness; 3) services must be integrated and coordinated so that for the individual recipient all the impairments and vulnerabilities that compromise recovery are efficiently and effectively addressed.

Psychiatric rehabilitation has a rapidly evolving array of methods for addressing specific vulnerabilities and impairments across the full range of human functioning. Although the services inventoried by the DACTS are a small subset of the evidence-based modalities currently available, the DACTS provides a prototype that can be expanded to include a more complete array. Part of the task would be simply to identify those services and develop operational definitions by which they can be recognized in an assessment. However, because of the similarities and overlaps among modalities, as discussed in the preceding section, there will be an additional task of identifying the critical features within different versions that qualify them as having known effectiveness for particular problems. This is a manageable task, but will require both scholarly skills and a first-hand familiarity with contemporary psychiatric rehabilitation. Therefore, expansion of the DACTS inventory of specific evidence based treatments to reflect the full array available in contemporary psychiatric rehabilitation emerges as an efficacious early step in development of the CIMHRRS.

While the use of technology associated with psychiatric rehabilitation has been useful in removing functional deficits associated with SMI, there appears to be a void of theory between the concepts of psychiatric rehabilitation and the concepts of recovery.

Some may even incorrectly view these concepts as contradictory. The recovery movement has been divorced from scientific investigation and rigor. Scientists are only now beginning to operationally define the concepts of recovery (Bellack, 2006). Furthermore, there is a void of how the scientific basis for rehabilitation has yet to be brought into dialogue with recovery principles. For example, when people are asked about what would enhance their recovery, they seldom if ever say "rehabilitation." They are much more likely to say a job, my own apartment, a car, or even a dog or sex (Davidson, 2003). How rehabilitation leads to these things needs to be examined more closely.

Preliminary Study

Preliminary development of the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS) began in the fall of 2005 with an extensive literature review of pertinent research and examination of mainstream services available to people with SMI and national policy on mental health. Another developmental starting point was identified in the Dartmouth Assertive Community Treatment Scale (DACTS, Protocol, 2005, SAMHSA: ACT Scale, 2005). The DACTS provided an initial framework for what types of services and organizational characteristics should be included in an evaluation of contemporary services. However, it was originally developed for a narrow purpose, to assess the fidelity of assertive community treatment teams, not necessarily associated with rehabilitation or recovery, and is not founded on theoretical or philosophical premises related to rehabilitation or recovery.

After many iterations of instrument development, the researchers fashioned a prototype instrument that was sufficient for the purposes of evaluation of service programs. In addition to the theoretical underpinnings, the instrument drew from the concepts of psychiatric rehabilitation, recovery from SMI, and evidence-based practice orientation to service provision. Design considerations derived from the development process determined that the instrument should contain eight domains that assess Program Mission, Program Demographics & Composition, Organizational Boundaries, Program Functioning, Treatment Team Structure & Process, Assessment Process, Treatment Planning, and Treatment Provision.

Initial work on the project comprised the principal investigator's Masters-level research project (MERP) that had the specific objectives of 1) constructing a prototype instrument which included a more comprehensive array of specific evidence-based modalities found in the current psychiatric rehabilitation literature and a more complete assessment of the organizational, theoretical and ideological principles that guide service provision and 2) evaluating the feasibility, interrater reliability, and internal consistency of the prototype instrument in a small-scale pilot study to determine whether its structured site review format was feasible for evaluating service programs. These objectives were accomplished in November 2007, after an initial field trial.

Instrument development included construction of two types of items, 1) objective qualitative and quantitative items to characterize specific service program characteristics, such as size of client population, staffing, etc., and 2) descriptions of program characteristics which cannot be expressed by descriptive values, but which can be measured on a Likert scale. As the items were constructed and included in the

instrument, a scoring system and manual were concomitantly developed to guide its administration. Additional materials were developed to enhance communication preparatory to and during the site visit, during which the instrument is actually administered. The completed instrument is included here as Appendix A.

The initial field trial tested the feasibility of the CIMMHRS and evaluated its interrater reliability and internal consistency by administering the instrument to two service programs that served an SMI clientele. Administration of the instrument was conducted by the principal investigator and graduate research assistants who were members of the University of Nebraska – Lincoln's Serious Mental Illness research group. As part of the field trial, a group of three evaluators visited each program to administer the CIMHRRS in the context of conducting a program evaluation. While on site, evaluators collected data from numerous sources (semi-structured interviews, policy and procedure manuals, chart reviews, and internal agency documents).

To assess the CIMHRRS capacity to address a breadth of potential service programs, two theoretically opposite programs were purposely selected by the investigators, 1) a comprehensive psychiatric residential rehabilitation and 2) an adult day program. It was hypothesized that the comprehensive psychiatric residential rehabilitation by virtue of its treatment format and approach to treatment would serve as a measure of the CIMHRRS ability to capture highly integrated recovery and rehabilitation focused services. The inclusion of the Adult Day Program, a SMI service in which no formal assessment or active treatment was provided, would serve as a measure of the CIMHRRS ability to assess programs of more limited scope. SMI service systems

typically include both types of program, which often operate in coordination, as was the case with the two selected for this study.

In this study, the researchers used an iterative, in vivo process to facilitate item development and ensure 100% agreement among raters. Evaluators rated individual items and were asked to report their scores. When disagreements on an item occurred between raters, the rating scale was revised and operationally redefined in such a manner that facilitated clarity of the item and agreement among raters. Upon evaluator agreement of the revised item, scoring of the item continued and again was subjected to the iterative process of item development discussed above. Changes that were identified by the evaluation team were assimilated into later revisions of the instrument.

Findings from the preliminary study supported further development of the instrument. The prototype format was shown to be feasible for assessing a wide range of service programs and is comparable in terms of administration and scoring time to other types of program evaluation or fidelity assessments. Analysis also indicated sufficient standardization in the administration and scoring of the CIMHRRS protocols. However, the high degree of consistency in the administration and scoring of the CIMHRRS as evidenced by 100% percent agreement between raters was an artifact of the iterative in vivo process used by the researchers to facilitate item development and standardization of the instrument. Future research and site visits utilizing blind interrater reliability would further enhance confidence in the instrument and the data it produces by addressing the question of whether agreement remains high without the iterative process.

The CIMHRRS demonstrated good internal consistency overall. However, there were elevated Cronbach's Alpha coefficients in some domains, which were judged to be

out of range of "real world" results. One explanation of the elevated alpha coefficients was the purposeful but limited selection of the evaluated programs by the principal investigator to establish the upper and lower limits of the CIMHRRS, perhaps falsely elevating the alpha coefficient due to the study's small sample size. It was hypothesized that exposure to additional and broad varieties of programs would bring the alpha coefficient into a more typical range. Additional explanations would include the question format (i.e. limited responses afforded by categorical items) or an insufficient number of questions within a domain to contextualize adequately the differences between the types of rated programs. A more in depth analysis of specific domains and items would potentially inform the researchers of the etiology of these results. It was hypothesized that the expansion of categorical variables into a Likert scale format could feasibly resolve this issue while providing the evaluators more defined criteria in which to rate and contextualize programs.

Purpose of Present Study

Until recently, there were not any comprehensive instruments that summarized the integration of recovery-oriented services across multiple service sites. The need for this type of instrument led the principal investigator to develop the *Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services* (CIMHRRS). The CIMHRRS is a theory driven instrument used to assess the organizational characteristics, specific services and related features of such programs. This project is expected to serve the purposes of both services research (e.g. characteristics of effective service programs) and program evaluation (performance of specific programs in the real world). To accomplish these multiple purposes, the format of the CIMHRRS is that of a structured

site review, wherein evaluators use the instrument to assess program organization, policy and procedures, in addition to more conventional fidelity and outcome assessment.

The purpose of the project described in this dissertation is the continued development, testing, and evaluation of the CIMHRRS for assessment of programs that provide integrated services to people with SMI. The specific objectives of this project are 1) ensure complete content validity through consultation with experts on specific evidence-based practice modalities, psychiatric rehabilitation, and recovery from SMI, 2) ensure that the feasibility and interrater reliability can be maintained as content validation proceeds, 3) test the instrument in a broad array of SMI service programs and settings, and 4) analyze the capacity of the CIMHRRS to differentiate qualitative aspects of service provision between various types of SMI service programs. Three hypotheses with key relevance to these objectives are empirically tested: 1) rater agreement will meet acceptable reliability criteria (90% rater agreement or better and an intraclass correlation coefficient of .70 or higher), 2) the internal consistency of the instrument's putative subscales will meet the appropriate alpha criterion (α=.60), and 3) the CIMHRRS will demonstrate the capacity to differentiate qualitative aspects of service provision between various types of SMI service programs.

Chapter 3

Method

Improving Interrater Reliability

The principal investigator implemented a variety of field methods throughout the project with the intent of improving the consistency in which project staff could rate various SMI service programs. In terms of standardizing the instrument, the principal investigator reviewed multiple iterations of the pilot instrument before it initial implementation within the context of the preliminary study. Applied applications of the pilot instrument and multiple revisions of the instrument allowed for streamlining of items, reduced double and tripled-barreled questions, increased the focus of potential rater responses, and made the instrument easier to score. Prior to rating any programs for the current project, graduate level research staff attended training sessions that familiarized them with the instrument, the intent of specific items, scoring procedures, and project expectations. After developing a basic understanding of the instrument, the principal investigator and project staff began conducting preliminary reviews of various SMI service programs. The principal investigator was a member of each evaluation team, which provided more junior members access to a more experienced rater in terms of familiarity with the instrument and program evaluation. Upon completion of each site visit, a feedback session was utilized to facilitate further instrument development and increase rater familiarity with the instrument. Practice administering the instrument with the intended population increased the experience of all staff in identifying and addressing common problems associated with not only the administration of the instrument but program evaluation of SMI service programs. Staff training and applied experiences with

the instrument was intended to reduce the amount of generational reinterpretation of the instrument or rater drift, thereby increasing standardized administration and scoring of the CIMHRRS. The details of the various applied activities are discussed in more detail within the body of the method section.

Instrument Development and Refinement

The first step in the continued development of the CIMHRRS was the thorough review of the findings of the preliminary study. Pertinent changes identified in field trials, results of the previous study, and lessons learned from subsequent documentation of program evaluation results were integrated into revisions of the instrument and associated materials prior to engaging in further program evaluation. Changes in the prototype instrument focused on clarifying scoring and reporting procedures, maintaining interrater reliability and standardization, and bringing the alpha coefficients reported in the previous study into more acceptable "real world" ranges. In addition, the principal investigator responded to the recommendations of the Ph.D. Supervisory Committee by reviewing, and when necessary, revising the instrument and associated documents to remove any potentially polarizing language. The principal investigator also developed a 27-item exit questionnaire (see Appendix C) that provided programs with the opportunity to provide feedback on their respective subjective experiences.

A panel of subject matter experts guided ongoing instrument refinement activities and ensured content validity. The panel included the principal investigator's graduate advisor and mentor, Dr. William Spaulding, an experienced SMI services researcher, and Drs. Kim Mueser and Larry Davidson, both prominent researchers, in the areas of psychiatric rehabilitation and recovery, respectively. Recognizing the importance of the

recovery perspective to the project, the principal investigator recruited J. Rock Johnson, JD, a nationally recognized consumer advocate, to be a member of the research team. While Ms. Johnson's consumer perspective complements the recovery perspective provided by Dr. Davidson, it is uniquely different. Ms. Johnson has been a member of the UNL Serious Mental Illness research team for several years. As part of that research team, she performs a mentoring role for all the research group members in the domains of consumers' experiences of mental illness and the mental health system. In addition to the general research supervision provided by the principal investigator's mentor, two Psychology Department faculty provided special supervision, mentoring, and statistical support. Dr. Calvin Garbin, an expert on psychometric scale development and related methods, was consulted on development and evaluation of the psychometric properties of the instrument. Dr. Brian Wilcox, an expert on program administration, management and evaluation, was consulted on the development and evaluation of the program evaluation aspects of the CIMHRRS. Lastly, another source of information about content validity was the UNL SMI research group, which provided invaluable feedback in capturing a breadth of functional assessment and treatment aspects of service provision and suggestions on numerous revisions of the instrument.

To maximize the content validity of the CIMHRRS, the principal investigator traveled to the two co-sponsor training sites and participated in extended training experiences. The principal investigator trained with Dr. Larry Davidson and staff at the Yale Program for Recovery and Community Health (PRCH) and Dr. Kim Mueser and associated staff at the Dartmouth Medical College's New Hampshire-Dartmouth Psychiatric Research Center (PRC) and the Dartmouth Evidence-Based Practices Center

(EBPC). Training at the co-sponsor sites provided greater assurance of the integration of the concepts, principles and values of psychiatric rehabilitation and recovery into the CIMHRRS instrument and ensured a complete review of evidence-based practices specific to a SMI population.

The PRCH is an interdisciplinary program positioned within the Yale Department of Psychiatry. The PRCH conducts state-of-the-art research, training, and consultation in the areas of recovery in mental health and addictions. As part of its mission, the PRCH focuses its resources on the development and evaluation of innovative, community-based interventions, training and deployment of peer providers, and the transformation of behavioral health care to promote recovery. In addition, the PRCH is involved in a range of activities from policy formulation, analysis, consultation, and technical assistance to workforce development, research, and evaluation.

During his tenure at the PRCH, the principal investigator was closely affiliated with the mental health transformation evaluation work group, which is responsible for carrying out the evaluation of the state of Connecticut's mental health transformation process. As part of his affiliation with this group, he attended staff meetings, observed organizational consultation activities, and attended group and individualized trainings focused on person-centered care, resiliency, and first-person experiences of people with serious mental illnesses. Also while at the PRCH, the principal investigator gained greater exposure to various measures of recovery-oriented care and worked directly with the developers of the Recovery Self-Assessment (RSA; Maria O'Connell et al., 2005), the Recovery Oriented Systems Indicators (ROSI; 2005) and the Recovery Enhancing Environment Measure (REE; 2005) both developed by Patricia Ridgway and colleagues.

Individual sessions with Drs. O'Connell and Ridgway provided special insights to the development of recovery-oriented measures, the unique differences between the various measures, and the usefully different ways in which their respective instruments and the CIMHRRS could be utilized.

Relevant to the development of the CIMHRRS, the principal investigator's experience at the PRCH provided direct access to information essential to the recovery movement and a more in-depth representation of consumer viewpoints as it related to evaluating the recovery orientation of service programs. This training assisted the principal investigator in translating his understanding of these subjective dimensions and processes of recovery and mental health service provision into objective and measurable indicators by which mental health services can be assessed, evaluated, and monitored to ensure quality, effectiveness of care, and recovery orientation.

The principal investigator's training at Dartmouth Medical College was based primarily at the New Hampshire-Dartmouth Psychiatric Research Center (PRC) and the Dartmouth Evidence-Based Practices Center (EBPC). As a public-academic liaison involving the New Hampshire Division of Behavioral Health and the Dartmouth Medical School the PRC conducts interdisciplinary research on services for individuals who have severe mental illness; with a particular focus on psychosocial rehabilitation. The PRC specializes in developing effective interventions under research conditions, then translates these interventions into actual mental health service practices and evaluates their effectiveness in routine practice settings. At the time of his visit, the PRC was involved in areas of research that included the implementation of evidence-based practices, vocational rehabilitation/supported employment, services for homeless

individuals, integrated treatment of co-occurring substance abuse, services for the elderly, trauma and posttraumatic stress disorder, HIV/AIDS and other infectious diseases, and methodology of services research. As a result, the PRC/EBPC staff were in a unique position to assist in the expansion of the CIMHRRS prototype by enhancing the instruments inventory of current modalities.

While at Dartmouth, the principal investigator attended meetings with Dr. Mueser and other PRC/EBPC staff. During his tenure, the principal investigator developed working relationships with its members, who have specialized experiences pertinent to the development of the CIMHRRS instrument. These individual meetings provided opportunities to discuss methods and issues related to measuring agencies' readiness to implement evidence-based practices and the fidelity of implementation of five different psychosocial EBPs for clients with SMI (supported employment, integrated dual disorder treatment, family psychoeducation, illness management and recovery, assertive community treatment). Access to this project provided the principal investigator with firsthand experience in the development of standardized fidelity measures and outcome measures.

In addition to the experiences at the PRC and EBPC, the principal investigator received training in ongoing evidence-based practice treatment programs in community mental health center settings serving a SMI population in the New Hampshire area. Specific activities included a meeting with departmental heads and administrative staff of the Mental Health Center of Greater Manchester. The Mental Health Center of Greater Manchester is a clinical research site in which many to the evidence-based practices protocols developed by PRC/EBPC staff are tested and refined. As such, the staff of the

Mental Health Center of Greater Manchester are well versed in providing feedback to nationally recognized researchers on the development and implementation of evidence-based practices in real-world settings. The input provided by staff members was invaluable in terms of developing the principal investigator's knowledge of collaborating with and consulting to mental health service organizations.

Upon completion of the visits at the respective co-sponsors sites, the principal investigator returned to UNL and began the process of instrument revision. Incorporating new ideas from his training experiences, the principal investigator created new items and revised old items to improve clarity and scoring of the instrument. The introduction of new project staff, the creation of new items and heuristic scoring systems, and formatting changes within the instrument necessitated the training of project staff to understand changes in the protocol.

Preliminary Issues and Staff Training

The specific objectives of the project and the environments in which the research was to be conducted created a unique set of problems that needed to be addressed early in the project. One of the difficulties identified early on was the inclusion of project staff with sufficient skill to evaluate adequately the clinical activities within the respective service locations. To address this issue, the principal investigator recruited four doctoral students from the University of Nebraska – Lincoln, Clinical Psychology Training Program, who specialize in the assessment and treatment of people with serious mental illness to function as graduate research assistants. Developing familiarity with the instrument and its administration to a point in which the researchers could conduct a

formal site evaluation was addressed through staff training and later refined during in vivo evaluation activities at the respective sites.

The principal investigator conducted three 90-minute training sessions. The first session provided background information on the preliminary study and highlighted information relevant to the current project. In addition, the theoretical underpinnings of the CIMHRRS were reviewed. Within the context of the first session, the principal investigator reviewed historical paradigms of assessment and treatment of serious mental illness, the history of the recovery movement in relation to psychiatric treatment, and a tripartite process model of evidence-based practice in psychology. Prior to the second training session, copies of the CIMHRRS instrument were distributed to project staff for review.

The second training session provided a précis of the research protocol and an opportunity to conduct a comprehensive review of the instrument. Major domains of the CIMHRRS were discussed, developing an understanding of the overall intent of each domain and the individual items contained within each. Individual items were also reviewed. Focused discussion was provided on specific items as requested by project staff. Finally, a written program evaluation document from the previous study was provided to project staff as an example of a finished product to assist them in contextualizing the capacity of the instrument.

The third and final session served two training goals, 1) to develop the project staffs' role as professional consultants and 2) provide a complete, preliminary run through of the research protocol, prior to actually conducting a site visit. In developing staffs' roles as professional consultants, professional conduct and attire was discussed in

addition to how programs react to being "evaluated." Time was spent highlighting the need for project staff to be relaxed and aware of the effects their presence may have within a program. In addition, staff were reminded to be cognizant and respectful of specific program rules. This aspect of training was particularly relevant to the inpatient programs that placed restrictions on items that could be brought into their respective facilities (i.e. glass or metal containers). Research staff were instructed to utilize language that was familiar to each specific program in order to develop a common language with program staff and to develop rapport. If a program referred to service recipients as "patients," "consumers," or "program participants," the project staff were instructed to reflect the practice of the hosting program. Project staff were reminded that all clinical concerns or emergencies were to be reported to program staff and the principal investigator and as research staff, they were not to resolve any clinical issues while at the respective programs despite their clinical training.

As an introduction to the research protocol, a review of site visit activities was conducted. The principal investigator reviewed the requisite pre-site visit activities such as conducting preliminary meetings with the program administrators, completion of the Program Face Sheet and the Evaluator's Pre-visit Checklist, discussion of the goals, processes, and potential benefits of the research and the need to provide program administrators with the Program Pre-visit checklist, Program Administrator Handout, and a Copy of Disclosure to Participate form. Activities to be conducted during the site were also reviewed; including conducting semi-structured interviews, review of pertinent program documents (e.g. policy and procedure manuals, program manuals and handouts), selection and review of clinical records, the process of rating a program, and conducting

exit interviews with the program administrator. Finally, a discussion of the after site visit activities was conducted including a review of Exit Questionnaire, consolidating findings, and conducting accuracy checks with the programs.

Ethical Issues

Protection of service recipients and program staff was another area of concern for the project. Prior to conducting any site visits, all project staff were required to obtain CITI certification in the protection of human subjects before conducting any research activities. While service recipients were not identified as subjects of the project, research staff, in conducting the various program evaluations, would be privy to protected health information (e.g. assessment and treatment plans) as part of the structural and process analyses of the programs. As such, there was potential for a breach of privacy or confidentiality of individuals who were service recipients despite researchers not collecting any individual identifying data. In addition to the aforementioned training in human subjects protection, this risk was further reduced by implementing field methods that eliminated the need for collection of individual service recipient data and observance of all confidentiality and privacy protection procedures at data collection sites.

An additional area of concern was the protection of program staff. This concern was identified not only by the researchers but also the Scientific Review Group of the National Institute of Health and some of the respective Research and Development Committees of the various programs. While the staff members in the respective programs were not considered human subjects, they would serve as key informants about the processes and the functioning of the program. As key informants about the performance of the program, there was an inherent risk of revealing sources of

information, which could be considered embarrassing to the site management. Providing such information could feasibly result in program staff being negatively evaluated or retaliated against by program management. To address this issue, the principal investigator developed a Disclosure to Participate form (Appendix B) as a precautionary measure. The Disclosure to Participate form explained the potential risks to each staff member that participated in the site evaluation and provided informed consent. To further reduce this risk, field methods were enforced to reduce collection of individually identifiable data. In addition, the data would be reported in the aggregate so the identities of the informants could not be easily inferred by those individuals who are in charge of the respective service programs. With the training of research staff and implementation of field methods, the risk of privacy or confidentiality breach of staff participating in the project was considered minimal.

Participants

Five SMI service programs in Nebraska and Missouri participated in the project. The service programs that participated in the project had recipient populations that reflected the demographics of seriously mentally ill populations at their respective locations. Collectively, the programs reflected national demographics of the seriously mentally ill population. Sites were selected based upon the accessibility to the University-based research group and a diversity of specific program characteristics, including inpatient, outpatient, and residential services, urban and rural locations, and a range of recovery-oriented and maintenance-oriented services.

SMI service systems typically include numerous and various types of programs, which provide a continuum of services to people as they progress through their personal

recovery. In order to assess the CIMHRRS capacity to capture differences between service programs across this spectrum, a broad array of programs were chosen to participate in this study. The programs chosen to participate in the project are considered to be representative of that spectrum of services and include maximum and medium security inpatient programs, residential, and community-based programs.

The medium security inpatient psychosocial rehabilitation program is a comprehensive, 17-bed program located within a public psychiatric hospital. Individuals admitted to the program typically have histories of severe and persistent psychiatric disorders, protracted institutionalization, minimal responsiveness to antipsychotic medication and failure to respond to community-based and short-term inpatient services. Utilizing a psychiatric rehabilitation and recovery model of treatment, the program employs numerous technologies developed by various rehabilitation research centers. Targeting multiple levels of functioning, treatment is designed to facilitate more independent levels of living and returning people to the community who would otherwise create significant safety risks in less restrictive functioning. At the time of the site visit, the program had recently undergone a series of administrative and infrastructural changes that affected program operations and reduced the program's caseload by more than half.

The residential program is a 15-bed community-based psychiatric residential rehabilitation program. The program provides recovery-oriented, biopsychosocial rehabilitation and other services to help program participants achieve more stable and independent functioning. The program is designed to provide a home-like environment where individuals with serious mental illness can receive therapy, support, medication, skills training and practice within a supervised, structured residential setting. The key

criterion of this program is increasing program participants' level of functioning so they may live in a less restrictive residential setting with greater independence while reducing the use of support and emergency services.

The intensive case management program is an outpatient program that serves approximately 650 adults with severe mental illness. The goals of case management services within the program are focused on enhancing independent living skills, linking consumers to community resources, acting as a liaison between consumers and other service providers, assuming the role of advocate when necessary, and monitoring psychiatric symptoms with the macro goal of reducing recidivism rates. The program is designed to provide an environment where individuals with severe mental illness can receive supportive services, primarily in the community rather than a traditional office setting. At the time of the site visit, the program was actively engaged in integrating functional aspects of psychiatric rehabilitation and recovery-oriented services, including the restructuring of its clinical treatment teams and various aspects of service delivery.

The psychiatric rehabilitation day program was designed to provide an environment where individuals can receive support, prevocational training, and socialization within a semi-structured setting. The facility consists of a host of small offices, two large communal areas, a kitchen, and dining area. The kitchen area is utilized to develop participant's skills in food production, sales, and general cleaning skills. Office space is used primarily to house the program administrator and staff and supports various program activities (psychological assessment, social activities, development of a monthly newsletter, and supportive counseling) on a rotating, as needed basis. The communal areas serve multiple purposes supporting social interactions

between participants and staff, housing computers to support vocational and recreational interests, and serves as an area to hold psychoeducational and support groups. At the time of the site review, the program was in the process of transitioning from its historical function as a clubhouse model of care to a more formal rehabilitation program. At the time of the site visit, the program had already initiated numerous steps to accomplish this goal (e.g. staff training, establishing work groups, developing programs) however it was still very much in the early stages of this transition.

The maximum-security inpatient program is a psychiatric rehabilitation and social learning program. The 57-bed program is comprised of three wards, one of which is co-ed and two of which are for men only. Each ward has 19 private bedrooms, and shared living areas and bathrooms. In addition to the living areas, each ward also has a designated area for classes, a television room, a seclusion room, and nursing stations. Outside the wards are several large meeting rooms, token shops where residents may redeem tokens for desired items, a canteen where residents may purchase additional items, a workshop, a game room, and a library. The program implements a comprehensive milieu-based social learning program, a model that has demonstrated effectiveness in promoting higher levels of psychosocial functioning in chronic and institutionalized patients in transitioning to less restrictive settings. The program utilizes a recovery-oriented approach to psychiatric rehabilitation services to achieve more stable and improve independent psychosocial functioning. The key objectives for this program are to: 1) reduce or eliminate bizarre, unusual, or aggressive behaviors, 2) promote the development of self-care skills, 3) promote the development of social skills, 4) improve instrumental role performance, and 5) aid clients in developing post-discharge goals.

Measures

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services is a 52 item, theory driven instrument used to assess the fidelity of various programs to particular service models. Additionally, it quantitatively and qualitatively characterizes programmatic differences in service settings for people with serious mental illness. Through a structured site review, evaluators assess the relative strengths and liabilities of service programs. The CIMHRRS, comprised of 8 domains (Program Mission, Program Demographics & Composition, Organizational Boundaries, Program Functioning, Treatment Team Structure & Process, Assessment Process, Treatment Planning, and Treatment Provision) was designed specifically to capture the level of integration of psychiatric rehabilitation and the recovery-oriented services, and consider the structural and organizational components of the program in addition to the functional processes of assessment and treatment provision.

The CIMHRRS was developed to rate individual programs on multiple dimensions of service provision. To enhance rigor and precision, these dimensions are defined in quantitative terms, the "scores" generated by the various items in the instrument. For several dimensions, the scores reflect the context and type of services a program provides. While the scoring format for the CIMHRRS is set up with higher scores indicating higher integration of recovery and rehabilitation oriented services, these score cannot necessarily be directly interpreted as measures of "better" or "worse" program functioning. Not all programs require the same range or level of intensity of specific services. Interpretation of the CIMHRRS should include consideration of the

context of the service program (e.g. its role and mission in the larger mental health system, funding and related resources) and be conducted only by trained individuals.

Procedures

Data collection. Pre-site visit activities were conducted in order to develop a working relationship with each service program. The principal investigator reviewed the purpose of the research and coordinated details of the site-visit. As part of this process, the principal investigator provided forms requesting detailed demographic and programmatic information to the programs, facilitating the efficiency of the evaluation and affording ample time for the program to gather information, while minimizing any undue imposition on the program or service provision.

Activities of the site visit were guided by the administration booklet and the various forms included in the CIMHRRS (Appendix A). Within the context of conducting a program evaluation, two trained evaluators (i.e. principal investigator and one graduate research assistant) independently administered and scored the CIMHRRS for each site. During the site visits, both evaluators collected data from numerous sources (semi-structured interviews, policy and procedure manuals, chart reviews, and internal agency documents). Semi-structured interviews were conducted with the program administrator and at least two additional clinical staff. To facilitate a representative sampling of staff, the investigators purposefully choose and interviewed staff from across various levels of staffing, education, and professional roles. While on site, investigators also conducted a review of policy and procedure manuals, internal agency documents, and client charts. In conducting chart reviews, programs were asked to provide a list of current clients. Upon receiving the program's list, the investigators randomly choose ten

charts to conduct the chart review. Code numbers were established and applied with a temporary adhesive to each of the ten individual client charts. This step allowed the researchers to refer to records by the assigned code number during the evaluation thereby minimizing the risk of a breach of confidentiality while ensuring consistency in rating activities. During the chart review, evaluators paid particular attention to the treatment planning and assessment sections of the chart. As the purpose of the chart review was to determine the general content of the records, the data collected was on the structure, organization and content of the program records, not the specific content of any individual record. No data on any individual client was collected.

Upon the completion of data collection and program evaluation, the raters independently rated each program. The ratings were then subjected to a preliminary review by the investigators to facilitate functional understanding and optimal development of the instrument. These reviews were conducted between each full administration of the CIMHRRS in order to implement changes in the instrument and subsequently train project staff before conducting the next program evaluation.

The iterative data analysis approach, discussed in more detail below, was used in refining the instrument over the course of numerous program evaluations and produced the final prototype of the instrument. In addition, at the completion of the final program evaluation, all project staff had completed a minimum of two program evaluations, ensuring familiarity and standardized implementation of the CIMHRRS. Equipped with the finalized and uniform prototype, the raters were then asked to review and independently rate each program using the information collected previously in their

respective site visits. These ratings were utilized in the subsequent analyses of the instrument and the evaluation of interrater reliability.

After the respective site visits, the investigators provided each identified program administrator with an exit questionnaire. Each program administrator was asked to confer with staff members and complete the questionnaire, sharing their experiences of having the CIMHRRS administered at their program. The questionnaire consisted of twenty Likert-scale questions that included activities prior to and during the site visit. In addition, the questionnaire included seven open-ended questions in which the programs could respond to perceived strengths and liabilities of the instrument, how the CIMHRRS differed from other review processes, and suggestions that could possibly complement or improve the evaluation process. It was anticipated that program responses would provide valuable insight into what it is like for a program to be evaluated with the CIMHRRS and had the potential to improve the quality of administration and scoring of the instrument.

Data analysis. This project served multiple purposes; instrument development, evaluation of the psychometric properties of the instrument, examination of the capacity of the CIMHHRS to differentiate the qualitative differences between SMI service programs, and determining the feasibility of the site visit format. As such, various analyses were used to answer the investigator's hypotheses and improve the functioning of the CIMHRRS.

As the purpose of the project was to facilitate functional understanding and optimal development of the instrument, data from individual programs was examined between site visits. An iterative process was utilized to facilitate item development. After evaluators independently rated the respective programs, they were asked to report

their scores. When disagreements occurred between raters on an item, it was examined, discussed, and rewritten to facilitate greater understanding and consistency among raters. Changes to the instrument were assimilated into the instrument and the Administration Booklet between site visits. Project staff were updated on the changes prior to starting the next site visit to insure standardized administration and scoring. After completing the iterative process for the fifth site visit, the principal investigator finalized the instrument that was used by the research staff to independently produce the final ratings that were used in the subsequent analyses. The instrument used to conduct the final program evaluation can be found in the appendix. However, in the interest in improving subsequent administrations of the CIMHRRS, the principal investigator added pages (4-8) of the Administration Manual after the analyses had been completed. It should be noted the text within these pages reflect the integration of previously written introductory material, verbalized instructions that had not been previously documented, and the integration of lessons learned from multiple administrations of the CIMHRRS. Individual items or scoring protocols were not changed.

To quantify and assess the degree of consistency among raters', CIMHRRS domains that included qualitative variables (Program Mission, Organizational Boundaries, Treatment Team Structure & Process, Assessment Process, and Treatment Planning) were examined. Scoring agreement between raters was initially established by percent agreement. For those programs that achieved less than 100% percent agreement, intra-class correlation (ICC) was used to determine the extent of disagreement between raters. Convention in scale construction and validation suggested an acceptable reliability criteria for rater agreement was 90% and an intraclass correlation coefficient of

.70 or higher. To assess the internal consistency possessed by the CIMHRRS, researchers determined Cronbach's alpha for all qualitative variables and domains. Internal consistency of the instrument's putative subscales for exploratory research would be expected to meet the appropriate alpha criterion (α=.60), however in order to be considered a "good scale" an alpha criterion (α=.80), would be required. Quantitative domains (Program Demographics and Composition, Program Functioning, and Treatment Provision), while of interest in describing individual differences between programs, offer no subjective rating differences between raters within a given program. Responses received by the program in this regard are deemed to be objective data and therefore not amenable to subjective ratings by the researchers. As such, that data was not analyzed, as it did not inform interrater reliability.

The CIMHRRS was administered to a breadth of SMI service programs, to determine its capacity to differentiate qualitative aspects of various types of SMI programs. An exploratory analysis was conducted, comparing each program across the subjectively rated domains of the instrument. In addition, an individual item analysis by program was also conducted.

Feasibility. The protocol utilized a site visit format to examine the intended audience of the CIMHRRS (i.e. SMI service programs). Feasibility is a subjective determination of design, process, and capacity to achieve a specified set of goals within a timely and efficient manner. It can be assessed from evaluator's point of view as well as that of the program being evaluated. As such, the investigator analyzed the feasibility of the site visit format from both perspectives. To determine feasibility, the CIMHRRS was compared to similar aspects of program evaluation / fidelity tools (e.g. administration

time). In addition, the information found within the Exit Questionnaire was analyzed. The Exit Questionnaire made available to the investigators' the program administrators' perceptions on activities that occurred before and during the site visit, efficiency of administration, and the utility of the CIMHRRS.

Chapter 4

Results

The overall purpose of this project was the continued development and evaluation of the CIMHRRS instrument for assessment of programs that provide integrated services to people with serious mental illness. As part of that development and evaluation, numerous subject matter experts in instrument development, program evaluation, and specific evidence-based modalities pertinent to psychiatric rehabilitation and recovery from SMI were consulted to ensure complete content validity. In addition, the iterative approach used in item refinement increased project staffs' understanding of the CIMHRRS, thereby improving standardized administration and consistency among raters prior to obtaining the last program ratings which produced the data used in the final analyses. To assess the CIMHRRS capacity to evaluate a range of SMI service programs, the instrument was administered to a broad continuum of SMI service settings. Hypotheses identified for the project were that percent agreement, interrater reliability, and internal consistency would meet acceptable reliability criteria, and that the CIMHRRS would demonstrate the capacity to differentiate qualitative aspects of service provision, between various types of SMI service programs. In addition, although not a formal hypothesis, determining whether or not the site review format utilized within the protocol would be feasible to evaluate programs in real-world settings is directly relevant to evaluating the administration and utility of the instrument.

Rater Agreement and Intra-class Correlation

Raters for the community-based residential psychiatric rehabilitation program and the maximum security inpatient social learning program, achieved 100% rater agreement.

Raters for the comprehensive psychosocial rehabilitation program (inpatient), intensive case management program, and the psychiatric rehabilitation day program intensive case management achieved 97% agreement. Intra-class correlation coefficient (ICC) was .99 for the comprehensive inpatient psychosocial rehabilitation program, the intensive case management program, and the psychiatric rehabilitation day program. Results of these analyses exceed reliability criterion for both percent agreement (90%) and intraclass correlation (.70) which suggests the CIMHRRS instrument has excellent rater consistency and inter-rater reliability.

Internal Consistency

The CIMHRRS exceeded the identified criteria (α=.60) for all qualitative variables and individual domains. Cronbach's alpha for all qualitative variables was (α=.98). Cronbach's alpha for the individual domains were Program Mission (α=.85), Organizational Boundaries (α=.85), Treatment Team Structure & Process (α=.82), Assessment Process (α=.96), and Treatment Planning (α=.92). As a whole and within the specified domains, the items are positively correlated with each other, reflecting a homogenous instrument and domains that consistently measured the same attributes. The results indicate the CIMHHRS has "good" to "excellent" internal consistency.

Capacity to Differentiate Programs

Analysis of domains by program demonstrated the capacity of the CIMHRRS to differentiate qualitative aspects of various types of SMI programs. A comparison of domains by program is graphically represented in Figure 4.1. Consistent with the researcher's a priori estimates, the programs that had highly integrated models of psychiatric rehabilitation and recovery-oriented services were rated consistently higher

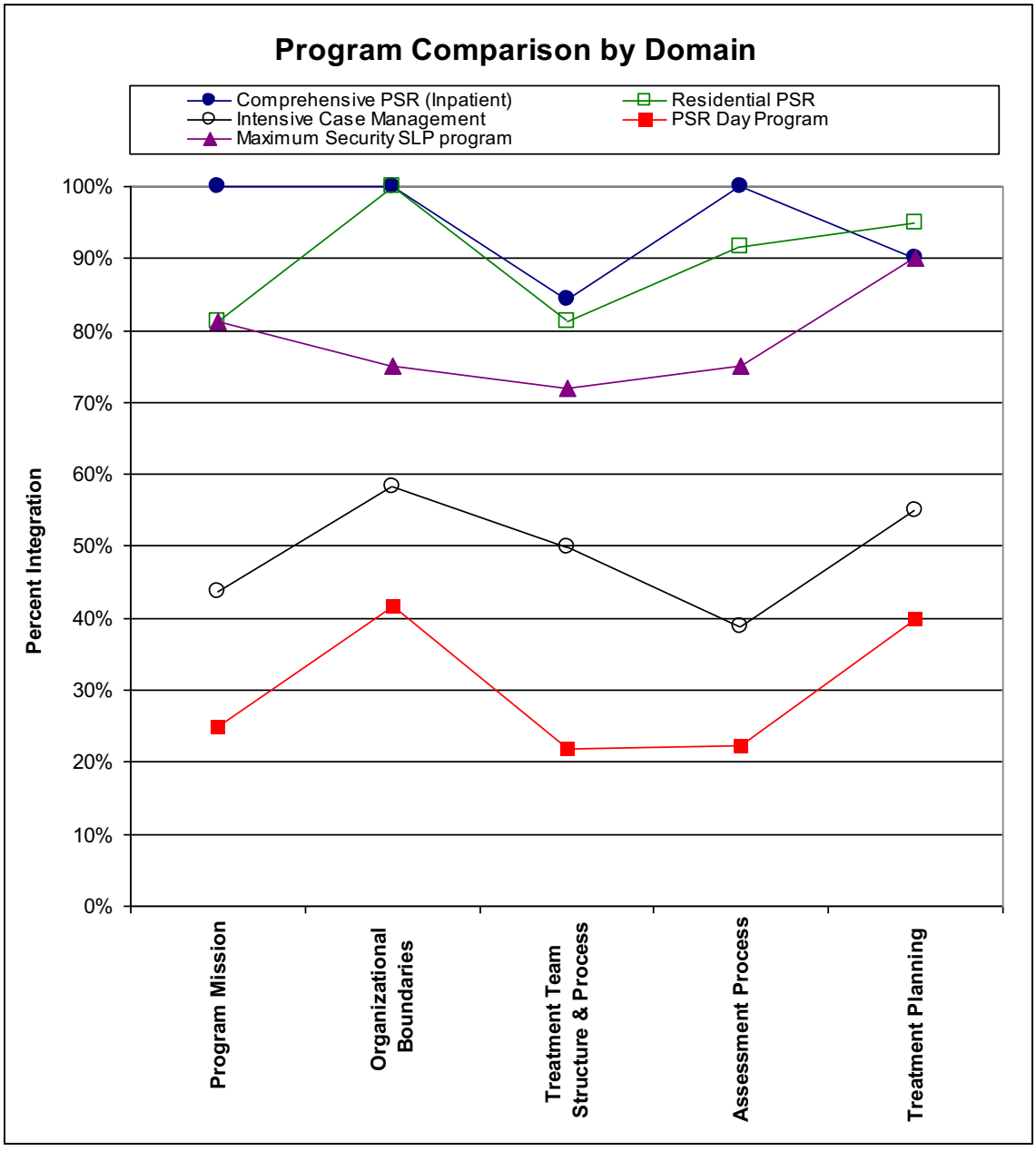


Figure 4.1. Program comparison by domain.[1]

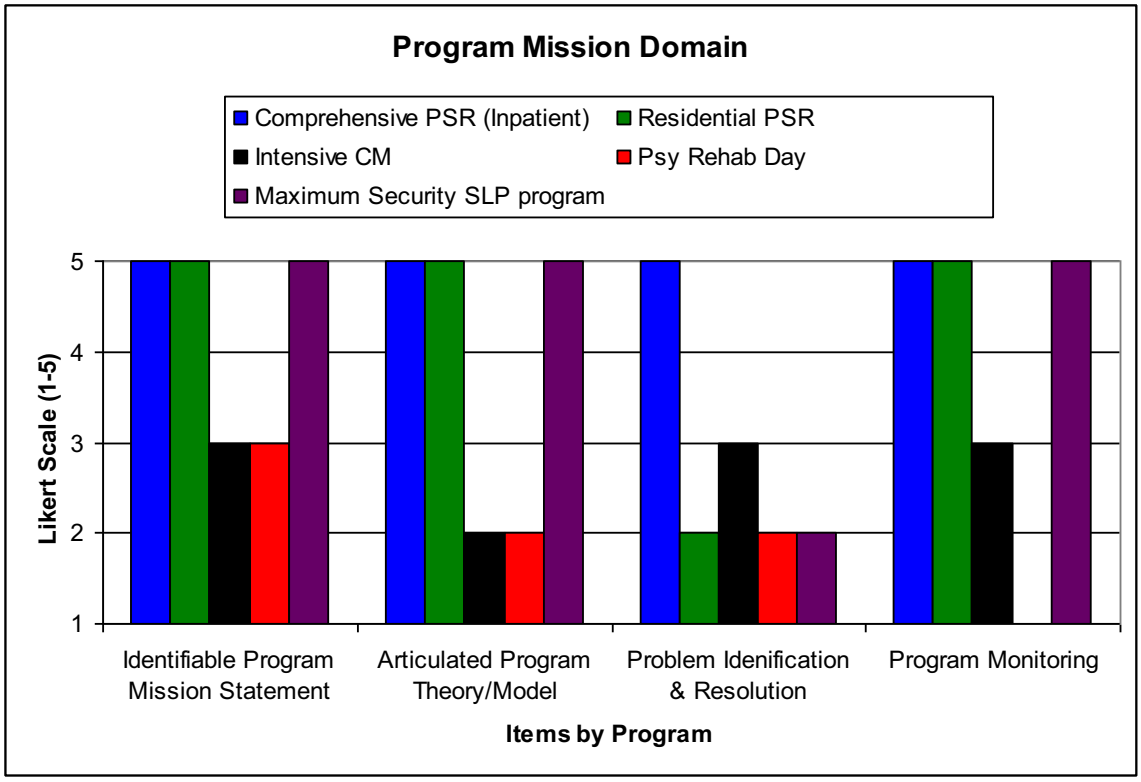
[1] *Direct comparison of different types of service programs is not the intention of the CIMHRRS. Rather it is the evaluation of integration of the concepts of rehabilitation and recovery oriented services. As a result, the graphs are represented in terms of percentages to allow a fair comparison.*

than those programs that did not. The medium security comprehensive inpatient psychosocial rehabilitation program, psychiatric residential rehabilitation program, and the maximum-security inpatient social learning demonstrated higher levels of integration of psychiatric rehabilitation and recovery-oriented concepts. The intensive case management program demonstrated moderate levels of integration whereas the psychiatric rehabilitation day program had moderate to low levels of integration. Regardless of program title or proclaimed model of service provision, the CIMHRRS was able to capture the functional integration of psychosocial rehabilitation concepts and the recovery orientation of individual service programs. Analyses of specific items within qualitative domains were also examined. A comparison of individual items by domain can be found below.

Program Mission Domain

Within the Program Mission domain, items such as Identifiable Program Mission Statement, Articulated Program Theory / Model, Problem Identification and Resolution, and Program Monitoring were compared across programs (see Figure 4.2).

Identifiable program mission statement. This item determines the degree to which the program has a clearly defined mission and mechanisms for monitoring how well the program is pursuing that mission. The comprehensive inpatient program, residential rehabilitation and social learning program were all rated a "5" indicating a mission statement that was highly specific to the program and met the four criteria outlined in the Administration Booklet of identifying the purpose, approach, population, and outcome of the program. In addition, the mission statement received 100% endorsement by program staff. The intensive case management program and the



Item scores were based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.2. Program mission domain.

psychiatric day rehabilitation program both were rated as a "3" which indicates a mission statement that is specific to the program (rather than pertaining to a larger organizational body) but contained less than four of the aforementioned criteria.

Articulated program theory/model. A program's theory or model is a set of assumptions about how the program envisions itself in relationship to its identified mission. A program's theory or model provides guidance on the approaches and strategies to use to accomplish its goals and objectives. In this item, programs were evaluated on the development and level of utilization of an identified programmatic

theory and its capacity to consistently use that model to effect change upon the social problem it identified as its social mission.

The comprehensive inpatient program, residential rehabilitation and social learning program were all rated a "5" indicating the program theory or model espoused by the program was articulated in program documents, was endorsed by program staff, and had credence in the program's day-to-day functioning. The intensive case management program and the psychiatric day rehabilitation program both were rated as a "2" which indicated the program theory or model was in the process of being developed but was not consistently implemented in policy or action. The rating of a "2" is consistent with these programs implementing changes in their model and infrastructure as part of a dedicated action to integrate more formal psychosocial rehabilitation and recovery-oriented services within their respective programs.

Problem identification and resolution. Problem identification and resolution focuses on the program's capacity to identify and process problems that occur within the context of providing services. Examples would include staffs' ability to identify problems within the program and the program's ability to respond to that information and make relevant changes within the program. Issues are not limited to clinical issues but rather the overall functioning of the program, which may include organizational and staffing issues.

The comprehensive inpatient program was rated a "5" indicating the program has demonstrable actions and outcomes that stem from its problem identification and resolution process. The intensive case management program as it demonstrated a formal process used to identify and resolve problems within the program (e.g. suggestion box,

policy manual). However, the process it is not well understood by staff resulting in being rated a "3". The residential rehabilitation, social learning program, and the psychiatric rehabilitation day program were all rated a "2" indicating these program utilized an informal process to identify and resolve issues, or has a plan in the process of being developed but was not being used at the time of the site visit.

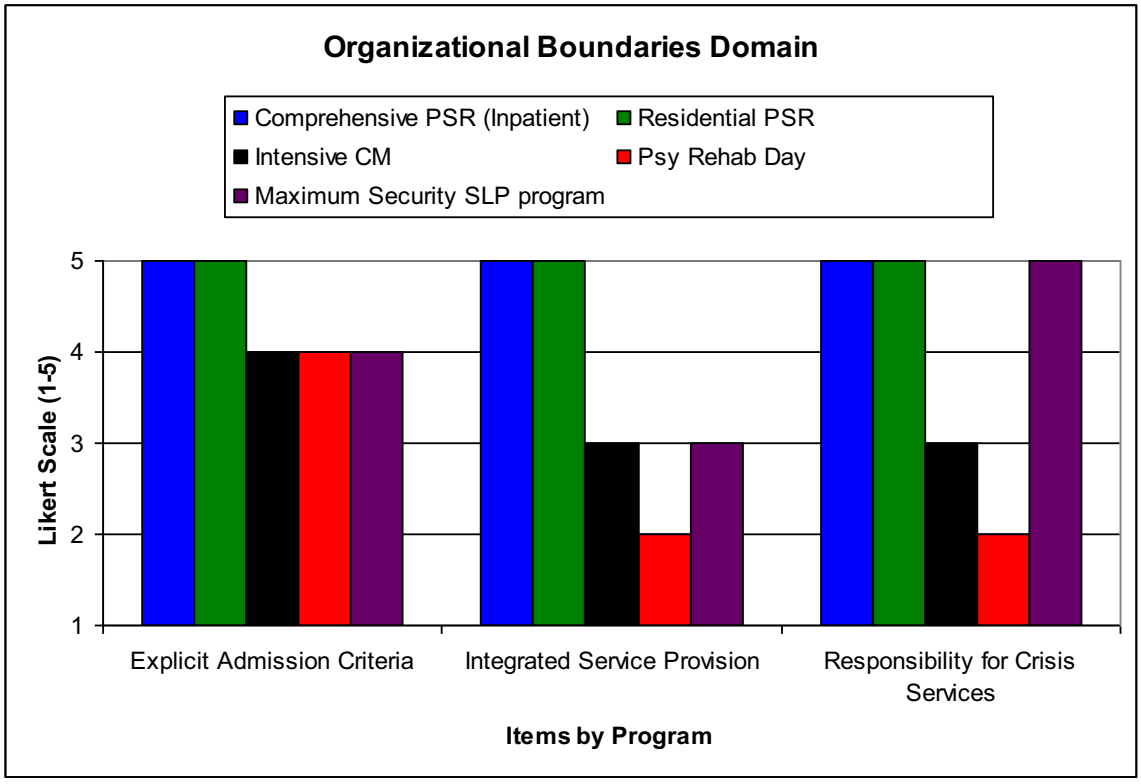
Program monitoring. Given that a program has an identified theory or model to address an identified social issue, it is imperative that the program be consistent in the application of that theory or model to reliably measure the intended impact of the program on the identified social issue and to avoid program drift. This item assesses a program's fidelity to its identified program mission and its effectiveness in following / implementing its articulated theory or model for change.

The comprehensive inpatient program, residential rehabilitation and social learning program were all rated a "5". These programs utilized information gathered from a program monitoring process to facilitate pertinent changes within the program to avoid or minimize program drift. The intensive case management program, rated a "3," was familiar with concept of program process monitoring and demonstrated the capacity of assessing fidelity to mission, theory, or effectiveness of program's implementation, however it struggles to consistently utilize this technology, leaving the extent of program drift unknown. The psychiatric rehabilitation day program was rated a "1" which indicates at the time of the site visit, it did not conduct program monitoring.

Organizational Boundaries Domain

An individual service program typically only represents a portion of the larger mental health system in which it operates, requiring interaction with other programs

within that system. The Organizational Boundaries domain examines a program's level of integration with other service providers within the context of the local mental health system as well as how clients enter and leave the program. Within the Organizational Boundaries domain, individual items such as Explicit Admission Criteria, Integrated Service Provision, and Responsibility for Crisis Services are examined. An analysis of individual items across programs is provided below and in Figure 4.3.



Individual item scores are based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.3. Organizational boundaries domain.

Explicit admission criteria. In order for a program to be effective, it has to recognize its limitations. These limitations are typically outlined by the program's mission statement, available resources, environmental factors, and staffing. For this item, the programs were evaluated on whether or not they had operationally defined criteria that allowed for the identification and integration of appropriate referrals.

The comprehensive inpatient program, residential rehabilitation were both rated a "5" which means the respective programs actively recruited a defined population and all clients meet explicit admission criteria. The intensive case management program, psychiatric rehabilitation day program and the social learning program were rated a "4" indicating these programs had an identified explicit admission criteria. In addition, these programs also actively sought and carefully screened referrals but occasionally had to bow to organizational pressure and were required to admit individuals who did not fit the stated admission criteria.

Integrated service provision. In an integrated model, all treatment aspects of a person's psychiatric well being are considered simultaneously. This comprehensive approach is typically developed and delivered by a multidisciplinary treatment team, which have representatives from various psychiatric specialties providing expertise to an individual's case. While some organizations might meet these criteria within the boundaries of its own program, others must accomplish this goal by developing professional relationships among multiple sites and service providers.

The comprehensive inpatient program and residential rehabilitation were both rated a "5" which indicated these programs provided all treatment in an integrated format. All services, whether they are internal or external to the program were reflected in the

client's treatment plan. The intensive case management and the social learning programs were rated a "3" meaning that an individual's multiple needs are addressed through isolated use of serial or sequential modes of treatment OR multiple parallel treatments. While the programs received the same rating, there were contextual differences between the programs that resulted in their ratings. Whereas the intensive case management program engaged in multiple parallel service provision, the social learning program, by virtue of its maximum-security status, was necessarily constrained in its ability to integrate with other programs outside of the unit. Consequently, the treatment needs that could not be met by the social learning program were addressed after clients had been discharged to a less restrictive setting (i.e. sequential service provision). The psychiatric rehabilitation day program was rated a "2" as it recognized that clients had additional service needs, however they addressed those needs through serial or sequential modes of treatment. In other words, an individual received treatment for one aspect of his or her mental health issues and received a referral to another treatment provider to address a separate aspect of their mental health issue. In similar service settings, individuals would not be eligible for treatment until another aspect is resolved or sufficiently stabilized.

Responsibility for crisis services. A person's psychiatric well being can be influenced by a program's response to a psychiatric "crisis" and / or accessibility to clinical staff. An immediate response from a supervisor can be useful in providing direction to clinical staff that are on duty or providing direct interventions for a client. Regardless of where services are provided, a minimal response time during a crisis can make a significant difference in a person's recovery; sometimes it can mean the differences between life and death. Depending on how the program is structured, various

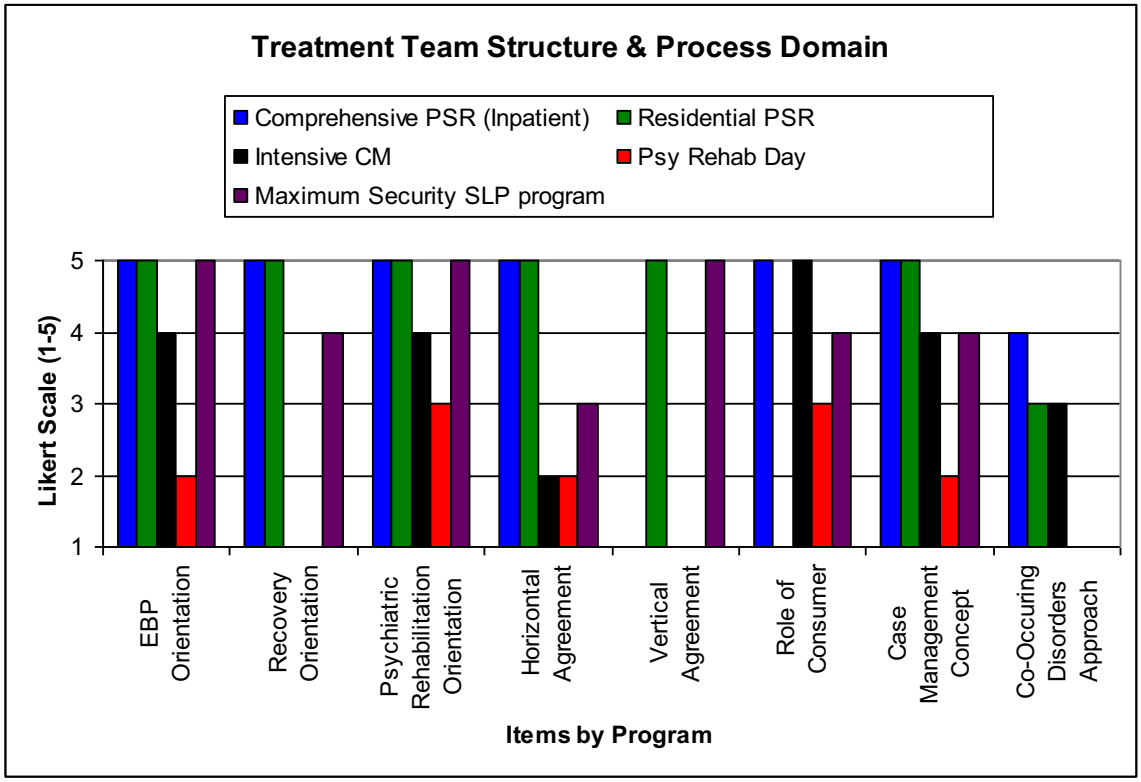
strategies can be employed to respond to a crisis. On this item, the program's response pattern in dealing with psychiatric crises is being assessed.

The comprehensive inpatient program, residential rehabilitation, and the social learning program, by virtue of twenty-four hour coverage were well positioned to respond quickly to crises and were rated a "5". The intensive case management program was rated a "4" as it provided emergency service backup via a call system and had the capacity to make decisions about the need for direct involvement by program staff. The psychiatric rehabilitation day program was rated a "2" as the emergency services were a program-generated protocol for clients (i.e. if a program staff cannot be reached or it is after hours, the client was instructed to call either 911 or some other crisis line). Although the program utilized a call service sponsored by its parent organization, program staff did not directly field crisis calls.

Treatment Team Structure and Process Domain

The Treatment Team Structure and Process domain seeks to establish answers for the questions "How does the clinical work get accomplished?" and "Who does it?" The items in this domain also approach questions about the type of positions / professions that comprise the team. Specific roles can typically be found within the context of a treatment team that are not limited by professional guilds or training (e.g. Supervising Practitioner, Consultant, Psychopharmacologist, etc.). These roles are filled depending on the contextual factors specific to the individual program. Additionally, this domain assesses horizontal (across team) and vertical (administration / management) agreement, the conceptualization of consumers on the team, the process of case management, and the program's use or lack of an evidence-based practice orientation. Together, these items

provide insights into a program's fidelity to its identified mission and level of integration of rehabilitation and recovery concepts. Within the Treatment Team Structure and Process domain, individual items such as Evidence-based Practice Orientation, Recovery Orientation, Psychosocial (psychiatric) Rehabilitation Orientation, Horizontal Agreement, Vertical Agreement, Role of Consumer in Service Provision, Organizational Concept of Case Management, and Approach to Co-occurring SMI and Substance Abuse are examined (see Figure 4.4). An analysis of individual items across programs is provided below.



Individual item scores are based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.4. Treatment team structure and process domain.

Evidence-based practice orientation. It is important to recognize that an evidence-based practice orientation goes beyond the use of empirically supported treatments or the solitary use of "evidence based practices" or packages of services. Evidence-based practice orientation as defined by the CIMHRRS refers specifically to the policy statements provided by the Institute of Medicine (2001) or the American Psychological Association (2005):

- Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values."
- Evidence-Based Practice in Psychology (EBPP) (2005) is the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

The comprehensive inpatient program, residential rehabilitation and social learning program were all rated a "5" indicating these programs fully and consistently integrated all components of EBP orientation into the process of case conceptualization and treatment. The intensive case management program was rated a "4" as it used all components of EBP orientation but did not integrate those components consistently. The psychiatric rehabilitation day program was rated a "2" because it only utilized one of the three components of EBP orientation (client preferences).

Recovery orientation. The concept of *recovery*, as defined by the CIMHHRS, is defined as a *process* that an individual engages in to support his or her personal wellness. Consequently, recovery is not an end-state to be achieved, as is the goal of being "cured." Given the episodic nature of mental illness, the recovery process is a dynamic endeavor.

As such, *recovery-oriented treatment* is defined as a dynamic set of services that are available to consumers of mental health services to facilitate personal wellness at any given stage of an individual's personal recovery and actively promotes community integration. Additional markers of a recovery-oriented system include recovery-oriented language (i.e. hope, respect, empowerment, autonomy), person first language, individualization of services, a focus on a client's personal strengths and desires, facilitating an active role in treatment, and promotion of a value driven life outside of the mental health system however defined by the individual.

The comprehensive inpatient program and residential rehabilitation program were rated a "5" signifying the programs assisted in the development of activities outside the mental health service system (i.e. career development, community integration, or development of leisure activities). The social learning program was rated a "4" indicating the program facilitated the shedding of a patient role (e.g. replacing passive recipient role with role of active consumer of mental health services). The intensive case management and psychiatric rehabilitation day programs were both rated a "2" which means the programs had an explicit statement in their respective program documents that supported a recovery orientation to service provision. However, the programs did not demonstrate a recovery orientation in practice (i.e. services were focused on symptom or risk management, people were referred to by his or her diagnosis).

Psychosocial (psychiatric) rehabilitation orientation. The theoretical basis of psychiatric rehabilitation is inseparable from the concept of a recovery-oriented system. Psychiatric rehabilitation is a comprehensive approach to assessment and treatment of people with serious mental illness and can be usefully understood as a technology for

enhancing recovery. A psychosocial rehabilitation orientation promotes personal recovery by increasing functional abilities through the acquisition of new skills by the client to avoid psychiatric relapse, normalize social roles, increase coping skills, and increase community functioning.

The comprehensive inpatient program, residential rehabilitation program and social learning program were rated a "5" which points to the promotion of the acquisition of new skills or coping abilities that support independent functioning in the community. The intensive case management program reported a rehabilitation focus and did promote social activities in the community, but was rated a "4" because it was incumbent on the provider to organize the activities (i.e. it did not develop clients' ability to independently plan and / or carry out the activity). Consequently, the service recipients remained dependent on the program in this regard. The psychiatric rehabilitation day program was rated a "3" which means it reported a rehabilitation focus but upon closer review, the services were determined to have a maintenance focus (i.e. medication adherence, staying out of the hospital).

Horizontal agreement. Serious mental illness is very heterogeneous. Consequently, the treatment needs of individuals with a serious mental illness are very broad and are typically unable to be met by a single clinician. A team-based approach is the dominant organizational model to address these varied and multiple needs of the client. Horizontal agreement is an organizational term that refers to the degree to which clinicians share an approach to treating a person with serious mental illness. This item assesses the level in which the provider group functions as team rather than a group of individual practitioners.

The comprehensive inpatient program and the residential rehabilitation program were rated a "5" which means the clinical teams within these programs used a consensus process to resolve disagreements. However, when needed, these teams relied on a formal mediation process, which was outlined in their respective program materials. These teams, upon identifying a plan of action, followed the decision outlined by the mediation process. The social learning program was rated a "3" as the clinical team operated within a consensus model. However, there was only an implicit understanding to following the consensus approach outlined by the team (i.e. not formalized in program documents). In addition, the clinical team within the social learning program utilized the developed treatment plan to guide clinical decision making. The intensive case management and psychiatric rehabilitation day programs were both rated a "2" given that the respective clinical teams attempted to function as a single unit but primarily operated as a group of individuals, providing an array of services that were loosely unified clinically. At times, decisions made by individuals within these programs that contradicted the consensus approach or the developed treatment plan.

Vertical Agreement. Strong and dedicated leadership are essential for a program to be effective. Leadership at all levels must support the program mission by developing an environment that supports the program's identified theory / model. This support can be shown by explicitly stating goals and requiring all staff develop the requisite clinical skills through formal and informal training in order to provide services in a consistent fashion, which includes a management plan that addresses how to supervise staff and monitor program implementation. Administrative buy-in to the program theory / model will assist in reducing program drift. Vertical agreement is an organizational term that

refers to the degree to which administrators and management support the treatment team, the identified theory / model of service provision in meeting the program's mission, and treating a person with serious mental illness.

The residential rehabilitation program and social learning program were rated a "5" indicating that within the respective programs, there was consistent agreement across levels of leadership in terms of supporting the model (within the program and the parent organization). In addition, most staff were fully trained and provided services that fell in-line with the program's identified model. The comprehensive inpatient program, intensive case management program, and psychiatric rehabilitation day program were all rated a "1" as the administration of the respective parent organizations of each program appeared to have failed in recognizing the importance of providing program level support in developing vertical agreement among management and how it would support the identified program theory or model.

Role of consumer in service provision. A consumer, as defined in this item, refers to those people who have disclosed a history of psychiatric and / or co-occurring serious mental illness and substance abuse treatment. Consumers are able to fulfill various roles in service provision; however, inclusion of consumers on treatment teams varies across settings ranging from no consumer involvement to having consumers as full-time employees with no differences in staffing responsibilities. This item *does not* measure a participant's input or role as a contributing member of the treatment team in his or her own personal recovery (i.e. currently a client). This concern is addressed within the domain of Treatment Planning. This item does however examine the role of consumers along a continuum of role functioning within the team, ranging from having

no formal involvement in service provision to a full-time paid employee who provides clinically related services to program participants (i.e. an employee who identifies him or herself as a consumer of mental health services).

The comprehensive psychosocial rehabilitation program and the intensive case management programs were rated a "5" indicating these programs or parent organizations had identified consumers employed full-time that functioned as full team members in addressing clients' treatment issues. The social learning program, rated a "4," employed consumers to work *full-time* in roles with reduced clinical responsibilities (e.g. driving clients around, courier, confirming appointments, miscellaneous tasks). The psychiatric rehabilitation day program, rated as a "3" employed consumers on a *part-time* basis and fulfilled roles with reduced responsibilities (e.g. driving clients around, courier, confirming appointments, miscellaneous tasks). The psychiatric residential rehabilitation program was rated a "1" as consumers had no formal involvement in service provision within the program.

Organizational concept of case management. The concept and activities of case management varies by location and by service provider. In some locations case management may be conducted by an individual paraprofessional or an entire team of clinicians. In other settings, the provision of case management is structured to reflect a client's progress in recovery. In such settings, various professionals handle the aspects of case management that are specific to the client's recovery. An example of this would be a nurse providing case management services at the onset of a hospitalization when acute stabilization is the focus of treatment. As the client's symptoms stabilize, a social worker

may assume the majority of case management services as the client moves toward a less structured clinical setting or the community.

The comprehensive psychosocial rehabilitation and psychiatric residential rehabilitation programs were rated a "5". Within these programs, although there may be a single identified case manager or treatment coordinator, specific case management functions were shared by members of a formal interdisciplinary treatment team, based on individual considerations and circumstances (e.g. rapport with staff or time availability). Both the intensive case management and social learning programs were rated a "4" as there was an identified case manager that supervised the implementation of an integrated individualized treatment plan. In addition, that case manager functioned as a member of a formal interdisciplinary treatment team that continuously monitored and evaluated a service recipient's response to treatment and progress in recovery. The psychiatric rehabilitation day program was rated a "2" as case management services were performed by one person that was not identified as part of a formal treatment team and implemented a list of services that did not constitute an integrated treatment plan.

Approach to co-occurring SMI and substance abuse. There is strong research evidence that people with a serious mental illness often have a co-occurring substance use history or disorder. Furthermore, lack of treatment provision for one or the other greatly increases the potential of relapse in the other area of functioning. The CIMHRRS assesses the program's approach to addressing the functional and interactive nature of substance use and serious mental illness.

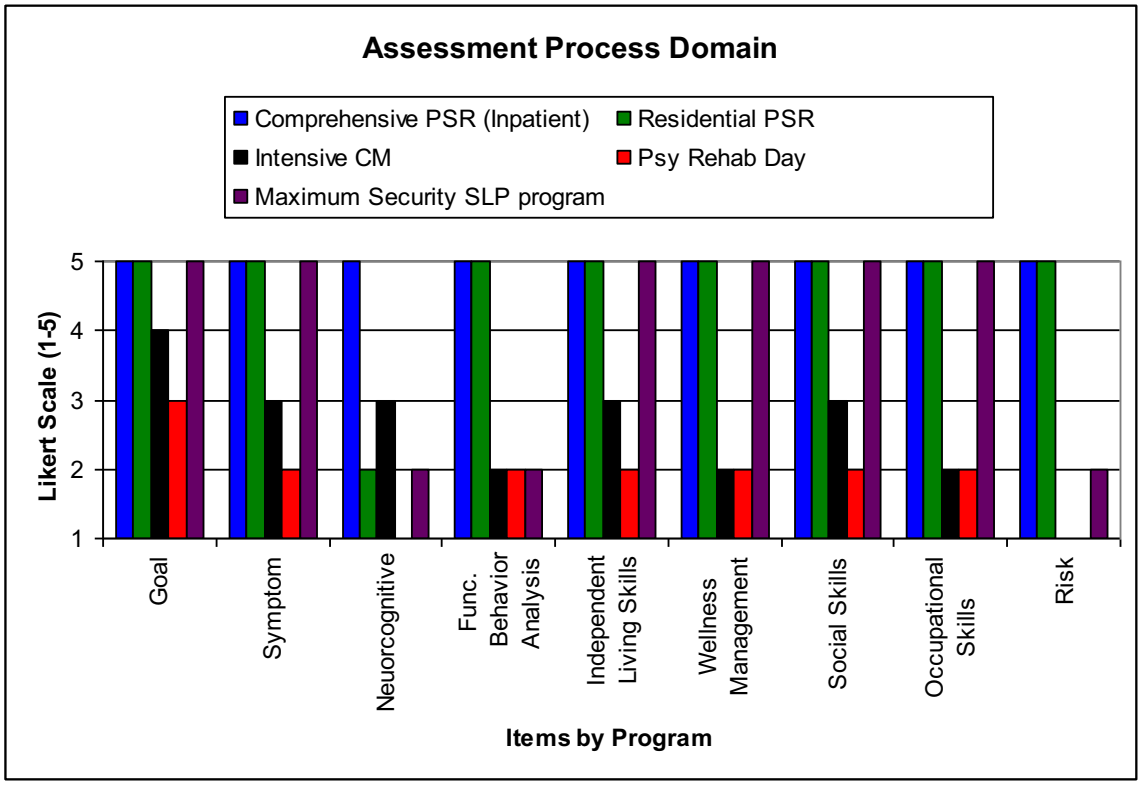
The comprehensive psychosocial rehabilitation program was rated a "4" indicating the program recognized the importance of integrated treatment within program

documents. In addition, the program had an integrated approach but the substance abuse program was primarily based on the traditional models of substance abuse treatment (e.g. confrontation, mandated abstinence, traditional 12- step models) which historically have had limited effectiveness for the SMI population. The psychiatric residential rehabilitation and intensive case management programs were both rated as a "2" because these programs variably addressed substance abuse concerns with service recipients and used separate assessment and treatment planning processes, providing sequential or parallel services without coordination between providers. The psychiatric rehabilitation day program and social learning program were both rated a "1" as the programs had no identifiable process to address these comorbid issues (i.e. no formal individualized substance abuse assessments or treatment was conducted or provided).

Assessment Process Domain

Multiple levels of assessment can occur within a program. Within the CIMHRRS, assessment is focused on a program's capacity to conduct individual assessment of a person's level of functioning at both the initial stages of treatment as well as an ongoing basis. The ability to assess the specific levels of care outlined by the biopsychosocial model of mental illness has implications for determining the program's ability to recognize the multitude of factors leading to the exacerbation, maintenance, or improvement of a person's level of functioning. This comprehensive approach to understanding and treating a whole person has become very important particularly in terms of case formulation within psychiatric rehabilitation. The examination a program's capacity and utilization of assessment affords insight into the program's ability to identify, provide and/or coordinate services. Within the Assessment Process domain,

individual items such as Goal Assessment, Symptom Assessment, Neurocognitive Assessment, Functional Behavior Analysis, Basic Independent Living Skills, Wellness Management / Relapse Prevention Skills, Social / Interpersonal Skills, Occupational Skills, and Risk Assessment are examined (see Figure 4.5). An analysis of individual items across programs is provided below.



Individual item scores are based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.5. Assessment process domain.

Goal assessment. A client's goal, as defined by the CIMHRRS, is what a client wants to achieve or change in the foreseeable future. The purpose of assessing client goals is to make rehabilitation personally relevant by linking rehabilitation objectives to

the client's personal goals. This purpose should not be confused with the traditional purpose of determining whether the client's goals are "realistic."

The comprehensive psychosocial rehabilitation program, the psychiatric residential rehabilitation program and social learning program were rated as "5" which indicates these programs had access or availability to a full range of assessment (both formal and in vivo) to assess goals. In addition, that information was used in both treatment planning and progress evaluation. The intensive case management program was rated a "4" as it systematically performed or accessed goal assessments. That data influenced treatment selection and progress evaluation, but there was no in vivo monitoring of performance in a natural environment. The psychiatric rehabilitation day program was rated a "3" as it systematically performed or accessed goal assessments however, there is no evidence the data influenced treatment selection and progress evaluation.

Symptom assessment. Symptom assessment, as defined by the CIMHRRS, is any evaluation that assesses the frequency, intensity, and duration of a client's reported symptoms. The comprehensive psychosocial rehabilitation program, the psychiatric residential rehabilitation program and social learning program were rated a "5" indicating these programs had access or availability to a full range of symptom assessment (both formal AND in vivo) and that assessment data was is used in both treatment planning and progress evaluation. The intensive case management program was rated a "3" meaning that the program systematically performed or accessed symptom assessments. However, there is no evidence the assessment data influenced treatment selection and progress evaluation. The psychiatric rehabilitation day program was rated a "2" as the program

has limited or anecdotal (informal) assessment capabilities. Furthermore, symptom assessment was sporadic and not associated with systematic monitoring.

Neurocognitive assessment. Neurocognition references the structural components that allow the processes of cognition to occur. Assessment of neurocognition includes the assessment of the relationship between specific neurological structures and the processes of cognition they support (i.e. to what extent does a person's ability to plan and organize become compromised as a result of suffering a traumatic brain injury to the frontal lobe). Typical areas of neurocognitive assessment include attention / vigilance, rate of processing, working memory, verbal learning, visual learning, reasoning, and problem solving.

The comprehensive psychosocial rehabilitation program was rated a "5" as it had access or availability to a full range of neurocognitive assessment (both formal and in vivo). In addition, that assessment data was used in both treatment planning and progress evaluation. The intensive case management program, rated as a "3" demonstrated the ability to systematically perform or access neurocognitive assessments. However there was no evidence the assessment data influenced treatment selection and progress evaluation. The psychiatric residential rehabilitation and social learning programs were both rated as a "2" due to having only limited or anecdotal (informal) assessment capabilities. Furthermore, assessments that were completed were sporadic and not associated with systematic monitoring. The psychiatric rehabilitation day program due to not having access or availability to neurocognitive assessments (anecdotal or formal) within the program or through the larger parent organization, was rated a "1".

Functional Behavior Analysis. Functional behavioral analysis (FBA), according to the CIMHRRS, is a formal method of determining internal events (e.g. thoughts, feelings) and external events (environmental cues, consequences) that exert controlling influences on specific behaviors of interest. Functional behavioral analysis is usually based on a combination of information from the social history and direct systematic observation of behavior and environmental events and performed by a mental health professional with specific expertise in that type of assessment, usually a clinical psychologist. The purpose of the functional behavioral analysis is to identify events that can be controlled or manipulated in order to enhance skill acquisition or replace undesirable behaviors with adaptive behaviors.

Both the comprehensive psychosocial rehabilitation program and psychiatric residential rehabilitation program were rated a "5" due to having access or availability to functional behavior analyses. In addition, the information gathered in FBA was used in both treatment planning and progress evaluation. The intensive case management program, social learning, and psychiatric rehabilitation day programs were all rated a "2" indicating these programs had limited or anecdotal (informal) FBA capabilities. FBA was used sporadically and not associated with systematic monitoring.

Self care/basic independent living skills. Basic self care and independent living skills, according to the CIMHRRS, are the abilities to perform necessary daily tasks and manage routine demands. Limitations in these skills produce limitations on the ability to living independently and function as a competent adult. A person's independent living skills are often a key determinant in discharge destinations, aftercare needs and housing options for people with serious mental illness. Formal assessments of self-care / basic

independent living skills are potentially useful to organizations to identify potential strengths and areas that may benefit from additional skills training.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, and social learning program were rated a "5" as these programs had access or availability to a full range of self-care and basic independent living skill assessments (both formal and in vivo). In addition, these programs used that assessment information to inform both treatment planning and progress evaluation. The intensive case management program was rated a "3" due to the program systematically performing or accessing these types of assessments. However, there was no evidence the assessment data influenced treatment selection and progress evaluation. The psychiatric rehabilitation day program was rated a "2" due to the program having limited or anecdotal (informal) assessment capabilities. Additionally, when the program did perform these types of assessments it was sporadic and not associated with systematic monitoring.

Wellness management/relapse prevention skills. Wellness management and relapse prevention skills, as defined by the CIMHHRS, are specific abilities associated with overcoming the effects of mental illness and related problems. These include medication-related skills, coping and management of stress, recognition of triggers, warning signs and risky situations, prevention of relapse, and related skills. Since individuals experience mental illness and related problems in unique ways, skills in this domain must be highly tailored to individual needs. Therefore, assessment of these skills must be sensitive to these individual differences. For this reason, formal assessment is generally done in the context of skill training in specific areas.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, and social learning programs were rated a "5" indicating these programs had access or availability to a full range of wellness management and relapse prevention skill assessments (both formal and in vivo). In addition, the assessment data was used in both treatment planning and progress evaluation. The intensive case management and psychiatric rehabilitation day programs were both rated a "2" because they had limited or anecdotal (informal) assessment capabilities. Even when these types of assessments were conducted, they were sporadic and not associated with any systematic monitoring.

Social/Interpersonal skills. The CIMHHRS defines social and interpersonal skills as the abilities involved in interacting with other people, in all the various ways in which people interact. Problems in this area range from deficits in the most basic skills (e.g. ability to make casual conversation) to the most complex (e.g. ability to solve conflicts and maintain friendships and intimate relationships). Clinical assessment must therefore also incorporate a wide range of skills, consistent with the diversity in skill levels found in the program's client population. Assessments may address the behavioral level of functioning, e.g. ability to actually perform specific social behaviors, and social cognition, e.g. the ability to apprehend social situations, recognize social cues, and understand the perspective of other people.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, and social learning programs were rated a "5" as these program had access or availability to a full range of social / interpersonal skills assessments (both formal and in vivo). All of these programs used the assessment data to inform both

treatment planning and progress evaluation. The intensive case management program was rated a "3" due to it systematically performing or accessing these types of assessments. However, there was no evidence the data influenced treatment selection and progress evaluation. The psychiatric rehabilitation day program because of its limited or anecdotal (informal) assessment capabilities was rated a "2". When it did complete an assessment, it was sporadic and not associated with any systematic monitoring.

Occupational skills. Occupational skills, according to the CIMHHRS, are those skills by which a person maintains meaningful activity beyond self-care, housekeeping and wellness management. Employment is often a hallmark that is associated with normal occupational functioning in adults, and for many people, employment is a key occupational goal. However, people generally have several occupational goals, and employment is not necessarily one of them. Others may include having an absorbing hobby or doing volunteer work. Whatever the occupational goal, there are specific skills required to pursue that goal, and these must be addressed if the goal is to be realized. Therefore, occupational assessment and skill training must be guided by the particular occupational goals that each individual brings to or develops in the rehabilitation / recovery process.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, and social learning programs were rated a "5" as these programs had access or availability to a full range of occupational skills assessments (both formal and in vivo). These programs used the assessment data to inform both treatment planning and progress evaluation. Both the intensive case management and psychiatric rehabilitation day program were rated a "2" because they had limited or anecdotal

(informal) assessment capabilities. Even when these types of assessments were conducted, they were sporadic and not associated with any systematic monitoring.

Risk Assessment. Risk assessment has become an important issue in the provision of clinical services and has ramifications for discharge not only for the client but for the organization as well. Generally speaking, risk assessment is an evaluation of potential issues that may pose a risk to the client, staff, or property. Risk falls into several domains, including risk for aggression, risk for self-injury, risk for substance abuse, risk for eloping or not adhering to treatment, and risk for engaging in illegal or exploitative behavior. These issues have temporal significance, as the potential risk factors when a client enters treatment are qualitatively and quantitatively different from when a client prepares to leave a treatment setting. As a result, a program should be able to assess risk at multiple time points in a client's treatment. Risk assessment may include formal actuarial measures, but these generally only assist experienced clinical judgments about the nature and severity of the risk and its optimal management. A complete risk assessment must usually include a complete functional analysis of the person's risk in the particular situation or environment in which the person is or will be functioning. In addition to the identification of risk, a program should feasibly be able to identify protective factors that reduce any potential for risk.

The comprehensive psychosocial rehabilitation program and psychiatric residential rehabilitation program were rated a "5" as these program had access or availability to a full range of risk assessment capabilities (both formal and in vivo). These programs used risk assessment data to inform both treatment planning and progress evaluation. The social learning program was rated a "2" because they had limited or

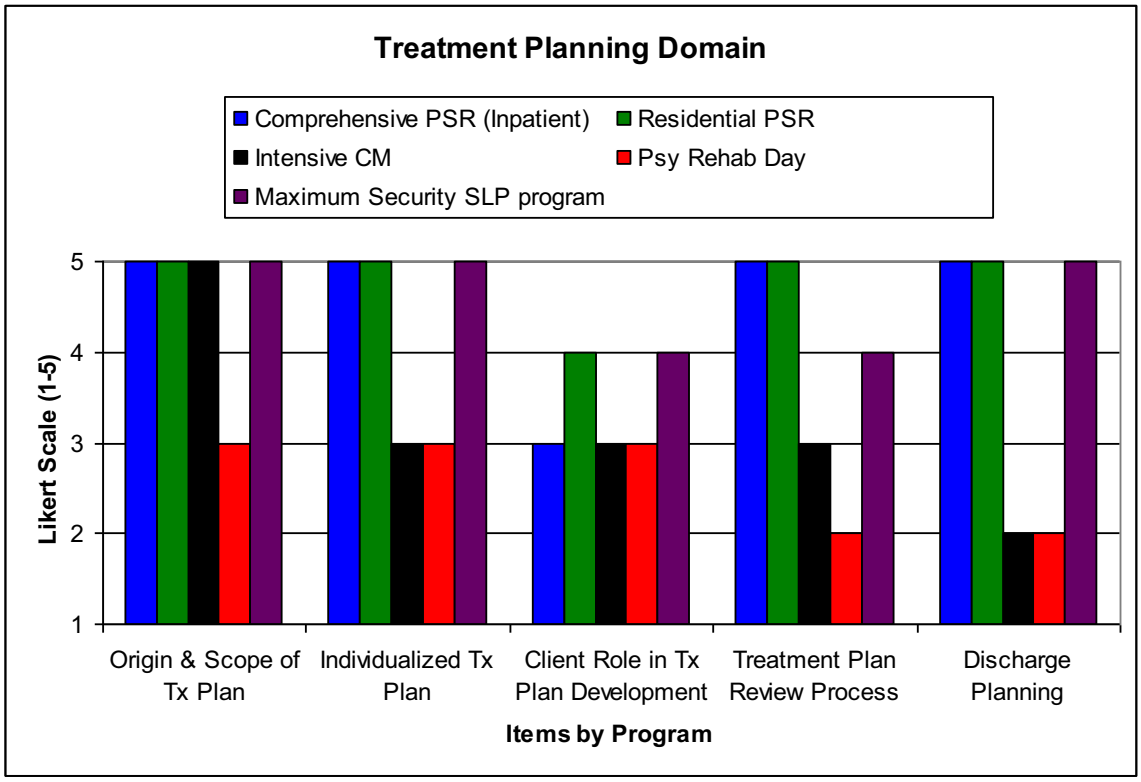
anecdotal (informal) risk assessment capabilities. When risk assessments were completed, they were sporadic and not associated with any systematic monitoring. Lastly, the intensive case management and psychiatric rehabilitation day programs were both rated a "1" because of no access or availability to risk assessments (anecdotal or formal) within the program or through the larger parent organization.

Treatment Planning Domain

Review of a program's treatment planning process allow for the evaluation of the "what" and "how" of service provision within the program. Questions in this domain help identify the processes used by a program in treatment planning and case formulation. Also within this domain, the individualization of treatment, inclusion of recovery concepts, and the focus of the treatment plan are reviewed. Within the Treatment Planning domain, individual items such as Origin and Scope of Treatment Plan, Individualized Treatment Plan, Client Role in Treatment Plan Development, Treatment Plan Review Process, and Discharge Planning are examined (see Figure 4.6). An analysis of individual items across programs is provided.

Origin and scope of treatment plan. Understanding the origin and scope of the treatment plan has implications for understanding the role a program fulfills within a larger organizational scheme. It highlights accessibility to the treatment plan and consequently the extent of control of its content. In addition, it assists the evaluators in determining the degree of specificity of program response and clientele.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, intensive case management program, and social learning program



Individual item scores are based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.6. Treatment planning domain.

were all rated a "5" indicating treatment plans were developed within the respective program and included all relevant services, including links to other programs when warranted. The psychiatric rehabilitation day program was rated a "3" as the program operated from a treatment plan that was developed outside of the program but had program staff input.

Individualized Treatment plan. This item examines the organizational commitment and capacity to individualize a response to a client's unique manifestation of symptoms and level of functioning. A highly individualized treatment plan will assist the

treatment team in providing a highly individualized response and measurement of treatment outcomes.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, and social learning program were rated a "5" as the diversity across treatment plans reflected the diversity of assessment results found in the service recipient population. Both the intensive case management and psychiatric rehabilitation day programs were rated a "3" as treatment plans incorporated only anecdotal personal information to guide treatment selection.

Client role in treatment plan development. The role of consumer in treatment plan development has implications for both a recovery-oriented system and psychiatric rehabilitation. The degree to which a client is involved in the development, monitoring, and implementation of a treatment plan, the greater relevance it has to a client's personal recovery. In terms of rehabilitation, the more that a client is able to identify and facilitate treatment planning activities, the greater the client's functional independence. This item evaluates a program's inclusion of consumers in treatment planning. It is expected that a program may meet a number of these anchor points due to the heterogeneity of individual clients being served. However, the intent of this item is to capture the functional aspects of the individual program and the mode in which it most frequently operates.

The psychiatric residential rehabilitation and social learning programs were rated a "4" indicating consumers actively collaborated with providers to develop the treatment plan. The comprehensive psychosocial rehabilitation program, intensive case management program, and psychiatric rehabilitation day programs were all rated a "3" as treatment plans were typically provider driven but based on consumer preferences.

Treatment plan review process. This item assesses the continuum of external versus clinical factors that prompts a program to conduct a treatment plan review (TPR). There are a number of reasons why a program may conduct a TPR. A TPR may occur to meet criteria established outside the program such as Medicaid, in order of maintain funding resources. However, a program may implement an internally driven TPR process that is responsive to changes an individual's clinical presentation, and by virtue of this process, meets the minimal criteria established by external stakeholders. Organizations may vary in this approach. As such, the purpose of this item is to determine if the TPR process is external or internal driven.

The comprehensive psychosocial rehabilitation program and psychiatric residential rehabilitation program were rated a "5" as there was a mechanism and procedure within the program documents that directed follow up and documentation on findings of insufficient progress. The social learning program was rated a "4" as its process allowed for the quantitative determination of progress (or lack there of) and distinguished between areas of lesser or greater progress in treatment. The intensive case management program was rated a "3" as program documents outlined features of internal TPR processes in addition to those required by regulation (e.g. who must attend TPRs) and/or a mechanism for a meeting schedule that exceeded regulatory standards. The psychiatric rehabilitation day program was rated a "2" as the only prescribed feature of a TPR process were those required by regulation (e.g. frequency).

Discharge planning. Depending on the program's identified mission or program theory / manual, discharge planning may vary greatly across programs. Some programs may not have well established discharge criteria or some programs discharge criteria may

be established by fidelity standards and limit the amount of discharges. For other programs, where discharge criteria is established and clients are expected to eventually leave or graduate from a program, the question remains of when discharge planning should begin and whether this is a passive or active endeavor.

The comprehensive psychosocial rehabilitation program, psychiatric residential rehabilitation program, and social learning program were all rated a "5" as the discharge process within these programs began at intake. These programs actively identified barriers to treatment and discharge during intake sessions and on an ongoing basis. The intensive case management program and psychiatric rehabilitation day program were both rated a "2" as both programs respective missions and program documents indicated some discharge criteria. However, discharges from these programs were atypical. Being discharged from these programs typically resulted from unmanageable risk factors, a client moving, treatment non-compliance, a client entering a different service system (e.g. jail), or death.

Feasibility

In order to evaluate the feasibility of the CIMHRRS, site visits were conducted with the intended population (i.e. service programs for people with SMI). The investigator purposefully selected service programs that represented an array of services specific to an adult SMI population that varied by location (e.g. urban, rural), setting (e.g. inpatient, residential, community), security (e.g. maximum, medium), service provision, and estimated levels of psychiatric rehabilitation and recovery-oriented services. Based upon the results of the domain and item analyses, the CIMHRRS appears to be capable of capturing the structure, process, and functioning of SMI service programs.

Another marker of feasibility is the cost associated with the time required to participate in an evaluation. The time to complete each program evaluation averaged 16 hours of being on site at the respective service locations. In some of the programs, the CIMHRRS was administered within two, eight-hour days whereas other programs were completed in as many as 5 sessions over the course of a week and a half, demonstrating flexibility in instrument administration and meeting individual program needs. Within each site visit, program administrator interviews averaged 1.5 hours whereas two program staff interviews averaged 1.0 hours each, comprising 22% of the time spent on site. It is important to note that that the overall approximated time on site included the iterative rating process of percent item development, which was completed before concluding a site visit. This process added a considerable amount of time to the overall process. Time to administer the CIMHRRS would be expected to decrease in the future, as item development would not be included as part of the process. Additional time considerations are the time required to consolidate data and providing feedback to programs either in written and / or verbal format(s). Depending on the program's request or needs, the evaluators provided programs with various types of feedback in the form of formal written evaluations with recommendations, executive summaries, or verbal consultation. As such, time varied based upon the type of feedback provided. Full reports could be provided within a week's time, whereas summaries and consultation could occur more rapidly. Based upon these factors, the investigator found the CIMHRRS administration, scoring, and reporting times to be consistent with similar types of program evaluation or fidelity assessment instruments.

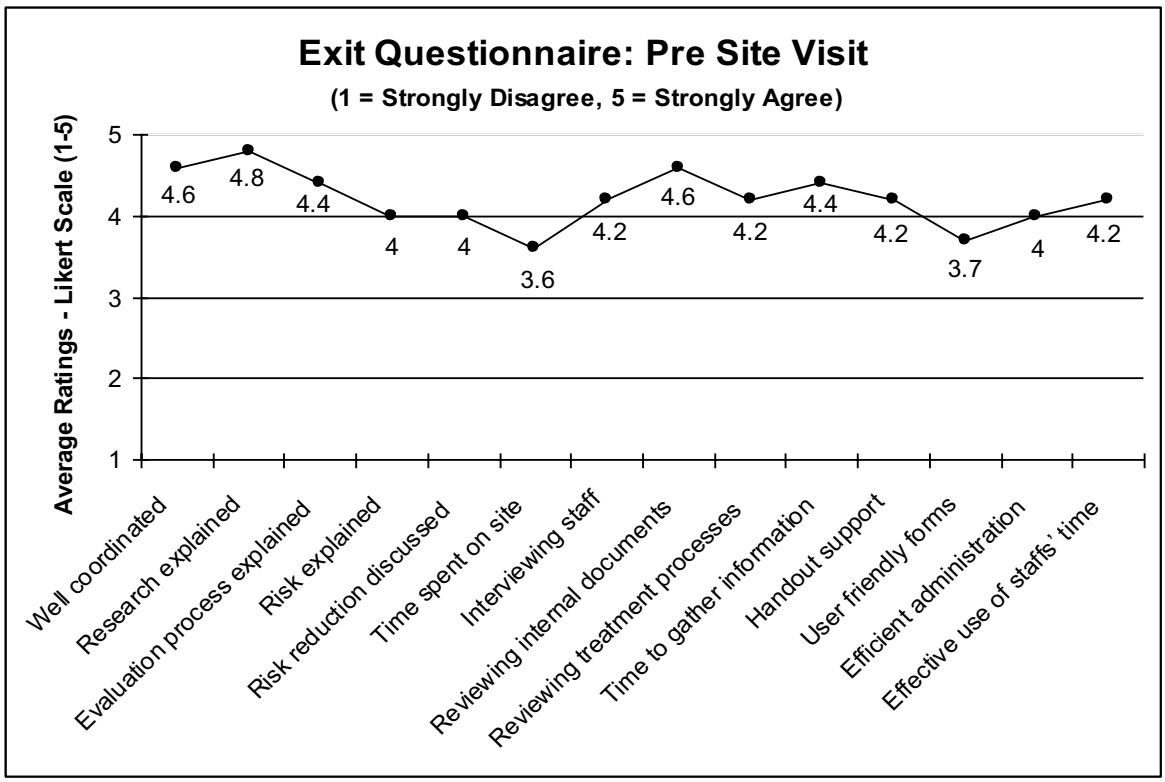
Markers of feasibility and utility such as clarity of purpose, engagement of stakeholders, competency and accessibility of evaluators, individualizing of the evaluation to each program, and minimizing disruption were captured within the Exit Questionnaire that was completed by the program after completing a site visit. Program responses are summarized below. The impact the report or consultation had on program functioning could most readily be evaluated in the program's ability to develop and implement an administrative intervention based upon the recommendations offered by the evaluator but is beyond the scope of the present study.

Using a five-point Likert scale (1 = Strongly Disagree and 5 = Strongly Agree), programs were asked to rate the investigators on activities that occurred prior to and during a site visit. The pre-site visit section of the questionnaire consisted of twelve questions that examined the coordination of the site visit, review of goals and risks of the project, processes involved during the site visit, and time and support provided to the program in completing the pre-site handouts (see Figure 4.7). The questionnaire also focused on activities that occurred during the site visit. This section is comprised of eight questions which considered various aspects of site reviewer conduct, efficiency of the site review, impact on clinical services and capacity of the CIMHRRS to capture the services provided by programs as well as information typically not collected in traditional program evaluation (e.g. clinical outcome studies) and accreditation reviews (e.g. CARF, JCAHO). See Figure 4.8.

Based upon the results of the Exit Questionnaire, the CIMHHRS overall appears to have sufficiently met the markers of fidelity and utility. Data collected from the exit questionnaire suggest the programs in general, perceived the evaluation experience

positively. Responses from the respective program administrators indicated the investigators were perceived as professional, interactive, and flexible in attempting to minimize impact on clinical programming and staff schedules. One program administrator shared that while the evaluation was "thought provoking" it took longer than anticipated. Perceived liabilities included the need to clarify terms used within the process of conducting interviews, suggesting a need to be more sensitive to all levels of staffing. In addition, some programs commented the process was time consuming and suggested shortening the time of clinical interviews. In contrast, the perceived strengths indicated the programs believed the evaluation to be very comprehensive and relevant to the type of work being completed within the respective programs. One program considered the CIMHRRS to be a "very valuable and useful evaluation." Another program shared that it "made me stop and think about how we integrate recovery into our program, how we evaluate recovery and possible changes that could be made better." When asked how might the CIMHRRS more efficiently gain access to the information gathered within the evaluation, programs suggested asking for program related information the day before the actual site visit which could be reviewed and potentially decrease time on site. In addition, when responding to this question, some programs identified how they themselves may more efficiently access the requested information such as training staff to be able to more readily access information from other departments and developing data-driven infrastructures that would make gathering and review of pertinent data more efficient thereby saving staff members of having to "dig" through files. In examining how the utility of the CIMHRRS differed from similar review processes, one program stated there was "nothing in the recent past to compare it

to." Other programs shared other review processes do not include interviews and that the interviews were thought provoking and useful, helping one program administrator to "think about and organize how we do business better in my head." Some of the useful benefits of the CIMHRRS in comparison to other review processes were that more time was spent on the processes of the program, which allows specific feedback to be provided to the program. Lastly, one program felt the CIMHRRS was "more focused on recovery and rehabilitation which is closer to our mission than (a) Joint Commission survey.



Individual item scores are based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.7. Exit questionnaire: pre site visit.

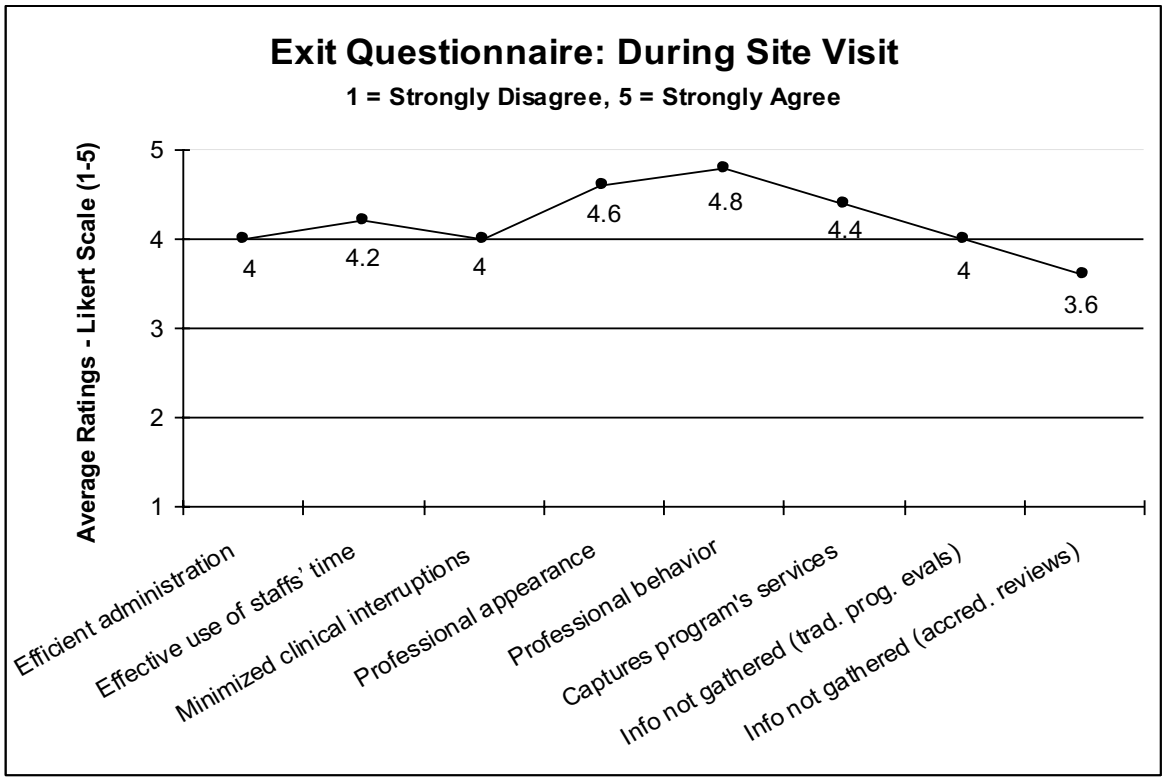


Figure 4.8 - Individual item scores are based on a 5-point Likert Scale, with the highest score for each section being a "5" and the lowest score being "1."

Figure 4.8. Exit questionnaire: during site visit

Chapter 5

Discussion

The initial conceptualization of the CIMHRRS was in response to changes in national mental health policy, more specifically, the President's New Freedom Commission on Mental Health Report (2003) and the 1999 Surgeon General's report on Mental Health. These documents mandated the transformation of mental health services for people with serious mental illness and changed the focus of service provision to rehabilitation and recovery models of treatment. The principles set forth in these documents set in motion major policy reformation in the U.S. Substance Abuse & Mental Health Services Administration (SAMHSA), the Joint Commission on Accreditation of Healthcare Organizations (JCHAO), the Veterans Administration and various national healthcare professional organizations. In the absence of an instrument that measured the integration of psychiatric rehabilitation and recovery principles at the program level and had the capacity to span the breadth of various SMI services, the various stakeholders have lacked an instrument to measure the comprehensive integration of these concepts into services settings. Furthermore, without such an instrument, there was no way of measuring functional changes within or across national or local mental service systems. While there are fidelity assessments that measures the adherence to particular psychosocial interventions, to date there is no known study that measures service program adherence to the principals of psychosocial rehabilitation or recovery-oriented principals.

Overall, there was strong support for the hypotheses of the study. In support of the first hypothesis, the CIMHRRS demonstrated excellent rater agreement and inter-

rater reliability across service settings, exceeding the reliability criterion. The second hypothesis was also supported as the CIMHRRS, as a whole demonstrated excellent internal consistency and good to excellent internal consistency within the specific domains. The results also supported the third hypothesis. While the intention of the CIMHRRS is not the direct comparison of different types of service programs, it demonstrated the capacity to differentiate qualitative aspects of various types of SMI programs in addition to evaluating the integration of psychiatric rehabilitation and recovery-oriented services.

The development of the CIMHRRS served the purpose of both services research (e.g. characteristics of effective service programs) and program evaluation (performance of specific programs in the real world). This process is best informed by a scientific, functional, and systematic approach to understanding the contextual processes in which SMI services are received and rendered, all of which are addressed by the CIMHRRS. As a result, the CIMHRRS could feasibly serve as a conduit between mental health policy and clinical practices informing the transformation of SMI service systems at both the national and local level.

Service Research Implications

Implementing policy changes that effectively brings about functional change at the program level can be difficult. Typically, policy mandates are implemented in a top-down approach. Consequently, valuable resources are distributed broadly across the highest levels of a service system in attempt to meet the mandated changes. This often leads to the trickling down of those resources which unfortunately all too often becomes bogged down, making system transformation slow or ineffective altogether. While it is

reasonable to expect a standard of service provision from a system, mandating that service systems implement broad sweeping changes without the assessment of the context in which those systems are operating or providing services is inefficient in effecting functional program-level changes. Ironically, this top-down approach to implementing systemic change is also contradictory to the individualized assessment and specified response delineated by psychiatric rehabilitation and the recovery movement. To bring about effective change at the program level of mental health services a new approach is required.

The CIMHRRS could provide a useful new methodology in which to assess mental health systems' adherence to mental health policy mandates (i.e. psychiatric rehabilitation and recovery). By virtue of its focus on the program level of functioning, the CIMHRRS has the capacity to assess the structure and processes of individual programs in relation to the larger mental health system and the mandates outlined in national mental health policy. This bottom up approach to bringing about change is nothing new to organizational consultants that provide individualized assessments of programs. Armed with the specifics of program functioning, a consultant can develop a highly individualized plan in response to an organization's goals. The CIMHRRS provides such a tool in which a structure and process analysis of program functioning can be conducted. As a result, an assessor would be in a position to provide highly specific feedback in meeting the mandates outlined in federal mental health policy to a program as it attempts to move toward integrating psychiatric rehabilitation and recovery-orientation concepts into its services and consequently the local mental health system. Furthermore, the CIMHRRS could provide a format in which those mandates could be

systematically assessed and monitored by program administrators or regulatory bodies, subjecting the concepts of recovery and rehabilitation to scientific rigor and providing a useful and meaningful instrument to compare SMI service programs.

Program Evaluation Implications

Despite being in the early stages of its development, project results indicate that the CIMHRRS is an effective program evaluation tool. It has the capacity to provide an objective, comprehensive assessment of program functioning and is capable of capturing the differences in structure, process, and functioning of SMI service programs. Regardless of program title or proclaimed model of service provision, the CIMHRRS was able to capture the functional integration of psychosocial rehabilitation concepts and the recovery orientation of individual service programs. This is particularly relevant in terms of moving service programs beyond text changes in internal program document and jargon driven treatment to functional changes within a program.

The CIMHRRS has the potential to provide clinicians, administrators, and relevant stakeholders with a structural and process analysis of individual programs. The results of the site visit could produce a list of program strengths and liabilities as well as specific recommendations that could be used to implement change. Administrators could feasibly use this information to implement and monitor organizational and program level interventions to increase the integration of psychiatric rehabilitation services, recovery-oriented concepts, and related clinical outcomes. This approach to program evaluation is uniquely different from evaluations that focus primarily on program demographics and clinical outcomes once a year as it provides insight to what processes produced the end of the year results. As a result, it equips programs with the information needed to affect

functional programmatic change and minimize program drift from its specified mission and program model.

Aside from being a useful tool in the evaluation individual programs, the CIMHRRS could be used in the transformation of mental health organizations or systems. Employed at multiple sites or programs within the same organization, the CIMHHRS could be used to develop an agency profile, providing clinicians, administrators, policy makers, and relevant stakeholders with an objective comprehensive assessment of agency need and functioning. Given across an entire agency, the CIMHRRS has the potential to identify redundancy or breaches in service provision. This information could inform organizational structure in terms of provision of clinical services as well as highlight areas in which to reallocate valuable resources such as personnel or finances in support of program mission and model, staff or client needs, or meeting mental health policy mandates.

Limitations of the Current Study

Due to the exploratory nature of this project, a limited number of programs were involved in the study. As the design of the project was to assess the capacity of the CIMHRRS to capture a breadth of services, the project purposefully evaluated programs that were unique in location, setting, and integration of psychiatric rehabilitation services and recovery orientation concepts. Consequently, the capacity of the CIMHRRS to evaluate similar types of programs (e.g. assertive community treatment teams) was not determined in this project. In addition, due to the iterative process used in item development, inter-rater reliability may have been artificially increased. This iterative process also contributed to the consistent reports that the overall process was time

intensive. While the result of this study is promising, replication of this study in a larger-scale project is warranted.

Future Directions

In addition to replicating the current project with a larger data set, the CIMHRRS could be evaluated though a variety of research designs with the intent of answering a distinct of questions. To further determine the instruments organizational or agency utility, a project designed to analyze the capacity of the CIMHRRS to differentiate qualitative aspects of service provision between multiple programs under the same administrative auspices could be conducted. In terms of measuring the stability of CIMHRRS ratings over time, pre and post studies could also be conducted. Arguably, this could be accomplished while assessing the instrument's capacity to function as program process monitoring tool (i.e. monitoring a program's response to administrative interventions). Finally, cross validation with other recovery surveys and / or psychosocial rehabilitation fidelity instruments would be useful in establishing construct validity.

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APPENDIX A

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS).

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS).

- Administration Manual
- Scoring Booklet
- Pre-visit Activity
  - Program Face Sheet
  - Evaluator's Pre-visit Checklist
  - Program Pre-visit Checklist
  - Program Administrator Handout
- During visit Activity
  - Program Administrator Interview
  - Staff Interview

COMPREHENSIVE INVENTORY OF MENTAL HEALTH
&
RECOVERY AND REHABILITATION SERVICES

(CIMHRRS)

ADMINISTRATION MANUAL

The Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS)

~

Administration Manual

Table of Contents

INTRODUCTION

This manual is intended to provide an overview of the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS) (pronounced "simmers"), and help guide its administration. The manual is divided into eight functional domains, Program Mission, Program Demographics and Composition, Organizational Boundaries, Program Functioning, Treatment Team Structure and Process, Assessment Process, Treatment Planning, and Treatment Provision. A definition is provided of each domain to facilitate understanding of its intent within the context of conducting a program evaluation. Within each domain, a definition and rationale for each individual item is also provided. Within each item, potential sources of information are identified to assist evaluators in finding the requisite information to rate a program, as are scoring rules, and keys to help an evaluator to determine a programs rating. In addition, throughout the manual, there are *CIMHRRS ADMISTRATION NOTES,* highlighted by gray text boxes that help guide evaluators in the administration of the instrument.

There are temporal markers within the administration of the instrument. As such, there are a series of forms and activities that are to be completed before and during a site visit. An overview of the CIMHRRS and its various forms are listed below. Details of the administration of the CIMHRRS are covered in more detail within the *HOW TO ADMINISTER THE CIMHRRS* section. Similarly, the scoring procedures can be found within the *HOW TO SCORE THE CIMHRRS* section of the manual.

OVERVIEW OF THE CIMHRRS

The CIMHRRS is a theory driven instrument used to assess the fidelity of various programs to particular service models, and to quantitatively and qualitatively characterize programmatic differences in service settings. However, the CIMHRRS does not function as a traditional fidelity measure in that it does not have a narrowed predetermined model that in which it compares the results of the program to some ideal level of functioning. Traditional fidelity measures are limited in their scope and are only applicable to vertical silos of treatment provision within a larger service program. In contrast, the CIMHRRS assumes a more comprehensive (i.e. horizontal) approach to assessing entire service programs. Designed to capture the level of integration of psychiatric rehabilitation and recovery-oriented services into settings that provide services to people with serious mental illness (SMI), the CIMHRRS, through a structured site review, provides a comprehensive and systematic approach with which to assess program structure, organization, and procedures for providing services to people with SMI. The anchors used in the CIMHRRS were established through expert consensus, extensive literature review, and empirical research.

Rooted in the concept of functional assessment; the CIMHRRS, is used in the programmatic evaluation of individual service providers by examining structural and organizational components and the processes of assessment and treatment provision to individuals with SMI. Strengths and liabilities of service programs are evaluated on a continuum that includes neurobiological, cognitive, behavioral and social-environmental levels of functioning. The most molecular levels of functioning include the impact of neurophysiological abnormalities. The intermediate levels include cognitive abilities (e.g. problem solving, self-monitoring, and ability to make social inferences). The most molar levels of functioning extend to the person's environment, and include family functioning, cultural attitudes about mental illness, and implications of public policy on service provision for individuals and families affected by SMI. The functional approach of the CIMHRRS recognizes the provision of services to people with SMI as complex integrated systems, while affording a comprehensive picture of a program's level of integration of psychiatric rehabilitation and/or recovery-oriented services. Most importantly, the CIMHRRS provides clinicians, administrators, and policy makers with an objective and

comprehensive assessment of a programs functioning and serves as an indicator of the level of integration of psychiatric rehabilitation and recovery-oriented services.

OVERVIEW OF CIMHRRS FORMS

Before Site Visit Forms

Program Face Sheet – The program face sheet is used to collect superficial information such as the program's name, parent agency, address, and the point of contact for the evaluation. In addition, it documents aspects of the evaluation such as the sources of information used within the evaluation and who conducted the site visit.

Evaluator's Pre-visit Checklist – This form directs the activities of the evaluator prior to conducting a site visit. It serves as a guide to establish rapport with a program and to develop a shared understanding of the processes that will occur during the site visit. It is useful in the coordination of site visits, identifying time requirements for various aspects of the visit, staff demands, materials and resources needed, and activities that will facilitate an efficient site visit.

Program Pre-visit Checklist - This form is time intensive and may take the program considerable time to gather the requested information. After establishing the details of the site visit, it is important to provide the program with ample time to complete this form in order to reduce any undue imposition to the program. Ideally, a program would have at least two weeks to review and complete this form prior to conducting the site visit. It is not necessary however, to have this form completed prior to beginning the on site evaluation, but doing so would facilitate a more efficient review.

Program Administrator Handout – This form is completed by the program administrator and is time intensive. Completion of this form includes gathering data about location of service provision, admission and discharge rates, staff vacancies, who fulfills various program roles, and the provision or coordination of evidence-based practices specific to SMI populations. Like the Program Pre-visit Checklist, this form should be sent to the program administrator in advance of the site visit, affording sufficient time to consolidate the information while reducing the burden of completing the form. It is not necessary to have this form completed prior to beginning the on site evaluation, but doing so would facilitate a more efficient review.

During Site Visit Forms

Program Administrator Interview – This is a semi-structured interview with an average administration time of approximately 90 minutes. However, the estimated time to conduct the interview is dependent on program administrator's responses. The interview provides access to a program administrator's perspective on various aspects of programmatic functioning, including identification of the program's mission and model of treatment, organizational boundaries, integrated service provision, crisis response, treatment team structure and process, incorporation of psychosocial rehabilitation and recovery concepts, role of consumers, and assessment and treatment processes including treatment and discharge planning.

Staff Interview – The staff interview is similar to the program administrator's in that it is a semi-structured interview. However, the questions are more focused on staff level knowledge and as a result, a shorter

administration time. On average, staff interviews take 60 minutes to administer however, the estimated time to conduct the interview is dependent on individual staff responses. At a minimum, this form is administered to two staff members who have been selected by the evaluator to represent a range of staffing; including direct care staff and an intermediate level professional (i.e. staff with increased responsibilities but do not function as program administrators). The purpose of interviewing a continuum of staffing is to facilitate a representative sampling of staff, obtain a breadth of perspectives on program functioning and to assess continuity of staff comprehension and penetration of program specific knowledge.

Scoring Booklet – The scoring booklet is used to consolidate the breadth of information gathered from the various stages of the program evaluation. The scoring booklet facilitates the rating process by serving as a platform in which information gathered before and during a site visit is integrated and subsequently used to rate the program.

WHO SHOULD USE THE CIMHRRS

The intended audience for the CIMHRRS is private or public sector mental health service programs. More specifically, the CIMHHRS is appropriate for programs who serve adults who have been categorized as having a serious mental illness. It is intended to be used as an evaluation tool to assist organizations who are interested in measuring and monitoring the integration of psychiatric rehabilitation, evidence-based practices, and recovery-orientation within individual service programs and provides clinicians, administrators, and policy makers with an objective assessment of these concepts.

The CIMHRRS may be administered to a single service program or multiple service programs within the same agency. Administering the instrument to multiple programs within the same agency would facilitate a larger organizational profile in which aspect of the different service programs could be compared. This information could feasibly be used to identify gaps or overlaps in service provision and facilitate more efficient use of valuable resources. The CIMHRRS could also be also used as an ongoing measure of program performance of individual service programs.

The recovery and rehabilitation focus of the CIMHRRS makes it usefully different from program evaluations that center specifically around clinical outcomes. While these types of evaluations are useful in letting service programs know the results of their work, they do little to nothing in determining the active ingredients of service provision. In other words, programs unfortunately do not have a clear understanding of how they achieved those results or how to effect change within their program to improve clinical outcomes, client satisfaction, or assess for program drift. The CIMHRRS provides a structural and process of analysis of a program that can be used to provide specific feedback to administrators on the functioning of service programs. The information provided by the CIMHRRS can be used develop and implement administrative interventions to effect change within organizations. It can be used in preparing for accreditation visits, meeting mandates outlined by national and local mental health policy, or transform mental health services.

Lastly, only individuals who have been trained in the standardized administration of the instrument should administer the CIMHRRS. An educational background or training in psychological assessment, clinical interviewing, and data collection and analysis would be ideal to conduct program evaluations with the CIMHRRS.

HOW TO ADMINISTER THE CIMHRRS

The format in which the CIMHRRS is administered is that of an on-site program evaluation. On-site activities take approximately 16 hours to complete. Ideally, these activities are completed over the course of two consecutive days. Gathering program level data within a narrow window of time will provide a comprehensive snapshot of program functioning at a specific time point. However, given the need to individualize the administration of the instrument to meet the contextual demands of a program, it can easily be administered in smaller time segments over an extended period.

While each site visit will require an individualized approach, administration of the CIMHRRS can functionally be understood to occur in three timeframes, before, during and after a site visit. The following will provide a general guideline for optimizing the administration of the CIMHRRS and conducting an efficient site review.

Prior to the site visit, evaluators should conduct the preliminary meetings with program staff to establish rapport and develop an understanding of why the program would like to have a program evaluation completed. As part of this process, the evaluator should complete the Program Face Sheet and conduct a review of the Evaluator's Pre-visit Checklist with the program administrator. Completion of these forms will help establish a basic understanding of the activities that will occur during the site visit, including demands of staff, and the materials and resources needed to conduct the evaluation. In addition, it will help in the coordination and confirmation of a time line for the site visit. The evaluator should provide the program with the Program Previsit Checklist and Program Administrator's Handout. These forms should be provided as early in the process as possible as they are time intensive and will require additional time by the program to complete.

If possible, the evaluator may want to consider requesting copies of program materials to preview prior to conducting the site visit. Such items may include a program's Policy and Procedure Manual, Program Handbook, or any relevant program document that would jeopardize the confidentiality of staff or service recipients.

Upon entering a program, a few initial steps taken by the evaluator will facilitate a smoother site visit. An evaluator's first priority should be to meet with the program administrator to reestablish expectations and discuss items that need to be reviewed and coordinated as part of the evaluation. As part of that process, the evaluator should request copies of the Policy and Procedure (P & P) manual, any relevant internal agency documents, and a list of current clients. Having access to these materials early on in the process will facilitate the site review. If the evaluator was unable to complete a review of the program's internal documents (e.g. P & P manual, program handbook), he or she should review those documents before conducting any interviews with the program administrator or staff. After reviewing the program's internal documents, it is recommended the program administrator interview be conducted. This will provide a good overview of the program, facilitate information gathering, and reduce the administration time of staff interviews. The administration of staff interviews is flexible and should be conducted as staff schedules permit, thereby reducing the evaluator's footprint on the clinical operations of the program.

After receiving the program's list if current clients, evaluators should randomly choose ten charts to conduct the chart review. When evaluating programs that serve less than twenty clients, evaluators will use all available charts. Notifying the program administrator early in the process which 10 charts will be reviewed will help ensure those charts will be available for review. In instances where a treatment plan is housed in another location, this will provide the program time to arrange for you to review the actual document or make copies for

your review. During the chart review, pay particular attention to the treatment planning and assessment sections of the chart. When examining the charts, the scoring booklet can be utilized as an instrument to guide your review and will assist in the overall scoring process. In reviewing assessment processes, using the heuristics contained within the Program Administrator's Interview and the Scoring Booklet will facilitate scoring of the items contained in that domain. Another key in conducting the chart review is to remember that clinicians and program staff require access to the chart to complete their job and document important aspects of the service recipients' treatment. As such, evaluators should be cognizant not to retain too many charts at any given time or for extended periods if it can be avoided.

Before leaving the program, evaluators should conduct a preliminary rating of the program. This will help identify any potential missing data and provide an opportunity to clarify any points of confusion. These issues can typically be resolved by meeting with the program administrator at the end of the site visit. Meeting with the program administrator also provides an opportunity for him or her to comment or ask any questions they may have about the evaluation process. This meeting is also very valuable in establishing a timeline in which the program could feasibly receive the results of the evaluation and scheduling a follow up meeting. Before the results of the evaluation are finalized, evaluators, program administrators, and relevant stakeholders should meet to review the written report. This meeting serves as a fact checking process in which the ratings and recommendations are reviewed and discussed with the program, thereby increases the ecological validity and functional utility of the results. Upon agreement, the evaluator finalizes the report and provides a final draft to the program.

HOW TO SCORE THE CIMHRRS

The CIMHRRS provides a comprehensive examination of service programs. As such, scoring of the CIMHHRS is not a linear process. The Administration Manual provides step-by-step guidance in identifying sources of information and scoring rules for each item, which can be found in the following text. However, final program ratings will require the collection and consolidation of information from multiple data points and sometimes requires the evaluator to resolve what appears to be disparate information. In such cases, evaluators should seek additional information in order to gain clarity and confidence in his or her final ratings. The purpose of the program evaluation is to determine the range in which the program functions but also the mode in which it operates most frequently. In scoring the CIMHRRS, evaluators should utilize the modal functioning of the program to determine a final rating. Exceptions to the program's modal functioning can be documented in the written report that will be provided to the program at the end of the evaluation. In addition, it is the nature of service programs to be in various stages of development and implementation. The same can be said of program documents such as policy and procedures manuals. Evaluators should use not use program materials that are still in the process of development and have yet to be approved by program management. Again, the purpose is to identify the modal functioning of the program. The developmental processes that are underway can be documented in the final report that will be provided to the program. Identification of these processes will facilitate the evaluation and later be useful in making program recommendations. Lastly, evaluators need to be cognizant of the individual differences of service program and the context in which a program is being evaluated, as this will have bearing on how the program defines itself and consequently what could feasibly be expected in terms of scope, mission, and function.

Program Mission

The questions posed in this section as well as other parts of the CIMHRRS stem out of key concepts in program evaluation. Evaluation of the effectiveness of individual programs requires a systematic approach. This section was developed to assess the global parameters of the organization. What is the program's identified mission? What processes are in place to assist the program in meeting its identified mission? In other sections of the CIMHRRS, you will be asked to evaluate the levels of which these concepts are integrated into the overall functioning of the program.

1. Identifiable Program Mission Statement

Definition: A program mission statement identifies a specific problem that a program hopes to address or resolve.

Sources of Information:

- Policy and Procedures Manual
- Staff Interviews

CIMHRRS ADMINSTRATION NOTE:

Interviewer needs to review for mission statement prior to conducting interviews)

It is important to recognize individual program differences among service providers. Programs evaluated with the CIMHHRS will inevitably vary in breadth of scope based upon an identified purpose, setting, and context. The scope of the program will determine the extent to which a population is defined or how specialized the program becomes in its approaches. Consequently, these factors may determine the outcomes that could feasibly be expected. As such, evaluators should be considerate of these factors when scoring programs with the CIMHRRS.

Scoring:

- Determine if there is an identified program mission.
- Determine number of criteria meet
- Determine staff levels of endorsement

  - 1 = No identified mission statement.
  - 2 = A score of "2" is warranted if:
    - Mission statement is that of a larger organizational entity and it does not identify a separate mission for the program.
    - The program mission statement belongs to the parent organization.
    - Program has two or less of the identified criteria (see definitions below).

    While an organizational-level program mission statement may be useful in conceptualizing the larger focus of the organization, it is often too broad to capture the specifics of programs purpose.
  - 3 = A score of "3" is indicated when:
    - There is an identified mission statement within the Policy and Procedures manual that is specific to the program but it contains less than four of the identified criteria (see definitions below).
  - 4 = Mission statement is specific to the program. The program, within the Policy and Procedures manual, addresses all four criteria (purpose, population, approach and outcome) but does not have 100% endorsement by staff. See below for definitions of key criteria and endorsement. Should a program have purpose, population and only one of the remaining criteria, is has failed to meet the identified cutoff point for this anchor point and a rating of "3" should be considered.

- 5 = Mission statement is specific to the program. Meets all four criteria identified in administration booklet and receives 100% endorsement my staff. See below for definitions of key criteria and endorsement.

KEY Criteria and Endorsement Definitions

1. Purpose as defined by the CIMHRRS, is the classification of services provided by the program that is not specific to any model or approach (e.g. the policy and procedure manual documents "Vocational Rehabilitation" globally as the type of service the program provides but gives no further specification of the model used).

2. Population is defined as the group of individuals for which the program seeks to provide services to in the process of addressing the program's identified social mission (i.e., adults with serious mental illness)

3. Approach is defined in the CIMHHRS as a model or specific intervention used by the program to ameliorate the social mission it has identified. Continuing with the example of the program identifying its purpose as "Vocational Rehabilitation with a population of adults with serious mental illness, a specific approach may be Supported Employment.

4. Outcome is defined as the programs expected results on the identified social mission based upon the population and approach the program has chosen. Examples for a program focused on vocational rehabilitation may include an increase in job attainment, retainment of employment, or attainment of general and specific skill related to employment.

Endorsement includes both staff agreement on the purpose (i.e. mission) of the program and staff knowledge that a mission statement exists. This information comes directly from the interviews conducted by the evaluator while on-site. It is not necessary for staff to provide a verbatim response of the mission statement. Rather, the evaluator is assessing for a functional understanding of program purpose and knowledge of policy and procedures.

CIMHRRS ADMINSTRATION NOTE:

It is the nature of policy and procedure manuals or internal program documents to be in various states of revision. When conducting a site visit, reviewers should utilize the most current and approved copy of the document. Raters should also review the changes that are being considered by the program and the potential impact these revisions may have. This will not effect the CIMHRRS score but may be relevant to overall program evaluation and program recommendations.

2. Articulated Program Theory / Model

Definition: A program's theory is a set of principles that guide program functioning.

It is this theory that outlines the program's approach / strategies and tactics that will be used to accomplish its goals and objectives. In this section, the evaluator is assessing the level of development and utilization of the program theory or model.

Sources of Information:

- Policy and Procedures Manual – (Interviewer needs to review for program theory / model prior to conducting interviews).
- Program documents
- Staff Interviews
- Evidence of program's theory of change in functional documents of the organization (e.g. assessment and treatment plans).

Scoring:

- Determine if there an explicit and documented theory has been developed that outlines how it plans to produce that changes in relationship to the problems it seeks to resolve.
- Determine staff levels of endorsement
- Determine mission statement impact on programmatic functioning

- 1 = No articulated program theory or model or program does not have an individualized plan (i.e. plan belongs to larger organization) to reach its specific goals in the context of the larger organization mission. Example: A case management program within the context of a larger community mental health center.

- 2 = An individualized program mission is in development or there is an individualized mission statement that is not currently functional in terms of identifying a social mission as it pertains to the program. There is a lack of formal policy however, the evaluator observes documents (e.g. meeting minutes), or conducts multiple interviews which support the organization being in the process of developing a program theory or model for achieving its goals. The program theory or model is not fully developed or understood and its impact on programmatic functioning is unable to be measured at this time.

- 3 = A program theory or model has been identified. Program has its own individualized program mission statement but receives mixed endorsement by staff. "Mixed endorsement" by staff is determined by staff interviews. As the CIMHRRS is designed to be administered to programs with varied staffing and missions, it will be important for the evaluator to determine the number of interviews to complete. However, this sampling should be conducted across clinical staffing ranges (pre-paraprofessional, bachelors-level or nursing, masters-level, doctorate-level). Furthermore it would be important to interview those people with in the administrative structure from the highest to lowest available person, which would include any identified "team leader." "Mixed endorsement" for this score would be 25-33% or less.

- 4 = A program theory or model has been identified. Program has its own individualized program mission statement that is endorsed by staff. "Endorsement" for this score would be 50-66% of endorsement for the mission statement.

- 5 = A program theory or model has been identified. Individualized program mission statement is articulated in policy and procedure manual, endorsed by staff and impacts program functioning. "Endorsement" for this score would be 50-66% or greater of endorsement by staff for the program theory or model *PLUS* "Credence"." "Credence" is obtained by identifying instances in which the program actually utilizes the identified program theory or model to guide its daily operations. This may also be reflected in other pertinent organizational documents.

Definition of Endorsement: Endorsement for this item is operationally defined as recognition of the model (i.e. ability to name a model / theory or functionally describe the processes). It is not a measure of staff competency or level of programmatic implementation of the identified model or theory.

CIMHRRS ADMINSTRATION NOTE: It is the nature of policy and procedure manuals or internal program documents to be in various states of revision. When conducting a site visit, reviewers should utilize the most current and approved copy of the document. Raters should also review the changes that are being considered by the program and the potential impact these revisions may have. This will not effect the CIMHRRS score but may be relevant to overall program evaluation and program recommendations.

3. Problem Identification and Resolution

Definition: This item focuses on the program's capacity to identify and process problems that occur within the context of providing services. This is not a measure of clinical outcomes but rather the identification of a format in which staff and others can openly make suggestions with the intent of improving the general operation of the program i.e. staff ability to identify problems within the program and the program's ability to respond to that information and make relevant changes within the program. Examples might include informal discussions, suggestion boxes, staff meetings, or a more formalized process to address suggestions. Issues are not limited to clinical issues but rather the overall functioning of the program, which include organizational and staffing issues.

Sources of Information:

- Policy and Procedures Manual
- Program documents
- Staff Interviews
- Evidence of program's theory of change in functional documents of the organization (e.g. assessment and treatment plans).

Scoring:

- Determine if there an explicit and documented policy that describes the problem identification and resolution process.
- Determine staff levels of recognition and understanding of the problem identification and resolution process.
- Determine the problem identification and resolution process on program functioning.

    - 1 = There is no formal or informal process identified.

    - 2 = Evaluator observes documents or through the process of interviewing staff uncovers that the program utilizes an informal process, or has a plan in the process of being developed but not in use. There remains a lack of formal policy. Since the process is not fully developed or understood, its impact on programmatic functioning is unable to be measured at this time.

    - 3 = A formal process has been identified (e.g. suggestion box, policy manual) but the process it is not well understood by staff. "Understanding" of the process is determined by staff interviews. As the CIMHRRS is designed to be administered to programs with varied staffing and missions, it will be important for the evaluator to determine the number of interviews to complete. However, this sampling should be conducted across clinical staffing ranges (pre-paraprofessional, bachelors-level or nursing, masters-level, doctorate-level). Furthermore it would be important to interview those people with in the administrative structure from the highest to lowest available person, which would include any identified "team leader." "Understanding" for this score would be 50% or less of endorsement for the process.

    - 4 = There is a formal process identified and is understood by staff. "Understanding" for this score would be 51-75% of endorsement for the process. Additional criteria for this marker include the utilization of the process by staff.

    - 5 = A performance improvement process has been identified. "Understanding" for this score would be endorsement at 76% or greater for the process. There are identifiable and demonstrable results from the process (i.e. staff identified a problem, utilized the process, the management or some administrative entity developed a solution to address the problem).

CIMHRRS ADMINSTRATION NOTE: It is the nature of policy and procedure manuals or internal program documents to be in various states of revision. When conducting a site visit, reviewers should utilize the most current and approved copy of the document. Raters should also review the changes that are being considered by the program and the potential impact these revisions may have. This will not effect the CIMHRRS score but may be relevant to overall program evaluation and program recommendations.

4. Program Monitoring

Definition: Given that, a program has an identified theory or model to address a social issue; it is imperative that the program is consistent in the application of its theory or model in order for there to be any reliable or valid measurement of the impact that the program is having is greater than chance or simply an artifact of time. This item was developed to assess the **program's fidelity to an identified program mission and the programs effectiveness in following / implementing its articulated theory or model for change.** The ability to monitor the program is critical in understanding if the program is moving away from its theory or hypothesis of how to produce the changes that it identified in its program mission. This movement away from this identified process is known as program drift.

Sources of Information:

- Policy and Procedures Manual
- Program documents
- Staff Interviews
- Comprehensive review of the other domains and individual items listed in the CIMHRRS
- Evidence that program has implemented technology or utilizes the scientific method in order to measure program functioning on an ***ongoing*** basis.

Scoring:

- Determine if there an explicit and documented policy that describes the program monitoring process.
- Determine the program's familiarity with concept of program monitoring
- Determine the program's capacity to implement and utilize program monitoring
- Does the program have the staffing to conduct program monitoring?
- Does the program have some identified technological resource to conduct ongoing assessment (e.g. computer, software programs, database, etc.)?
- Does the program have the technological understanding of how to formulate pertinent questions and utilize the findings to support the program mission?

    - 1 = Program does not conduct program monitoring. There is no program monitoring process articulated in organizational policy.

    - 2 = Program is not capable of assessing fidelity to mission, theory, or effectiveness of program's implementation at this time. Evaluator observes documents or through the process of interviewing staff uncovers support that the organization lacks the capacity (staff, knowledge, administrative support, etc.) to implement a program. There is a lack of formal policy on program monitoring. Since the program monitoring process is not fully developed or understood, extent of program drift unknown.

    - 3 = A program monitoring process has been identified but the program fails to utilize this resource consistently. Consistent use of the process would be measured by use in assessing fidelity to mission, theory (model), or effectiveness of program's implementation. If program fails to address one or more of these areas, then a score of "3" is indicated.

    - 4 = A program monitoring process has been identified and the program consistently uses the concepts and technology associated with program monitoring to assess fidelity to mission, theory (model), or effectiveness of program's implementation. Program is able to monitor program drift but lacks ability to facilitate pertinent changes in the program.

    - 5 = A program monitoring process has been identified and consistently uses the concepts and technology associated with program monitoring to assess fidelity to mission, theory, or effectiveness of program's implementation. Program is able to utilize the information gathered from the program monitoring process to facilitate pertinent changes in the program. Examples would include utilization of processes (e.g. ongoing assessments) to avoid or minimize program drift via staff development or training.

Program Demographics and Composition

Programs should be evaluated within the context of the location services are provided, the number, type of clientele is serves, and who provides the services to the identified client. This section was developed to assess program specifics, composition and educational levels of staff, and contextual information about the program's clientele.

5. What is the population of the city / town in which services are received?

Definition: Many times, the capacity of programs to provide services and client's access to treatment are linked to the geographic setting in which services are rendered. Many compensatory strategies have been used to facilitate the provision of services depending on the location of the program. In assessing differences across programs and program settings, the developer of the CIMHRRS deemed it important to determine the categorical label of frontier, rural, or urban settings, which is typically determined by population.

Sources of Information:

- Program Pre-visit Checklist
- Web-based searches

Scoring:

- If population is in question, verify the population provided by the program via web-based searches. Enter the population on line provided

6. Where does the program provide the majority of services?
Definition: Location of service provision, places unique environmental factors and constraints on programs. Furthermore, a program's approach to service provision is directly related to its program mission. Identification of where service is provided will allow the evaluator to make inferences about the program's fidelity to mission and model. In addition, it will help define the program within the context of the larger mental health system.

Sources of Information:
- Program Administrator Handout

Scoring: On the Program Administrator Handout, the program administrator is asked to provide a percentage of where the program provides the majority of its services. If the program suggests a location other than those listed, list it in the "other" category and document the identified location on the form. Verify the percentages equal 100 percent and transfer the percentages from the Program Administrator Handout to the Scoring Booklet.

7. What is the capacity of the program?
Definition: Capacity is defined as the maximum number of clients the program can feasible admit or provide services to effectively.

Sources of Information:
- Program Pre-visit Checklist

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the clients that the program has established as its cutoff point (i.e. e.g. number of beds, average program caseload). Enter the number provided by the program administrator in the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

8. Total number of clients currently being served by program?
Definition: The number of clients that are receiving services from the program.

Sources of Information:
- Program Pre-visit Checklist

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the sum of the clients currently on the program's caseload. If a tally is not readily available, it may require the evaluator contact several program staff to obtain the total number of clients being served. Enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

9. Number of clients currently with a substitute decision maker?
Definition: Substitute decision maker is appointed by a court when a person with mental illness is unable to make decisions that are fundamental to his or her well-being. When a person is unable to make these decisions, the substitute decision maker, act in their stead. Common substitute decision makers include guardians, conservators, representative payees, and or an attorney-in-fact (a person named in a written power of attorney to act on behalf of a person with mental health issues).

Sources of Information:
- Program Pre-visit Checklist

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the sum of current clients that have a substitute decision maker. Enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

10. Number of clients with a deferred adjudication or withheld adjudication status?
Definition: These terms are legal determinations based upon the outcome of a criminal case. There are many alternative dispositions of criminal cases specific to people with mental illness (not guilty by reason of insanity, not responsible by reason of insanity, guilty but insane, and incompetent to stand trial). The criminal justice system is increasingly interfacing with people with serious mental illness. However, service providers have varied experiences with this population. This question is ascertaining the distribution of this population within the program being evaluated and which providers are addressing this population within the larger service system.

Sources of Information:
- Program Pre-visit Checklist

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the sum of the current clients with a deferred adjudication or withheld adjudication status. Enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

11. Number of clients under civil commitment?
Definition: Civil commitment is a process of involuntarily institutionalizing a person who may be suffering from mental illness, addiction, or developmental delays. A civil commitment is a court order that seeks to protect the general public and / or patient from themselves. Civil commitment may occur separately from criminal charges or adjudication.

Sources of Information:
- Program Pre-visit Checklist

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the sum of current clients under civil commitment. Enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

12. Number of clients with mental health advance directives?
Definition: Advance directives in mental health are legal processes in which a person with mental illness can indicate a preference for particular medications or treatments. These preferences can be expressed prior to a crisis or period of decreased functioning. In this regard, advance directives are similar to the concepts of a living will in which a person specifically identifies a course of treatment, during a time in which their capacity to make decisions for themselves is not potentially questioned by treatment providers.

Sources of Information:
- Program Pre-visit Checklist

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the sum of current clients with mental health directive. Enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

13. What is the total number of clinical staff currently working within the program?
Definition: Clinical staff is defined as those staff that play a role in provision of services whether that is case management, direct care services, assessment, or treatment planning.

Sources of Information:
- Program Pre-visit Checklist
- Program administrator or human resources director

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. This number is the sum of all clinical staff. Enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

14. What is the formal educational level of paraprofessional and professional staff? (Clinical Staff)
Definition: Paraprofessional staff includes those individuals who within the context of their job duties ***do not*** utilize an advanced degree (e.g. Master's degree). Professional staff is defined by those individuals who within the context of completing his or her job duties utilize an advanced degree or professional license (e.g. nurses, occupational or recreational therapists).

Sources of Information:
- Program Pre-visit Checklist
- Program administrator or human resources director

Scoring: Utilize the data provided by the program on the Program Pre-visit Checklist. In cases where "Other" educational or professional affiliations are indicated, list each type of position. If there is more than one type of "Other" formal education / professional certification, tally the total number of positions and enter the final sum into the space provided. Tally the raw number of staff for each level of formal education / professional certification and enter the final sum into the space provided in the scoring booklet. This number will later be utilized to establish programmatic ratios.

Organizational Boundaries

Individual service programs typically only represent a portion of the larger mental health system. As such, programs are required to interact with other programs within the local mental health system. This section will determine where the evaluated program's level of integration with other service providers within the context of the local mental health system and determine how clients enter and leave the evaluated program.

15. Explicit Admission Criteria:

Definition: In order for a program to be effective, it has to recognize its limitations. These limitations are typically outlined by the program's mission statement, available resources, environmental factors, and staffing to name a few. The program has an explicit and identifiable mission to serve people who fall into the category of serious mental illness (SMI) or serious and persistent mental illness (SPMI). The program has operationally defined criteria that allows for the identification of appropriate referrals.

Sources of Information:

- Policy and Procedures Manual
- Program administrator interview

Scoring:

- Determine if there an explicit and documented policy that describes explicit admission criteria.
- Determine if program makes an effort to seek a defined set of clientele.
- Determine to what extent organizational pressures dictate intake rate.
- Determine what extent the program follows its own admission criteria.

    - 1 = Program has no set criteria and takes all types of clients as determined outside the program. Entities "outside the program" may include administrative bodies that stem from a larger organization or funding source. The definitive measure is that the criteria are not well defined or explicitly stated. As such, it is not able to identify appropriate referrals to the program.

    - 2 = Admission process is dominated by organizational convenience suggests that the admission process falls outside the purview of the clinical team. Decisions on admissions are decided by an administrative entity with little to no consideration of the clinical factors of the individual client. Example: Client's are assigned to a program regardless of the clinical aspects of the case *OR* clients are moved between programs not for the clinical aspects of a case but rather for environmental control purposes or meeting some larger organizational goal.

    - 3 = Implicit criteria identified by program (i.e. no explicit criteria identified in program documents) Program makes an effort to seek and select a defined set of clients from a passive referral program (e.g. a program accepts clients that are referred and as a second priority actively seeks out clients that fits its mission). Accepts most referrals.
    - 4 = Explicit criteria identified in program documents. Program actively seeks and screens referrals based on an identified clientele and mission and bases admission to the program primarily on the clinical factors of the case. Occasionally bows to organizational pressure from administrators in order to facilitate organizational goals.

    - 5 = The program actively recruits a defined population and all cases comply with explicit admission criteria. Organizational or administrative goals are inline with clinical aspects of the case.

16. Integrated Service Provision:

Definitions:
Serial or Sequential Treatment – In this model of service delivery a person would receive treatment for one aspect of their mental health issues and receive a referral to another treatment provider to address a separate aspect of their mental health issue. In such a service setting, would not be eligible for treatment until the another aspect is resolved or sufficiently stabilized. An example of this would be denial of substance abuse treatment until mental health issues are resolved or vice versa, thus the terms serial or sequential.

Parallel Treatment – In a parallel model of intervention, the person may receive treatment for their mental health disorder from one provider or treatment setting and receive treatment for their substance use disorder from another provider – simultaneously. There is no mechanism for coordinating the two treatment systems or reconciling inconsistent treatment recommendations.

Integrated Treatment – In this model, all treatment aspects of a person's psychiatric well-being are considered simultaneously. This comprehensive approach is typically developed and delivered by a multidisciplinary treatment team, which have representatives from various psychiatric specialties providing expertise to the person's case.

Sources of Information:
- Program Administrator Interview
- Staff Interview
- Policy and Procedure Manual
- Chart Review

Scoring:
- 1 = Program is isolated from other treatment providers, concentrating only the parameters of the service it provides with little to no assessment of other treatment parameters that may affect the client's psychological well-being. No contact with other service providers.
- 2 = Program staff recognize that client has additional service needs. Client's multiple needs are addressed with serial or sequential modes of treatment.
- 3 = Client's multiple need are addressed through isolated use of serial or sequential modes of treatment OR multiple parallel treatments
- 4 = Isolated use of parallel services.
- 5 = Provides all treatment in an integrated format. All services (internal or external) are reflected in the client's treatment plan.

CIMHRRS ADMINSTRATION NOTE: If the client receives additional services (e.g. mental health, behavioral health, physical health) outside of the program but there is no mechanism in place to evaluate progress or impact on client's functioning (i.e. recognition of issue on treatment plan) then by definition, it is not integrated services.

17. Responsibility for Crisis Services:
Definition: A person's psychiatric well-being can be influenced by a program's response to psychiatric "crisis" and / or accessibility to clinical staff that is familiar with the client. An immediate response from a clinician can be useful in providing direction to staff that is on duty or providing direct intervention to a client. Regardless of location of where services are provided, a minimal response time in a crisis is ideal. Depending on how the evaluated program is structured, various strategies can be employed to respond to a crisis. On this item, the evaluator is assessing the program's response pattern in dealing with psychiatric crises.

Sources of Information:
- Program Administrator Interview
- Staff Interview
- Policy and Procedure Manual
- Chart Review

Scoring:
- Determine if there an explicit and documented policy that describes responsibility for crisis services.
  - 1 = Program has no responsibility for handling crises after hours.
  - 2 = Emergency service has program-generated protocol for clients (e.g. If the program cannot be reached or it is after hours, the client has been informed to call either 911 or some other crisis line). Another form of this would be a safety plan with identified and scripted responses in which to follow should an emergency occur that a client does not feel he or she can resolve independently. This may include a call service sponsored by the organization, but not directly staffed by the client's team.
  - 3 = Program is available by telephone, beeper, or call service but the team's response is predominantly a consulting role. An example would include actual members of the team verbally responding to a client's request but not physically responding to a crisis. A responder may intervene by assessing the situation and coordinating efforts between the client and other service providers (ambulance, law enforcement, other mental health workers, etc.).
  - 4 = Program is available by telephone, beeper, or call service. Program provides emergency service backup; i.e. makes decisions about need for direct program involvement. Program may or may not respond physically by meeting another service provider at an identified location to assist the client through a crisis but is available to do so. An example may be a responder meeting an ambulance or law enforcement officer at an acute psychiatric hospital.
  - 5 = Program provides 24-hour coverage. This can be accomplished in a residential setting or though actual documented physical responses to client crises after regular "office hours."

18. Intake Rate

Definition: In order to maintain a stable service environment and therapeutic level of care, a program must be able to control the environmental challenges that threaten to affect the programs ability to provide consistent, comprehensive, and individualized treatment. One such venue that is potentially within the auspices of program is the rate in which client's matriculate into the program thus allowing the program an avenue to maintain a stable service environment.

Sources of Information:
- Program Administrator Handout

Scoring:

Enter the monthly admission totals provided by the program administrator in the Program Administrator Handout into the spaces provided. Enter the data from the past to the present beginning on the farthest left space available. For example, if the month in which the site visit was conducted were June, the evaluator would enter the number of intakes that correspond with the 12 months that preceded the site visit.

3	7	3	4	6	7	9	6	2	5	4	2
June	July	August	September	October	November	December	January	February	March	April	May

12 months Ago ← 6 months ago → Last month

Later, when asked to calculate the "intake rate," the evaluator will use the raw numbers from each month and divide that number by the programs capacity (see question # 7). This will provide the monthly intake rate over a twelve-month period, which later could be compared to other data sources.

FORMULA: (# of admissions per month) / (Program Capacity) = Intake Rate.
EXAMPLE: For a 40-bed unit in the month of August (provided in the data above).

$$\frac{3}{40} = 0.075 =$$ The equivalent to an 8 percent intake rate for the month of August.

19. Discharge Rate:
Definition: Depending on the program's identified mission or program theory / manual, discharge rates may vary greatly across programs. Some service programs, such as Assertive Community Treatment (ACT) may have time-unlimited services in which discharge or "graduation" from the program is considered to meet high fidelity standards if fewer than 5% of clients served graduate in the course of a year. However, other service settings such as an acute psychiatric unit may have a much higher turn over rate. The purpose of this item is to determine the rate in which clients leave the program and assess the program's fidelity to its stated mission and model of service provision.

Sources of Information:
- Program Administrator Handout

Scoring:
Enter the monthly discharge totals provided by the program administrator in the Program Administrator Handout into the spaces provided. Enter the data from the past to the present beginning on the farthest left space available. For example, if the month in which the site visit was conducted were June, the evaluator would enter the number of discharges that correspond with the 12 months that preceded the site visit.

3	7	3	4	6	7	9	6	2	5	4	2
June	July	August	September	October	November	December	January	February	March	April	May

12 months Ago ← 6 months ago → Last month

19a) Enter the estimated number of discharges for the upcoming 12 months provided by the program administrator in the Program Administrator Handout into the spaces provided.

Later, when asked to calculate the "discharge rate," the evaluator will use the raw numbers from each month and divide that number by the programs capacity (see question # 7). This will provide the monthly intake rate over a twelve-month period, which could be compared to other data sources.

FORMULA: (# of discharges per month) / (Program Capacity) = Discharge Rate.
EXAMPLE: For a 40-bed unit in the month of December (provided in the data above).

$$\frac{9}{40} = 0.0225 =$$ The equivalent to a 23 percent discharge rate for the month of December.

Program Functioning

This section examines the contextual realities of providing services from within the walls of the identified organization, program, or system. There are many attributes of a program that can lead to its ability to function and / or meet a program's identified mission. One such item is the program's capacity to obtain, train, and retain qualified staff and provide specific services. Lack of staff and / or high staff turnover can have devastating impacts upon a program. However, just having the staff to fill the vacancies is not enough. Staff must be trained or at least willing to be trained in the program's envisioned approach to resolving the social mission it says it will be addressing. This section examines the program's staffing situation (percentages of operating at full staff over the past 12 months, staff turnover, vacancy rates of administrators, clinicians, and peer positions. In addition, this section will determine the quantity (time) and type of training staff receive. The information gathered in this sections will help the evaluator evaluate the congruency between a program's stated mode of operation and the way in which the program actually operates (i.e. Is there a psychiatric rehabilitation orientation? Is there a recovery from SMI focus?)

20. Clinical Staff Capacity:

Definition: The capacity of a program to provide safe and consistent service depends upon the ability to the program to operate and meet full staffing requirements.

Sources of Information:

- Program Administrator Handout
- Human resources officer

Scoring:

For each of the previous 12 calendar months, determine the vacancy rate of clinical staff (see question #13 for definition of clinical staff) and enter the raw data into the 12 lines located underneath the question. The number of vacancies on the far left should correlate with the month furthest (i.e., in the past) from the date of the evaluation. As the evaluator continues to enter data, he or she should be entering data for months that are closer to the date of the evaluation. For example, if the month in which the site visit was conducted were June, the evaluator would enter the number of staff vacancies that correspond with the 12 months that preceded the site visit.

0	0	2	3	1	1	2	1	1	0	1	2
June	July	August	September	October	November	December	January	February	March	April	May

12 months Ago ← 6 months ago → Last month

Later, when asked to calculate the clinical staff capacity of the program, include all clinical staff. Exclude any administrative support staff when determining total clinical staff positions. Calculate the vacancy rate for the preceding 12-month period using the formula provided below

FORMULA: 100 X (SUM OF # VACANCIES EACH MONTH) / (TOTAL # STAFF POSITIONS x 12)
EXAMPLE: For a program that has 30 clinical staff positions and the data provided above:

$$100 \text{ X } \frac{14}{30 \text{ X } 12} = 100 \text{ X } \frac{14}{360} = 100 \text{ X } 0.0388 =$$ 3.9 percent clinical staff vacancy rate for the 12-month period preceding the site visit.

21. Continuity of Staffing:
Definition: In this section, the evaluator is determining the program's ability to maintain the same staff over time. Having consistent staffing over time affords the development of therapeutic relationships between clients and service providers. In addition, consistency in staffing will afford continuity and predictability in the responses provided by the treatment team.

Sources of Information:
- Program Administrator Handout
- Human resources officer

Scoring:
For each of the previous 12 calendar months, determine the number of clinical staff (see question 13 for definition) that have ***left the program*** and enter the raw data into the 12 boxes located underneath the question. The number of vacancies on the far left should correlate with the month furthest (i.e., in the past) from the date of the evaluation. As the evaluator continues to enter data, he or she should be entering data for months that are closer to the date of the evaluation. For example, if the month in which the site visit was conducted were June, the evaluator would enter the number of staff that left the program in the twelve months that preceded the site visit.

0	0	2	0	0	0	0	0	2	0	0	2
June	July	August	September	October	November	December	January	February	March	April	May

12 months Ago ← 6 months ago → Last month

Later, when asked to calculate the continuity of staffing for the program, include all clinical staff. Exclude any administrative support staff when determining total clinical staff positions. Sum the number of staff that left the program during the preceding 12-month period using the formula provided below

EXAMPLE:
Sum the number of staff that left the program, in this case, the sum would be six people. Divide that number by the total number of available clinical staff positions (see question #13 for definition of clinical staff). Typically, the sum of the number of clinical positions and number of staff that have left will not be more than the total number of workers that held that position over the period time being evaluated, however in cases of extreme staff turnover or centralized staffing this may not be the case. For our example, 32 staff members have occupied the 24 clinical positions within a program over a 12-month period (the 6 staff that left the program plus the 24 available positions). The next step is to divide the number 12 by the number of months (i.e. 12 months or if a new team, the number of months in operation). Multiple the dividends of each problem and then multiple X 100 to achieve the percentage of staffing.

FORMULA: (# STAFF TO LEAVE/TOTAL # POSITIONS) X (12/#MONTHS) X 100
EXAMPLE: For a program that has 24 clinical staff positions and the data provided above:

$$\frac{6}{24} \times \frac{12}{12} = 0.25 \times 1 = 0.25 = 0.25 \times 100 = 25$$ percent staff turnover rate for the 12-month period preceding the site visit.

CIMHRRS ADMINISTRATION NOTE: A staff member who has been on an extended leave for 3 months or more is considered among the number of staff who has left, even if they technically remain in their position. Additionally, in cases where centralized staffing is utilized, make note of this in any follow up reports in order to accurately reflect the programs status. A definitive rate cannot be determined for the program due to organizational structure.

22. What is the number of training(s) / in-service(s) provided or supported by the program (or parent organization) in the past 12 months

Definition: The amount of training that a program provides, supports, or develops is an indicator of the commitment of which a program seeks out training and staff development opportunities that supports the identified program mission and theory / model.

Sources of Information:
- Program Pre-visit Checklist
- Program administrator

Scoring: Utilize the Program Pre-visit Checklist to determine the number of trainings offered and enter that number in the line provided. The most accurate assessment of the number of trainings would be supported by internal documents. If the program administrator is unable to provide supporting documents evaluators may want to assist the program administrator with developing a realistic estimate and document such in any written program evaluation.

23. How many hours of trainings / in-services provided or supported by the program (or parent organization) in the past 12 months (by subject)

Definition: The amount and type of training that a program provides, supports, or develops is an indicator of the commitment of which a program seeks out training and staff development opportunities that correlate with the program's identified mission and theory / model. Training in this case is defined as any educational presentations and / or educational materials that are distributed with the intent of staff development, which is later reviewed and discussed within a group format with a supervisor.

Sources of Information:
- Program Pre-visit Checklist
- Program Administrator Interview
- Internal program documents

Scoring: Utilize the Program Pre-visit Checklist to determine the hours of training provided by the program or parent organization. Evaluators may need to assist the program administrator, in estimating whether or not the type of trainings listed have been supported or provided by the organization in the past 12 months. If there is an indication that a specific type of training has occurred, determine how many hours of training in that area has occurred.

24. Does organization supports "off-site" training for staff.

Definition: Off-site refers to training that is not provided by the evaluated program or its parent organization.
Sources of Information:
- Program Administrator Interview
- Staff Interviews
- Internal program documents

Scoring: During the interviews, determine if the program supports "off-site" training for staff. Evaluators should also request and review any internal documents that would lend support to these claims. Raters should document the staff responses with tic marks for each interview in the scoring booklet, thereby capturing individual responses but also capturing the range of staff responses.

25. Does "off-site" training appear to facilitate the program's mission or theory/model (see program mission section)?

Definition: Off-site refers to training that is not provided by the evaluated program or its parent organization.

Sources of Information:
- Policy and Procedures manual
  - Identified program mission
  - Identified program theory model

- Program Administrator Interview
- Staff Interviews
- Internal program documents

Scoring: During the interviews, determine if the program supports "off-site" training for staff. Evaluators should also request and review any internal documents that would lend support to these claims. Additionally, evaluators should compare the type of training staff is attending and its relevance to the program's mission or model (see questions 1 and 2). If the connection is not obvious, the evaluator should ask the program administrator or staff for clarification. Raters should document the staff responses with tic marks for each interview in the scoring booklet, thereby capturing individual responses but also capturing the range of staff responses.

26. Is there an attempt to integrate these "off-site" trainings into the current program?

Definition: Are programs seeking to enhance the program by not only seeking out other sources of information but also utilizing that information.

Sources of Information:
- Program Administrator Interview
- Staff Interviews
- Internal program documents

Scoring: During the interviews, determine if the program attempts to integrate "off-site" training for staff. Evaluators should also request and review any internal documents that would lend support to these claims. Raters should document the staff responses with tic marks for each interview in the scoring booklet, thereby capturing individual responses but also capturing the range of staff responses.

Treatment Team Structure and Process

This section seeks to establish an answer to "how does the clinical work get accomplished and who does it?" The CIMHRRS approaches questions about the type of positions that make up team. However, there are specific roles that can be found within the context of a treatment team that are not limited by professional guilds or training (e.g. Supervising Practitioner, Consultant, Psychopharmacologist, etc.). These roles are filled depending on the contextual factors, specific to the evaluated program. In addition, this section assesses horizontal (across team) and vertical agreement (administration / management), the conceptualization of consumers on the team, the process of case management, and the program's use or lack of an evidence-based practice orientation. All of these items will allow the evaluator to make inferences about a program's congruence with its identified mission, and level of integration of rehabilitation and recovery concepts.

27. Within the program, what is the number of positions?

Definition: How the program is structured will have an effect on how the program operates. In this section, the evaluator is merely identifying how many paid positions the program has developed for a particular position based on a full-time equivalent (FTE) schedule (.25 = 10 hours/week, .50 = 20 hours/week, .75 = 30 hours/week, 1.0 = 40 hours/week, etc.). In addition, the evaluator will determine if the available position is filled or vacant. Unfilled positions can be calculated by examining the number of slotted positions versus number of filled slots.

Sources of Information:
- Program Pre-visit Checklist
- Program administrator
- Internal program documents

Scoring: Request the Program Pre-visit Checklist. If the checklist has not been completed prior to the site visit, assist the program administrator, in estimating the number of Full Time Equivalent (FTE) positions within the program and how many of those positions are filled. Enter the FTE amounts in the space provided in the scoring booklet.

28. Who in the program fulfills the roles outlined below? Use identifiers from question 27. Multiple identifiers may be used or needed.

Definition: There are specific roles that can be found within the context of a treatment team that are not limited by professional guilds or training (e.g. Supervising Practitioner, Consultant, Psychopharmacologist, etc.). These roles are filled depending on the contextual factors, specific to that team which may reflect structural processes, approaches to service provision, or changes in circumstances that change as a result of the rehabilitation or recovery process. This question is provided to the program in the pre-site visit checklist. For standardization purposes, the program must fill this out this section.

Define these terms:

a) Administrator – someone who functions as immediate management and assumes some responsibility in the functioning of the program.
b) Supervising Independent Practitioner – the staff person who assumes the primary responsibility for the narrative formulation of a treatment plan and provides professional oversight. A prerequisite for this role is some form of professional credentialing that is legally recognized and grants a person to practice "independently."
c) Case Coordinator – the staff person(s) whose role is to coordinate, manage, or link services to facilitate a client's process through the mental health system.
d) Skills Trainer – the person whose role it is to teach the acquisition of new skills to clients, through highly developed and systematic training to improve a client's level of functioning (social skills, problem solving, independent living, occupational, illness/wellness management, etc.)
e) Change Agent Coordinator – the person whose role it is to train direct line staff
f) Psychopharmacotherapist – the person whose role it is to prescribe psychotropic medications
g) Consultant – the person who provides ***professional*** expertise in fulfilling an organizational need on a short-term, less than full-time employment, or hired for a very specific activity by the program (i.e. hiring someone to conduct fidelity assessment). While off-site treatment providers may provide professional consultation that informs the treatment process of individuals, (i.e. off-site treatment provider) the definition of this position is specific to services provided on-site directly to the program.

Sources of Information:

- Program Administrator Handout
- Internal program documents

Scoring: From the available options listed in question #27, list the letter that coordinates with the roles identified in this question. Multiple designators may be needed to express the different and varied roles staff plays in different organizations or how roles change in relation to changes in a client's personal recovery. If during the site visit the site evaluator identifies a role that is not identified by the program administrator, seek clarification and make documentation in the scoring booklet.

Example: Psychopharmacotherapist: b, c, d, e
Consultant: b, f, n

If no one fills the identified role, please enter "N/A" in the space provided.

29. Evidence-based practice orientation:

Definition: It is important to recognize that an evidence-based practice orientation goes beyond the use of empirically supported treatments or the solitary use of "evidence based practices or packages of services. Evidence-based practice orientation in this instance refers specifically to the policy statements provided by the Institute of Medicine (2001) or the American Psychological Association (2005):

- Institute of Medicine (2001, p. 147) as adapted from Sackett and colleagues (2000): "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values."
- Evidence-Based Practice in Psychology (EBPP) (2005) is the "integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.
- http://www2.apa.org/practice/ebpstatement.pdf

DIRECTLY FROM THE APA POLICY STATEMENT (2003)

Best Research Evidence

"Best research evidence refers to scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields."

Clinical Expertise

Clinical expertise is used to integrate the best research evidence with clinical data (e.g., information about the patient obtained over the course of treatment) in the context of the patient's characteristics and preferences to deliver services that have a high probability of achieving the goals of treatment. Integral to clinical expertise is an awareness of the limits of one's knowledge and skills and attention to the heuristics and biases—both cognitive and affective—that can affect clinical judgment. Moreover, psychologists understand how their own characteristics, values, and context interact with those of the patient."

Patients' Characteristics, Values, and Context

"Services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences. Many patient characteristics, such as functional status, readiness to change, and level of social support, are known to be related to therapeutic outcomes. Other important patient characteristics to consider in forming and maintaining a treatment relationship and in implementing specific interventions include a) variations in presenting problems or disorders, etiology, concurrent symptoms or syndromes, and behavior; b) chronological age, developmental status, developmental history, and life stage; c) sociocultural and familial factors (e.g., gender, gender identity, ethnicity, race, social class, religion, disability status, family structure, and sexual orientation); d) environmental context (e.g., institutional racism, health care disparities) and stressors (e.g., unemployment, major life events); and e) personal preferences, values, and preferences related to treatment (e.g., goals, beliefs, worldviews, and treatment expectations).

Sources of Information:

- Program Administrator Interview
- Verify Program Administrator comments with a Chart Review
- Informal discussions with clinical staff
- Internal Program Documents

Scoring:

- 1 = Program does not recognize definition of EBP orientation (i.e. process vs. singular intervention) as defined American Psychological Association or Institute of Medicine (see above).
- 2 = Utilizes 1 of the 3 components of EBP orientation. List the component used.
- 3 = Utilizes 2 of the 3 components of EBP orientation. List the components used.
- 4 = Utilizes 3 of the 3 components of EBP orientation but not consistently. An example of not consistently using the components of an EBP orientation would be the organization utilizes all three components but ***does not integrate*** the EBP orientation across a single case. (e.g. the use of clinical expertise only on case #1, the use of client preferences only on case #2, etc.)
- 5 = Fully & consistently utilizes all components of EBP orientation, ***integrating*** the best available research with clinical expertise in context of client characteristics, culture & preferences within the context of single cases.

30. Recovery Orientation:

Definition: Within this item, the concept of recovery is defined as a ***process*** that an individual engages in to support his or her personal wellness. Consequently, recovery as defined by the CIMHRRS is not an end-state to be achieved similar to the goal of being "cured." Given the episodic nature of mental illness, the recovery process is a dynamic endeavor. As such, recovery-oriented treatment is defined as a dynamic set of services that are available to consumers of mental health services to facilitate not only personal wellness at any given stage of a client's personal recovery and actively promotes the integration of clients with his or her community; separate of the mental health system. Additional markers of a recovery-oriented system include recovery oriented

language (i.e. hope, respect, empowerment, autonomy), person first language, individualization of services, a focus on a client's personal strengths and desires, facilitating an active role in treatment, and promotion of a value driven life outside of the mental health system as defined for the individual.

Sources of Information:
- Policy and Procedures Manual
- Program Administrator Interview
- Staff Interview
- Internal Documents

Scoring:
- 1 = No policy statement or internal documents to support claims of recovery orientation care.
- 2 = Explicit statement in policies or internal documents that supports recovery orientation but does not demonstrate a recovery orientation in practice (i.e. services are exclusively focused on symptom or risk management; people are referred to by diagnosis).
- 3 = Recovery orientation is evident in treatment planning and staff interactions (i.e. recovery oriented language in clinical documents, consumer strengths & desires are incorporated into treatment planning process, staff utilize person-first language).
- 4 = Program facilitates the shedding of patient role (e.g. replacing passive recipient role with role of active consumer of mental health services).
- 5 = Program assists in developing activities outside the mental health service system (i.e. career development, community integration, or development of leisure activities).

31. Psychosocial (Psychiatric) Rehabilitation Orientation

Definition: Psychiatric rehabilitation is a comprehensive approach to assessment and treatment of people with serious mental illness and can be usefully understood as a technology for enhancing recovery. The theoretical basis of psychiatric rehabilitation is inseparable from the concept of a recovery-oriented system. Like the concept of recovery, rehabilitation is seen as a process in which the goal is increasing functional abilities rather than having the end goal of "curing" someone. As such, a psychosocial rehabilitation orientation promotes the acquisition of new skills by the client to avoid psychiatric relapse, normalize social roles, increase coping skills, and increase community functioning.

Sources of Information:
- Chart Review (treatment plan).
- Program Administrator Interview
- Staff Interview

Scoring:
- 1 = Psychosocial rehabilitation is not a service option.
- 2 = Program reports rehabilitation focus but services focus on symptom reduction and psychiatric stabilization.
- 3 = Program reports rehabilitation focus but services are maintenance focused (i.e. medication adherence, staying out of the hospital).
- 4 = Program reports rehabilitation focus but services promote social activities in the community but client remains dependent on provider to organize activities (i.e. does not develop clients ability to carry out activity).
- 5 = Services promote the acquisition of new skills or coping abilities that supports independent functioning in the community.

32. Team Approach (Horizontal agreement): Serious mental illness is very heterogeneous. The treatment needs of people with serious mental illness are very broad are unable to be met by a single clinician. A team based approach is the dominant organizational model to address these varied and multiple needs of the client. This item was developed to assess the level in which the provider group functions as team rather than a group of individual practitioners.

Definition: Horizontal agreement is an organizational term that refers to the degree to which clinicians share an approach to treating a person with serious mental illness.

Sources of Information:

- Chart Review
- Program Administrator Interview
- Staff Interviews
- Internal Program Documents

Scoring:

- 1 = Provider group operates independently of one another with little knowledge of other treatment provider activities or overall treatment plan. There is no discussion between providers regarding treatment planning or service provision. (One provider does not know what the other is doing or it does not appear to be of concern).
- 2 = Team attempts to function as a unit but primary mode of operation remains highly individualized. More reflective of a group of individuals providing an array of services. Decisions are made by individuals that contradict a consensus approach or a developed treatment plan.
- 3 = Team operates within a consensus model. There is an implicit (no formal policy or process) understanding to follow the consensus approach outlined by the team. Team utilizes the developed treatment plan to guide clinical decision making.
- 4 = Team operates within a consensus model and has an identifiable, explicit policy which outlines the consensus approach. Policy includes a formal process to resolve clinical disagreements among team members.
- 5 = Team uses consensus process to resolve disagreements, and when needed a formal mediation process. Upon identifying a plan of action, team members follow decision of mediation process.

33. Team Approach (Vertical agreement): Strong and dedicated leadership are essential for a program to be effective. Leadership at all levels must support the program mission by developing an environment that supports the program's identified theory / model. This support can be shown by explicitly stating goals and requiring all staff develop the requisite skills through formal or informal training in order to provide services in a consistent fashion, which includes a management plan that addresses how to supervise staff and monitor program implementation (i.e. do they have the requisite skills to perform job related tasks). Administrative buy-in to the program theory / model will assist in reducing program drift.

Definition: Vertical agreement is an organizational term that refers to the degree to which administrators and management supports the identified theory / model of service provision in meeting the program's mission and treating a person with serious mental illness.

Sources of Information:

- Program Administrator Interview
- Staff Interviews
- Internal Program Documents

Scoring:

- 1 = Administration fails to recognize the importance of providing support in developing vertical agreement and how it will support the identified program theory or model. This score may be used if there is no verbal or written program theory or model.
- 2 = There is an identified program theory or model with implicit support.

- 3 = Training of staff has begun; however, there appears to be a lack of consensus among leadership about program mission and theory / model of service provision.
- 4 = There is consensus among leadership about program mission and theory / model of service provision. A majority of clinical staff have been trained in the model.
- 5 = There is consistent agreement across levels of leadership supporting model. Most staff are fully trained and are providing services that fall in-line with the model.

34. Role of Consumer in service provision:
Definition: Individuals who have a history of psychiatric difficulties and treatment are able to fulfill various roles in service provision. However, the inclusion of consumers in the provision of services has been interpreted in various ways. It is feasible that programs evaluated using the CIMHRRS may have a range of consumer involvement from not having any consumer involvement to having consumers as full-time employees that function as full members of the team and helping clients in the recovery process. The CIMHRRS also examines the role of the consumer from a volunteer status to paid employment.

A consumer, as defined in this item refers to those people who have disclosed a history of psychiatric and / or co-occurring serious mental illness and substance abuse treatment and are not currently receiving services from the program. Services provided within the program by current clients are considered to be part of treatment rather than service provision to program.

Should a program have access to a consumer that is employed by the larger parent organization, raters should consider the amount of time spent by that consumer within the evaluated program and rate the program accordingly.

Sources of Information:
- Program Administrator Interview
- Staff Interview

Scoring:
- 1 = Consumer(s) have no formal involvement in service provision within the program.
- 2 = Consumer(s) fill consumer-specific but *unpaid* service roles with respect to program.
- 3 = Consumer(s) *paid* to work *part-time* in roles with reduced responsibilities (e.g. driving clients around, courier, confirm appointments miscellaneous tasks, etc.).
- 4 = Consumer(s) *paid* to work *full-time* in roles with reduced responsibilities (e.g. driving clients around, courier, confirm appointments miscellaneous tasks, etc.).
- 5 = Consumer(s) employed full-time by program and functions as full member of the team in addressing client treatment issues.

35. Organizational concept of case management:
Definition: The concept and activities of case management varies by location and by service provider. In some locations case management may be conducted by an individual paraprofessional or an entire team of clinicians. In other settings, the provision of case management is structured to reflect a client's progress in recovery. In such settings, various professionals handle the aspects of case management that are specific to the client's recovery. An example of this would be a nurse providing case management services at the onset of a hospitalization when acute stabilization is the focus of treatment. As this client's symptoms stabilize, a social worker may assume the majority of case management services as the client moves toward a less structured clinical setting or the community.

Sources of Information:
- Program Administrator Interview

Scoring:
- 1 = Program provides no case management services.

- 2 = Case management is performed by 1 person, not identified with a formal treatment team, implementing a list of services that do not constitute an integrated treatment plan.

- 3 = An identified case manager oversees the implementation of an integrated individualized treatment plan but not as a member of a formal treatment team (i.e. the plan was provided to them, they had no input on the development of the plan and no role in assessing progress or outcome).

- 4 = An identified case manager oversees the implementation of an integrated individualized treatment plan, as a member of a formal interdisciplinary treatment team that continuously evaluates treatment response and progress in recovery.

- 5 = Although there may be a single identified case manager or treatment coordinator, specific case management functions are shared by members of a formal interdisciplinary treatment team, based on individual considerations and circumstances, e.g. rapport with staff or time availability.

36. Approach to Co-occurring SMI & Substance Abuse:
Definition: There is strong research evidence that people with a serious mental illness often have a co-occurring substance use history or disorder. Furthermore, lack of treatment provision for one or the other greatly increases the potential of relapse in the other area of functioning. The CIMHRRS assesses the program's approach to addressing the functional and interactive nature of substance use and serious mental illness.

Key concepts:
Serial or Sequential Treatment – In this model of service delivery a person would receive treatment for one aspect of their mental health issues and receive a referral to another treatment provider to address a separate aspect of their mental health issue. In such a service setting, would not be eligible for treatment until the another aspect is resolved or sufficiently stabilized. An example of this would be denial of substance abuse treatment until mental health issues are resolved or vice versa, thus the terms serial or sequential.

Parallel Treatment – In a parallel model of intervention, the person may receive treatment for their mental health disorder from one provider or treatment setting and receive treatment for their substance use disorder from another provider – simultaneously. There is no mechanism for coordinating the two treatment systems or reconciling inconsistent treatment recommendations.

Integrated Treatment – In this model, all treatment aspects of a person's psychiatric well-being are considered simultaneously. This comprehensive approach is typically developed and delivered by a multidisciplinary treatment team, which have representatives from various psychiatric specialties providing expertise to the person's case.

Sources of Information:
- Program Administrator Interview
- Staff Interview
- Chart Review

Scoring:

- 1 = Program has no stated policy or process to address these comorbid issues. Variably addresses substance abuse concerns with clients; no formal, individualized substance abuse assessment or treatment provided.

- 2 = Program recognizes these issues as separate. Separate assessment and treatment (sequential or parallel services without coordination between providers). No direct, individualized substance abuse assessment or treatment is provided by the team.

- 3 = Recognition of importance of integrated treatment. Lacks capacity to provide integrated services. Parallel but simultaneous treatment occurs with coordination between providers. All of substance abuse services referred (persuasion groups; uses hospitalization for rehab.; refers to 12-step & self-help groups)

- 4 = Recognition of importance of integrated treatment in policy. Program has an integrated approach but substance abuse program is primarily based on traditional models of substance abuse treatment: (confrontation; mandated abstinence; traditional 12- step models, etc.).

- 5 = Recognition of importance of integrated treatment in policy. Program provides assessments and integrated approach is reflected in treatment plan (services provided by program or outside services are highly integrated). Identifies with a stage-wise model and seeks to modify use behaviors (harm-reduction) on the way to sobriety.

Assessment Process

This section is focused on a program's capacity to conduct various assessments of individuals, initially and on an ongoing basis. The ability to assess functioning at multiple biopsychosocial levels reflects the program's ability to address problems at these levels. The scope of the program's assessment capabilities should correspond to the program's mission.

CIMHRRS ADMINISTRATION NOTE: Evaluators should rate programs on the accessibility or availability of specific assessments. On or off site, directly or by referral.

Each item in the Assessment Process domain is individually defined below. However, the sources of information and anchor points remain the same for items 37 through 45 and will not be repeated for each item. Evaluators should use the scoring protocol described below.

Sources of Information:

- Program Administrator Interview
- Chart Review

Scoring: During the Program Administrator Interview, determine if the program assesses goals. Evaluators will also review charts and verify administrator's comments. Based upon reviewer's assessment, circle the description that best fits the program's functioning.

- 1 = Program has no access or availability to assessment (anecdotal or formal) within the program or through the larger parent organization.
- 2 = Program has limited or anecdotal (informal) assessment capabilities. Assessment is sporadic and not associated with systematic monitoring. EXAMPLE: Assessment consists of progress notes anecdotally describing client performance.
- 3 = Program systematically performs or accesses assessments but there is no evidence the data influences treatment selection AND progress evaluation. EXAMPLES: 1) structured diagnostic interview identifies active positive symptoms but there is no mechanism to measure changes with treatment, 2) A formal assessment of client's ability to balance a checkbook is administered at intake but not repeated after a budget coaching intervention.
- 4 = Program systematically performs or accesses assessments, the data influences treatment selection AND progress evaluation, but there is no in vivo monitoring of performance in the natural environment. Assessments are limited to interviews, laboratory tests (biological or psychological), or structured functional assessments (e.g. formal assessments of self-care or cooking or budget management). EXAMPLES: 1) structured diagnostic interview identifies positive symptoms, progress evaluation includes review of repeated assessments, but there is no direct assessment on symptom's occurrence or impact in a natural environment. 2) Formal functional assessment reveals that client is able to balance a checkbook, skills are formally assessed at 3-month intervals, but there is no data on whether the client actually keeps his or her checkbook balanced.
- 5 = Program has access or availability to a full range of assessment (both formal AND in vivo) and that information is used in both treatment planning AND progress evaluation. Evaluators should verify evidence of the integration of assessment data as well as performance monitoring within treatment plans.

37. Does the program assess clients' goals?
Definition: A client's goal is what a client wants to achieve or change in the foreseeable future. The purpose of assessing client goals is to make rehabilitation personally relevant by linking rehabilitation objective to the client's personal goals. This purpose should not be confused with the traditional purpose of determining whether the client's goals are "realistic."

38. Does program conduct symptom assessment?
Definition: Does the program conduct some type of evaluation that assesses the frequency, intensity, and duration of a person's reported symptoms? EXAMPLES: Brief Psychiatric Rating Scales, (BPRS); Scale for the Assessment of Negative Symptoms (SANS); Scale for the Assessment of Positive Symptoms (SAPS); or Positive and Negative Symptom Scale (PANSS).

39. Does program conduct Neurocognitive Assessment?
Definition: The presence of a neurocognitive impairments are assessed with neuropsychological test and related methods. The domains of assessment include attention/vigilance, rate of processing, working memory, verbal learning, visual learning, reasoning and problem solving and social cognition. EXAMPLES: Recognized neuropsychological batteries or comparable specific tests (e.g. The Halstead Reitan Battery, Repeatable Battery for the Assessment of Neuropsychological Status (R-BANS), Neuropsychological Assessment Battery (NAB), WAIS-IV, Wisconsin Card-sorting test, verbal fluency, trail making).

40. Does the program conduct functional behavioral analysis?
Definition: Functional behavioral analysis is a formal method of determining internal events (e.g. thoughts, feelings) and external events (environmental cues, consequences) that exert controlling influences on specific behaviors of interest. FBA must be performed by a mental health professional with specific expertise in that type of assessment, usually a clinical psychologist. FBA is usually based on a combination of information from the social history and direct systematic observation of behavior and environmental events. The purpose of the FBA is to identify events that can be controlled or manipulated in order to enhance skill acquisition or replace undesirable behaviors with adaptive behaviors.

41. Does the program assess self-care / basic independent living skills?
Definition: Basic self care and independent living skills are the abilities to perform necessary daily tasks and manage routine demands. Limitations in these skills produce limitations on the ability to living independently and function as a competent adult. A person's independent living skills are often a key determinant in discharge destinations, aftercare needs and housing options for people with serious mental illness. Formal assessments of self-care / basic independent living skills are potentially useful to organizations to identify potential strengths and areas that may benefit from additional skills training. EXAMPLES: Independent Living Skills Inventory (ILSI), UCSD Performance-Based Skills Assessment (UPSA), formal functional assessments of routine daily demands (finances, housing, cooking, hygiene).

42. Does the program assess wellness management / relapse prevention skills?
Definition: Wellness management and relapse prevention skills are specific abilities associated with overcoming the effects of mental illness and related problems. These include medication-related skills, coping and management of stress, recognition of triggers, warning signs and risky situations, prevention of relapse, and related skills. Since individuals experience mental illness and related problems in unique ways, skills in this domain must be highly tailored to individual needs. Therefore, assessment of these skills must be sensitive to these individual differences. For this reason, formal assessment is generally done in the context of skill training in specific areas. EXAMPLES: Illness Management and Recovery (IMR), UCLA Skills Training Modules (e.g. medication management and symptom management modules of within the Social and Independent Living Skills (SILS) program), or directed psychotherapy in this regard.

43. Does the program assess social / interpersonal skills?
Definition: Social and interpersonal skills are the abilities involved in interacting with other people, in all the various ways in which people interact. Problems in this area range from deficits in the most basic skills, e.g. ability to make casual conversation, to the most complex, e.g. ability to solve conflicts and maintain friendships and intimate relationships. Clinical assessment must therefore also incorporate a wide range of skills, consistent with the diversity in skill levels found in the program's client population. Assessments may address the behavioral level of functioning, e.g. ability to actually perform specific social behaviors, and social cognition, e.g. the

ability to apprehend social situations, recognize social cues, and understand the perspective of other people. EXAMPLES: Assessment of social cognition, social competencies, role performance, leisure and recreational activities, community integration, and social and family networks. EXAMPLES: Bell Lysaker Emotion Recognition Task, Hinting Task, Assessment of Interpersonal Problem-Solving Skills (AIPSS), Maryland Assessment of Social Competence (MASC).

CIMHRRS ADMINSTRATION NOTE: While self-care and independent living skills are often associated with social functioning, these items are assessed elsewhere in the CIMHRRS. Consequently, evaluators should NOT consider these skills in the evaluation of this item.

44. Does the program assess occupational skills?
Definition: Occupational skills are those skills by which a person maintains meaningful activity beyond self-care, housekeeping and wellness management. Employment is often a hallmark that is associated with normal occupational functioning in adults, and for many people employment is a key occupational goal. However, people generally have several occupational goals, and employment is not necessarily one of them. Others may include having an absorbing hobby or doing volunteer work. Whatever the occupational goal, there are specific skills required to pursue that goal, and these must be addressed if the goal is to be realized. Therefore, occupational assessment and skill training must be guided by the particular occupational goals that each individual brings to or develops in the rehabilitation/recovery process. EXAMPLES: Assessment of work history, preemployment capabilities (general work skills, specific work skills), assessment of skill acquisition, assessment of independent functioning on work related tasks, and assessment of structural supports needed to be successful.

CIMHHRS ADMINSTRATION NOTE: While self-care and interpersonal functioning are often associated with occupational performance, these items are measured elsewhere in the CIMHRRS. As such, evaluators should NOT include self-care and interpersonal functioning in the systematic evaluation of this item. It will also be useful for evaluators to assess if the program subscribes to "train and place" model vs. a "place and train" model of occupational rehabilitation or if the program refers occupational services to a traditional vocational rehabilitation service.

45. Does program conduct risk assessment?
Definition: Risk assessment is the identification and management of specific risks associated with mental illness or related behavior. Risk falls into several domains, including risk for aggression, risk for self-injury, risk for substance abuse, risk for eloping or not adhering to treatment, and risk for engaging in illegal or exploitative behavior. When risks are present, they must usually be re-assessed over time as the person recovers and/or their life situation changes. Risk assessment may include formal actuarial measures, but these generally only assist experienced clinical judgments about the nature and severity of the risk and its optimal management. A complete risk assessment must usually include a complete functional analysis of the person's risk in the particular situation or environment in which the person is or will be functioning. EXAMPLES: HCR-20, Psychopathy Checklist-Revised (PCL-R)

Treatment Planning

Review of the program's treatment planning process will allow the evaluator to determine the "what" and "how" of how services are provided within the program. By answering the questions outlined in this section, the evaluator will determine the process of treatment planning (if the program conducts treatment planning) and how cases are formulated. Is there a focus on individualizing treatment or do the treatment plans look almost exactly the same with the only differences being whose name is at the top of the form? Is there a recovery-oriented focus? Does the person have a voice in the "plan" or is there an established plan of action that the majority of clients must comply? Does the plan lead to acquisition of new skills or does it focus only on stabilization or maintenance?

46. Origin and scope of treatment plan
Definition: Understanding the origin and scope of the treatment plan has implications for understanding the role a program fulfills within a larger organizational scheme. It highlights accessibility to the treatment plan and consequently the extent of control of its content. In addition, it assists the evaluators in determining the degree of specificity of program response and clientele.

Sources of Information:
- Policy and Procedure Manual
- Program Administrator Interview
- Chart Review

Scoring:
- 1= Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.
- 2 = Program operates from a treatment plan that is developed outside of the program without program staff involvement.
- 3 = Program operates from a treatment plan that is developed outside of the program with program staff input.
- 4 = Treatment plan is developed within program but does not comprehensively include all relevant services. EXAMPLE: Within its mission statement, the program identifies itself as a comprehensive psychiatric rehabilitation program but consequently fails to include skills training as part of its coordinated services.
- 5 = Treatment plan is developed within the program and includes all relevant services, with links to other programs where needed.

CIMHRRS ADMINSTRATION NOTE: "Relevance" of services will vary based upon the program's identified mission statement. "Comprehensiveness" is determined by the extent to which services that are identified by the mission statement are provided or coordinated. Anchor points "4" and "5" require the evaluator to make a determination based upon a review of the Policy and Procedures Manual, treatment plans, and program administrator interviews.

47. Individualized treatment plan?
Definition: This item examines the organizational commitment and capacity to individualize their responses to a client's individualized manifestation of symptoms and level of functioning. A highly individualized treatment plan will assist the treatment team in providing a highly individualized response and measurement of treatment outcomes.

Sources of Information:
- Program Administrator Interview
- Staff Interview
- Chart Review

Scoring:
- 1 = Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.
- 2 = There is no indication that any personal information about the client has been incorporated into the treatment plans.
- 3 = Treatment plans incorporate only anecdotal personal information (Post hoc descriptions of behavior not accompanied by operational definitions or quantitative measures). EXAMPLES: 1) A description of a person "responding to voices in a natural setting" is anecdotal whereas a rating of auditory hallucinations in a structured clinical interview is not, 2) information in the form of stories, historical narratives; after-the-fact description or explanation of a person's behavior is anecdotal, whereas formal checklists of specific historical events are not.
- 4 = Treatment plans incorporate formal assessment results that are logically linked to treatment selection, but similarities across treatment plans are greater than the range and diversity of assessment results indicate.

- 5 = Diversity across treatment plans reflects the diversity of assessment results found in the program's client population.

CIMHRRS ADMINSTRATION NOTE: Assessment of individual tailoring of treatment plans can be difficult because program's admission criteria may select for a relatively homogenous population. A lack of diversity in treatment plans ("they all look the same") does not necessarily indicate a lack of personalization. To rate this item, it is necessary to consider the diversity of assessment results. If sufficiently complete assessments show little diversity across the client population, treatment plans are expected to have extensive similarities as well. Assessments are "sufficiently complete" when they include all the areas of functioning that fall within the scope of the program's mission and its array of services.

48. Client role in treatment plan development

Definition: The role of consumer in treatment plan development has implications for both a recovery-oriented system and psychiatric rehabilitation. The degree to which a client is involved in the development, monitoring, and implementation of a treatment plan, the greater relevance is has to a client's personal recovery. In terms of rehabilitation, the more that a client is able to identify and facilitate treatment planning activities, the greater the client's functional independence. This item evaluates a program's inclusion of consumers in treatment planning. It is expected that a program may meet a number of these anchor points due to the heterogeneity of individual clients being served. However, the intent of this item is to capture the functional aspects of the individual program and the mode in which it most frequently operates.

Sources of Information:

- Program Administrator Interview
- Staff Interviews
- Chart Review

Scoring:

- 1 = Program does not conduct treatment planning
- 2 = Treatment plan is developed in the absence of consumer input.
- 3 = Treatment plan is provider driven but based on consumer preferences
- 4 = Client actively collaborates with provider to develop treatment.
- 5 = Treatment plan is client driven.

49. Treatment plan review (TPRs) process

Definition: The evaluator's task in answering this question is assessing the continuum of external versus clinical factors that prompts a program to conduct a treatment plan review. There are a number of reasons why a program may review a treatment plan. A TPR may occur to meet criteria established external of the program such as Medicaid, in order of maintain funding resources. The polar opposite is a TPR process that is internally imposed, clinically driven, and by virtue of this process, meets the minimal criteria established by external stakeholders. Organizations may vary in this approach and it will be incumbent on the evaluator to determine the process by which the organization is driven by external or internal forces to review a TPR.

Sources of Information:

- Program Administrator Interview
- Staff Interviews
- Chart Review
- Internal documents

Scoring:

- 1 = Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.
- 2 = Only prescribed feature of TPR are those required by regulation (e.g. frequency)
- 3 = Policy and Procedures manual outlines features in addition to those required by regulation (e.g. who must attend TPRs) and/or a mechanism for a meeting schedule that exceeds regulatory standards.
    - An example of a program that would receive a rating of "3" would include an identified process that is utilized by the program to address unpredicted happenings that occurs within the auspices of service provision.
- 4 = Process allows for quantitative determination of progress (or lack) and distinguishes between areas of lesser or greater progress. EXAMPLE: Program has a process that affords the capacity to monitor a client's progress over time to determine if interventions are having the intended effect.
- 5 = There is a mechanism and procedure in P&P that directs follow up and documentation on findings of insufficient progress.

50. Discharge planning

Definition: Depending on the program's identified mission or program theory / manual, discharge planning may vary greatly across programs. Some programs may not have well established discharge criteria or some programs discharge criteria may be established by fidelity standards and limit the amount of discharges. For other programs, where discharge criteria is established and clients are expected to eventually leave or graduate from a program, the question remains of when discharge planning should begin and whether this is a passive or active endeavor.

Sources of Information:

- Policy and Procedures Manual
- Interview with program administrator
- Staff interviews

Scoring:

- 1 = Services are time unlimited OR Program does not have any formal discharge criteria. (see policy and procedures manual)
- 2 = Program mission / policy indicates discharge criteria. Discharges from program are atypical, resulting from unmanageable risk factors, client moving, treatment non-compliance, client entering a different service system (jail, etc.), or death.
- 3 = Program mission / policy indicates a discharge criteria. Discharge from program is expected. Discharge process begins when client ***meets criteria*** (i.e. toward the end of treatment).
- 4 = Program mission / policy indicates a discharge criteria. Discharge from program is typical. Discharge process begins at various points in treatment as client progresses in treatment.
- 5 = Discharge process begins at intake. Program actively identifies barriers to treatment and discharge at intake and on an ongoing basis.

Treatment Provision

This section identifies the use of services and specific psychotherapies that are well documented in the SMI literature and what percentages of services are provided in house or outsourced. It will also identify a lack of use of identified best practices. Obviously, the more comprehensive a program, the potential for providing services that "match" with the client's needs increases, however, it is unrealistic to think that a program can be everything to everyone. Nor is it realistic to think that everyone will need everything a program has to offer. As such, it is important to identify a client's needs and either be able to provide the service or link the client to a provider who can.

51. Does program provide or coordinate these services?

Sources of Information:

- Program Administrator Handout

Scoring:

Transpose answers from the Program Administrator Handout to the Scoring Booklet. Evaluators should ensure all answers are completed, not more than one answer is circled, and to clarify any answers that are unclear.

Definition:

- **Collaborative Psychopharmacotherapy** – There is research evidence that the combination of pharmacotherapy and psychological interventions is more effective than the use of medications alone. This approach is considered standard practice. This approach requires that entire treatment team, including the psychopharmacologist and client work collaboratively to determine the optimal balance between medication regimens and psychosocial treatments to maximize a client's level of functioning.

- **Rehabilitation Counseling** – Rehabilitation counseling in SMI populations stem out of the key concepts found in traditional physical rehabilitation. This involves an initial and ongoing meeting with a client and his or her treatment team to identify and integrate issues that require treatment (i.e. rehabilitation), to address a client's concerns and /or desires, and to develop and address these issues. The identified counselor works with the client to assess the objective and subjective processes of treatment to inform the process of rehabilitation.

- **Social Skills Training –** Often the functional aspects of serious mental illness is manifested in a reduction in interpersonal effectiveness, making it difficult to establish and maintain relationship or fulfill social roles that are key to a person's individual recovery. Formal social skills training have been shown to improve personal and social functioning. This training typically occurs in a structured group format, includes role-playing, focuses on skill development in the identification of contextual aspects of interactions, and develops social competence via positive reinforcement and repetition.

- **Problem Solving Skills Training** – This widely accepted type of social skills training utilizes cognitive-behavioral techniques to teach clients interpersonal problem-solving skills. Following a heuristic model of problem-solving, clients learn how to identify a problem, develop possible solutions, select a solution, and then implement and evaluate the solution.

- **Independent Living Skills Training** – This training is focused on developing the skills associated with the activities of daily living (e.g. grooming and hygiene, housekeeping, budgeting, cooking, utilization of community supports / resources, etc.). This training typically includes didactic instruction as well as in vivo coaching to solidify a client's knowledge and performance capabilities.

- **Supported Employment** – Traditional vocational rehabilitation for people with SMI has resulted in placements in sheltered workshops or in placements that were reserved for people with mental illness. This traditional model is known as the "train-place" model of vocational rehabilitation and averages only 10%-20% of competitive employment placements. Supported employment / occupational skills training is known as the "place-train" model with the result being competitive, "real-world" employment for the client rather than sheltered workshops, etc. Supported employment emphasizes the rapid attainment of work and matching the client's skills and interests to the job rather than teaching new skills for some undetermined job sometime in the future. In this model, the client rather than the program assumes the responsibility for attainment and maintenance of employment. An employment specialist typically serves the client by identifying client preferences, strengths, and previous employment, collaborates with the treatment team, completes vocational assessments, and provides assistance with finding a job and ongoing job support. In addition to the vocational skills learned in supported employment,

training which is very specific to types of jobs, programs may also provide more generalized training. General occupational skills are those skills that are generalizable to multiple work settings such as showing up to work on time, having a neat and clean appearance, managing work schedule, etc.

- **Illness/Wellness Management Skills Training** – The ability of a person with SMI to identify, understand, and manage the multiple aspects of his or her mental illness is key in developing strategies to avoid psychiatric relapse. This approach is highly individualized to the person who is in recovery as the functional aspects and range of symptoms of the person's disorder is very heterogeneous. Skills training in this area, examines the idiographic factors of a person's disorder such as symptom presentation, the relationship between symptoms and functional impairments, techniques to control symptoms and improve levels of functioning. Additionally, clients learn to identify "triggers" or "warning signs" of relapse, receive training about psychotropic medications, and develop interpersonal skills to facilitate psychological well-being.

- **Family Consultation, Education, and Therapy** – The effects of serious mental illness extend beyond the individual to friends and family members. Often there are unresolved feelings of shame and guilt experienced by family members resulting in a great deal of distress. Additionally, the interactions between friends / family and the person in recovery may increase the potential for psychiatric relapse. Services that include psychoeducational training on mental illness and behavior management, the effects of expressed emotion, and provide support to family members have been shown to reduce recidivism.

- **Contingency Management** – Contingency management, rooted in learning and social learning theories utilizes a number of techniques that are important in various psychiatric settings to bring about change in maladaptive behavior (e.g. aggression and polydipsia). In contingency management, a program makes predictions about a client's behavior and through highly specified behavioral approaches and positive reinforcement brings about behavioral change that a client may not otherwise perform (i.e. engagement in rehabilitation activities, learning how to be assertive versus being aggressive, etc.). Contingency management techniques such as token economies have been found effective in inpatient settings and continue to find wider acceptance in community-based settings.

- **Supported Housing** – The concept of supported housing is focused on assisting people with SMI living as independently as possible within his or her community, including living in their own home. Programs that follow supported housing ideals work with the individual to identify preferences, resources, and needs and develop flexible services to support the client in successfully remaining in the home and community. This is in contrast to being placed in residential treatment facilities, which is often based on bed availability.

- **Specialized Integrated Treatment for Co-occurring Substance Abuse** – The prevalence of a co-occurring substance use problem in those people with serious mental illness is high. The presence of substance abuse issues can have implications for a person's recovery and rehabilitation and serve as a catalyst for psychiatric relapse. This approach is different from a traditional approach to addressing substance abuse in that within an integrated services setting the program provides both mental health and substance abuse service including assessment, treatment planning, and treatment.

- **Cognitive Rehabilitation** – As a result of their disorder or the antipsychotic medication used to treat their symptoms, people with serious mental illness often have deficits in their cognitive functioning. Research on cognitive rehabilitation demonstrates the effectiveness of a number of approaches in improving a person's cognitive functioning (i.e. coping with auditory hallucinations, remediation of learning disabilities, executive functioning, developmental delays, attention shaping, generalized improvement in real-world settings). Examples of this type of intervention would include Neuropsychological Educational Approach to Rehabilitation (NEAR), Integrated Psychological Therapy (IPT), Cognitive Enhancement Therapy (CET), Cognitive Adaptation Training (CAT), Attention Shaping, Errorless Learning, and ecologically valid behaviorally supported cognitive interventions.

- **Specialized Models for Service Integration and Provision** – Specialized models of integrating and providing services to people who have severe disabilities associated with SMI. Three models that have been developed and are supported by outcome data include Psychosocial Clubhouse Model, Assertive Community Treatment, and Social Learning Programs.

- **Trauma-based services** – Trauma and violence can have a deleterious effect on a person's physical and psychological well being. Trauma-based services seek to address the pervasive impact resulting from violence and trauma, including sexual, physical, and emotional abuse on a person's life and level of functioning. This type of service supports highly individualized treatment and prevention.

- **Peer Support (specify service)** - Within the context of the literature, the term "peer support" assumes multiple definitions. Within the context of a recovery-oriented system, people with SMI should be included in all aspects of research and service provision; however, the implementation of this concept is varied. Generally speaking, peer support indicates some type of involvement of peers in the management of a person's disorder. This may come in the form of peers being treatment team members as in some versions of assertive community treatment (i.e. peer specialists) or self-help groups / interventions that are based off well-known programs such as Recovery Inc. or Wellness Recovery Action Plan (WRAP). Empirical support for these interventions are limited but are considered to be "promising practices."

52. Does program provide these specific Psychotherapies?

Sources of Information:
- Program Administrator Handout

Scoring:
Transpose answers from the Program Administrator Handout to the Scoring Booklet. Evaluators should ensure all answers are completed, not more than one answer is circled, and to clarify any answers that are unclear.

Definition:
- **Cognitive Behavioral Therapy** – A type of psychotherapy that challenges client attributions of events and their interpretations of how he or she views the world and develops novel approaches to behaving as a result of new cognitions.
- **Dialectical Behavior Therapy (DBT)** – (Linehan) - A psychosocial treatment developed specifically to treat people with borderline personality disorder. Contains individual and group therapy components that seek to develop skills in mindfulness, interpersonal effectiveness, distress tolerance, and emotion regualtion.
- **Psychoanalytic / Psychodynamic** - A psychotherapeutic approach that focus early life experiences, basic instincts, and unconscious processes that lead to a person's behavior.
- **Personal Therapy** (Hogarty, 2003) - A form of individual psychotherapy for chronic psychotic disorders that considers the role that cognition plays but emphasizes personal and social functioning rather than specific symptoms and / or behaviors.
- **Integrated Psychological Therapy** (IPT) – (Brenner et. al.) IPT is a highly structured, cognitive behavioral group therapy specifically for people with schizophrenia, which incorporates cognitive retraining. Groups are small, consisting of 5-7 clients with sessions lasting 30-60 minutes three times per week over a period of a few months.

COMPREHENSIVE INVENTORY OF MENTAL HEALTH
&
RECOVERY AND REHABILITATION SERVICES

(CIMHRRS)

SCORING BOOKLET

PROGRAM MISSION

Rate on Likert scale. Choose the ***one*** item that best represents the program.

	1	2	3	4	5
1. Identifiable Program Mission Statement:	Program has no identified program mission statement.	Mission statement is that of a larger organizational entity (and does not separate mission for the program).	Mission statement is specific to the program but contains less than 4 of criteria listed in administration booklet (purpose, approach, population, and outcome).	Mission statement is specific to the program. Meets all four criteria identified in administration booklet (purpose, approach, population, and outcome) but does not have 100% endorsement by staff.	Mission statement is specific to the program. Meets all four criteria identified in administration booklet (purpose, approach, population, and outcome) and receives 100% endorsement my staff.
2. Articulated program theory /model:	Program theory or model for fulfilling program mission is not identified or program theory or model is that of the larger organizational entity.	Program theory or model is in the process of being developed but is not consistently implemented in policy or action.	Program theory or model is articulated but staff provides mixed endorsement.	Program theory or model is articulated and endorsed by staff.	Program theory or model is not only articulated and endorsed but has credence in program functioning.
3. Problem Identification and Resolution:	There is no formal or informal process identified.	Utilizes an informal process, or has a plan in the process of being developed but not in use.	There is a formal process identified (e.g. suggestion box, policy manual) but the process it is not well understood by staff.	There is a formal process identified and is understood and used by staff.	Program has demonstratable actions and outcomes that stem from identified process.
4. Program Monitoring:	Program does not conduct program monitoring.	Program is not capable of assessing fidelity to mission, theory, or effectiveness of program's implementation at this time. Extent of program drift unknown.	Program is familiar with concept and has capacity of assessing fidelity to mission, theory, or effectiveness of program's implementation but struggles to consistently utilize program monitoring. Extent of program drift remains unknown.	The program consistently uses the concepts and technology associated with program monitoring. Program is able to monitor program drift but is unable to facilitate pertinent changes in the program.	The program is able to utilize the information gathered from the program monitoring process to facilitate pertinent changes in the program to avoid or minimize program drift.

PROGRAM DEMOGRAPHICS & COMPOSITION

5. What is the population of the city / town in which services are received? ……_____

6. Where does the program provide the majority of services? (Please provide a percentage. All areas should total 100%)

a	Inpatient – Locked – Maximum Security	
b	Inpatient – Locked	
c	Inpatient – Unlocked	
d	Residential Locked	
e	Residential – Unlocked	
f	Residential - 24 Supervision	
g	Residential – Partial Supervision	
h	Community Mental Health Center	
i	Partial Hospitalization Program	
j	Day Treatment Program	
k	Job Site	
l	In home	
m	In vivo community setting	
n	Drop-In Center (peer ran)	
o	In jail / prison (non SMI focus)	
p	Probation office	
q	Mental Health Court	
r	Drug Court	
s	Substance Abuse Treatment Center	
t	Other (List)	
	TOTAL	

7. What is the capacity of the program (e.g. number of beds, average program caseload)? ……_____

8. Total number of clients currently being served by program?……_____

9. Number of clients currently with a substitute decision maker? ……_____

10. Number of clients with a deferred or withheld adjudication status? ……_____

11. Number of clients under civil commitment? ……_____

12. Number of clients with mental health advance directives? ……_____

13. What is the total number of clinical staff currently working within the program? ……_____

14. What is the formal educational levels of paraprofessional and professional staff? Currently, what is the number of staff with:

a	Less than a high school education	
b	High School diploma or equivalent	
c	Professional License (LPN, etc)	
d	Associates degree	
e	Bachelors degree	
f	Masters degree	
g	Doctoral degree	
h	Other (List)	

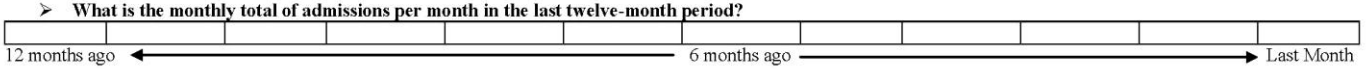
ORGANIZATIONAL BOUNDARIES

Choose the ***one*** item that best represents the program.

	1	2	3	4	5
15. Explicit Admission Criteria:	Program has no set criteria and takes all types of clients as determined outside the program.	Programs admission process is dominated by organizational convenience. No explicit criteria identified.	Implicit criteria identified by program. Accepts most referrals.	Explicit criteria identified. Program actively seeks and screens referrals carefully and occasionally bows to organizational pressure.	The program actively recruits a defined population and all clients meet explicit admission criteria.
16. Integrated Service Provision:	Program is isolated from other treatment providers; concentrating only on the parameters of the service it provides with little to no assessment of other treatment parameters that may affect the client's psychological well-being. No contact with other service providers.	Program staff recognize that client has additional service needs. Client's multiple needs are addressed with serial or sequential modes of treatment.	Client's multiple need are addressed through isolated use of serial or sequential modes of treatment OR multiple parallel treatments	Isolated use of parallel services	Provides all treatment in an integrated format. All services (internal or external) are reflected in the client's treatment plan.
17. Responsibility For Crisis Services:	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage

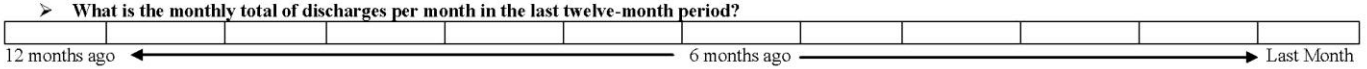
18. Intake Rate:

- **What is the monthly total of admissions per month in the last twelve-month period?**



19. Discharge Rate:

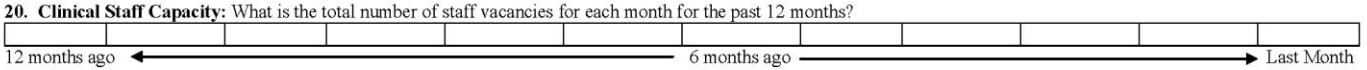
- **What is the monthly total of discharges per month in the last twelve-month period?**



19a. What is the number of current clients expected to be discharged in the next twelve months? _____

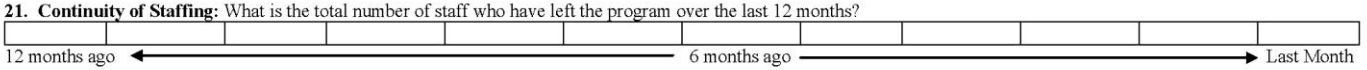
PROGRAM FUNCTIONING

20. Clinical Staff Capacity: What is the total number of staff vacancies for each month for the past 12 months?



Staffing percentage that program has operated at in the past 12 months _____

21. Continuity of Staffing: What is the total number of staff who have left the program over the last 12 months?



Percentage that the program has maintained the same staffing over the past 12 months _____

22. What is the number of training(s) / in-service(s) provided or supported by organization (or parent organization) in the past 12 months? ……_____

23. How many hours of trainings / in-services provided or supported by the program (or parent organization) in the past 12 months (by subject)

a	Psychotropic Medication	
b	Psychological Treatments	
c	Combined Psychopharmacological Treatment	
d	Psychiatric (Psychosocial) Rehabilitation	
e	Recovery	
f	Integrated Treatment Modalities	
g	Co-occurring Serious Mental Illness & Substance Use	
h	Evidence-based practice (process not interventions)	
i	Empirically Supported Treatment (specific interventions)	
j	Organizational Mission / Improvement	
k	Trauma Informed Services	
l	Relapse Prevention	
m	Psychiatric	
n	Substance Abuse	
o	Integrated	
p	Risk Management	
q	Other (List)	

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
24. The organization supports "off-site" training for staff.					
25. "Off-site" training facilitates the program's mission or theory/model					
26. The program attempts to integrate "off-site" trainings into the current program					

TREATMENT TEAM STRUCTURE & PROCESS

27. Within the program, what is the current number of positions		**Slotted**	**Filled**
a	Administrator		
b	Psychiatrist		
c	Nurse practitioner		
d	Physician assistant		
e	Other prescribing professional		
f	Psychologist		
g	Psychology Intern		
h	Psychology Extern		
i	Psychometricians		
j	Other Psychology extenders		
k	Nursing staff		

l	Vocational staff		
m	Substance abuse staff		
n	Social Workers (Masters level or higher)		
o	Para-professionals (Technicians, Case Managers / workers, etc.)		
p	Peer providers (specify position / duties)		
q	Other		
	TOTAL(S)		

28. Who in the program fulfills the roles outlined below? Ask the program point of contact for the pre-site visit checklist as the program need to complete this task for standardization purposes. Use identifiers from question 27. Multiple identifiers may be used as needed.

a	Administrator	
b	Supervising Independent Practitioner	
c	Case Coordinator	
d	Skills Trainer	
e	Change Agent Coordinator	
f	Psychopharmacotherapist	
g	Consultant	

Rate on Likert scale. Choose the ***one*** item that best represents the program.

	1	**2**	**3**	**4**	**5**
29. Evidence-based practice orientation:	Program does not recognize definition of EBP orientation (i.e. process vs. singular intervention).	Utilizes 1 of the 3 components of EBP orientation. List _____	Utilizes 2 of the 3 components of EBP orientation. List _____ _____	Utilizes 3 of the 3 components of EBP orientation but does not consistently integrate all of the components into cases.	Fully integrates all components of EBP orientation. Consistently integrates all of the components into cases.
30. Recovery Orientation	No policy statement or internal documents to support claims of recovery orientation care.	Explicit statement in policies or internal documents that supports recovery orientation but does not demonstrate a recovery orientation in practice (i.e. services are exclusively focused on symptom or risk management; people are referred to by diagnosis).	Recovery orientation is evident in treatment planning and staff interactions (i.e. recovery oriented language in clinical documents, consumer strengths & desires are incorporated into treatment planning process, staff utilize person-first language).	Program facilitates the shedding of patient role (e.g. replacing passive recipient role with role of active consumer of mental health services).	Program assists in developing activities outside the mental health service system (i.e. career development, community integration, or development of leisure activities).

Rate on Likert scale. Choose the ***one*** item that best represents the program.

	1	2	3	4	5
31. Psychosocial (Psychiatric) Rehabilitation Orientation	Psychosocial rehabilitation is not a service option.	Program reports rehabilitation focus but services focus on symptom reduction and psychiatric stabilization.	Program reports rehabilitation focus but services are maintenance focused (i.e. medication adherence, staying out of the hospital).	Program reports rehabilitation focus but services promote social activities in the community but client remains dependent on provider to organize activities (i.e. does not develop clients ability to carry out activity).	Services promote the acquisition of new skills or coping abilities that supports independent functioning in the community.
32. Team Approach (Horizontal agreement):	Members of the provider group operate independently of one another with little knowledge of other treatment provider activities or overall treatment plan.	Team attempts to function as a unit but primarily operates as a group of individuals, providing an array of services. Decisions made by individuals contradict consensus approach or a developed treatment plan.	Team operates within a consensus model. There is an implicit understanding to follow the consensus approach outlined by the team. Team utilizes the developed treatment plan to guide clinical decision making.	Team operates within a consensus model and has an identifiable, explicit policy which outlines the consensus approach. Policy includes a formal process to resolve clinical disagreements among team members.	Team uses consensus process to resolve disagreements, and when needed a formal mediation process. Upon identifying a plan of action, team members follow decision of mediation process.
33. Team Approach (Vertical agreement):	Administration fails to recognize the importance of providing support in developing vertical agreement and how it will support the identified program theory or model. This score may be used if there is no verbal or written program theory or model.	There is an identified program theory or model with implicit support.	Training of staff has begun; however, there appears to be a lack of consensus among leadership about program mission and theory / model of service provision.	There is consensus among leadership about program mission and theory / model of service provision. A majority of clinical staff have been trained in the model.	There is consistent agreement across levels of leadership supporting model. Most staff are fully trained and are providing services that fall in-line with the model.
34. Role of consumer in service provision:	Consumer(s) have no formal involvement in service provision within the program.	Consumer(s) fill consumer-specific but *unpaid* service roles with respect to program.	Consumer(s) *paid* to work *part-time* in roles with reduced responsibilities (e.g. driving clients around, courier, confirm appointments miscellaneous tasks, etc.)	Consumer(s) *paid* to work *full-time* in roles with reduced responsibilities (e.g. driving clients around, courier, confirm appointments miscellaneous tasks, etc.)	Consumer(s) employed full-time by program and functions as full member of the team in addressing client treatment issues.

Rate on Likert scale. Choose the ***one*** item that best represents the program.

	1	2	3	4	5
35. Organizational concept of case management:	Program provides no case management services.	Case management is performed by 1 person, not identified with a formal treatment team, implementing a list of services that do not constitute an integrated treatment plan.	An identified case manager oversees the implementation of an integrated individualized treatment plan but not as a member of a formal treatment team (i.e. the plan was provided to them, they had no input on the development of the plan and no role in assessing progress or outcome).	An identified case manager oversees the implementation of an integrated individualized treatment plan, as a member of a formal interdisciplinary treatment team that continuously evaluates treatment response and progress in recovery.	Although there may be a single identified case manager or treatment coordinator, specific case management functions are shared by members of a formal interdisciplinary treatment team, based on individual considerations and circumstances, e.g. rapport with staff or time availability.
36. Approach to Co-occurring SMI & Substance Abuse:	Program has no identifiable process to address these comorbid issues. No formal, individualized substance abuse assessment or treatment provided.	Variably addresses substance abuse concerns with clients. Separate assessment and treatment (sequential or parallel services without coordination between providers).	Importance of integrated treatment recognized but not formalized in policy. Parallel treatment occurs with coordination between providers. All of substance abuse services referred (persuasion groups; uses hospitalization for rehab.; refers to 12-step & self-help groups)	Recognition of importance of integrated treatment in policy. Program has an integrated approach but substance abuse program is primarily based on traditional models of substance abuse treatment: (confrontation; mandated abstinence; traditional 12-step models, etc.).	Recognition of importance of integrated treatment in policy. Program provides assessments and integrated approach is reflected in treatment plan (services provided by program or outside services are highly integrated). Identifies with a stage-wise model and seeks to modify use behaviors (harm-reduction) on the way to sobriety.

ASSESSMENT PROCESS

Rate on Likert scale. Choose the *one* item that best represents the program.	No availability	Limited or anecdotal (informal)	Systematic access or performance of assessment but data does not influence treatment	Systematic access or performance of assessment; influences treatment AND progress evaluation; limited in scope / monitoring	Full range of assessment integrated with Tx. planning AND progress evaluation
37. Does the program assess clients' goals?	1	2	3	4	5
38. Does program conduct symptom assessment?	1	2	3	4	5
39. Does program conduct neurocognitive assessment?	1	2	3	4	5
40. Does the program conduct functional behavior analysis?	1	2	3	4	5
41. Does the program assess basic independent living skills	1	2	3	4	5
42. Does the program assess wellness management / relapse prevention skills?	1	2	3	4	5
43. Does the program assess social / interpersonal skills?	1	2	3	4	5
44. Does the program assess occupational skills?	1	2	3	4	5
45. Does program conduct risk assessment?	1	2	3	4	5

TREATMENT PLANNING

Rate on Likert scale. Choose the ***one*** item that best represents the program.

	1	2	3	4	5
46. Origin and scope of treatment plan	Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	Program operates from a treatment plan that is developed outside of the program without program staff involvement.	Program operates from a treatment plan that is developed outside of the program with program staff input.	Treatment plan is developed within program but does not comprehensively include all relevant services	Treatment plan is developed within the program and includes all relevant services, with links to other programs where needed.
47. Individualized treatment plan	Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	There is no indication that any personal information about the client has been incorporated into the treatment plans.	Treatment plans incorporate only anecdotal personal information that guides treatment selection.	Treatment plans incorporate formal assessment results that are logically linked to treatment selection, but similarities across treatment plans are greater than the range and diversity of assessment results indicate.	Diversity across treatment plans reflects the diversity of assessment results found in the program's client population.
48. Client role in treatment plan development	Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	Treatment plan is developed in the absence of consumer input.	Treatment plan is provider driven but based on consumer preferences	Client actively collaborates with provider to develop treatment.	Treatment plan is client driven.
49. Treatment plan review (TPRs) process	Does not conduct treatment planning and there is no identifiable treatment plan OR program does not operate from a treatment plan.	Only prescribed feature of TPR are those required by regulation (e.g. frequency)	Policy and procedures manual outlines features in addition to those required by regulation (e.g. who must attend TPRs) and/or a mechanism for a meeting schedule that exceeds regulatory standards	Process allows for quantitative determination of progress (or lack) and distinguishes between areas of lesser or greater progress.	There is a mechanism and procedure in policy and procedures manual that directs follow up and documentation on findings of insufficient progress.

Rate on Likert scale. Choose the ***one*** item that best represents the program.

	1	2	3	4	5
50. Discharge planning	Services are time unlimited OR Program does not have any formal discharge criteria.	Program mission / policy indicates discharge criteria. Discharges from program are atypical e.g. resulting from unmanageable risk factors, client moving, treatment non-compliance, client entering a different service system (jail, etc.), or death.	Program mission / policy indicates a discharge criteria. Discharge from program is expected. ?Discharge process begins when client ***meets criteria.*** (i.e. toward the end of treatment).	Program mission / policy indicates a discharge criteria. Discharge from program is typical. Discharge process begins at various points in treatment as client progresses in treatment.	Discharge process begins at intake. Program actively identifies barriers to treatment and discharge at intake and on an ongoing basis.

TREATMENT PROVISION

Rate on Likert scale. Choose the ***one*** item that best represents the program.

51. Does program provide or coordinate these services?	**PROVIDES**	**COORDINATES**	**N/A**
a) Collaborative Psychopharmocotherapy	3	2	1
b) Rehabilitation Counseling	3	2	1
c) Social Skills Training	3	2	1
d) Problem-Solving Skills Training	3	2	1
e) Independent Living Skills Training	3	2	1
f) Supported Employment	3	2	1
g) Illness/Wellness Management Skills Training	3	2	1
h) Family Consultation, Education, and Therapy	3	2	1
i) Contingency Management	3	2	1
j) Supported Housing	3	2	1
k) Specialized Integrated Treatment for Co-occurring Substance Abuse	3	2	1
l) Cognitive Rehabilitation	3	2	1
n) Specialized Models for Service Integration and Provision	3	2	1
m) Trauma-based services	3	2	1
n) Peer Support (specify service)	3	2	1

52. Does program provide these specific Psychotherapies	**PROVIDES**	**COORDINATES**	**N/A**
a) Cognitive Behavioral Therapy	3	2	1
b) Dialectical Behavior Therapy	3	2	1
c) Psychoanalytic / Psychodynamic	3	2	1
d) Personal Therapy	3	2	1
e) Integrated Psychological Therapy	3	2	1

COMPREHENSIVE INVENTORY OF MENTAL HEALTH AND RECOVERY AND REHABILITATION SERVICES (CIMHRRS)

~

Program Face Sheet

Date: _____/_____/_____

Rater(s): _____

_____

Program Name: _____

Program Code: _____

Parent Agency: _____

Address: _____
_____
_____

Point of Contact: _____
Telephone: ( ) -
E-mail:
Address if different than above
_____
_____
_____

Sources Used:
____ Review of Policy and Procedures Manual
____ Review of Internal Documents
____ Chart Review
____ Program Administrator interview
____ Program Staff Interview
____ # interviewed
____ Other: Describe below

COMPREHENSIVE INVENTORY OF MENTAL HEALTH AND RECOVERY AND REHABILITATION SERVICES (CIMHRRS)

~

Evaluator's Pre-visit Checklist

Prior to the Site Visit:

_____ Contact the organization and enter the contact information on the face sheet.
_____ Begin coordination and confirmation of a timeline for the site visit.
_____ Develop a shared understanding and trust with the program.

- The goal of the research:
  - Establish the psychometric properties of the CIMHRRS
    - Interrater reliability
    - Internal consistency
    - Feasibility of the site visit format
  - What is hoped to be determined by the research?
    - Services research
  - How it will benefit the program being assessed?
    - Program evaluation
    - What information will be provided
    - Who will see the results of the evaluation
    - Confidentially

_____ Inform the program's point of contact about the activities that will need to occur before and during the site visit. Stress the fact that notifying staff in advance would be extremely helpful in coordinating materials and schedules.
  - The site visit is expected to take 14-16 hours on site.

_____ Identify who you will need to potentially interview and how long the interview may take
  - program administrator (approximately 90 minutes)
  - different levels of staff (approximately 60 minutes each)

_____ Identify the organizational items you will need to review:
  - Policy and procedures manual
  - Client charts
    - The evaluators will need to access to 20 charts. Remind the program that the purpose of the evaluation to is to get an accurate reading of the programs functioning and that the selection process for the charts should be random.
    - Having the charts pulled prior to the evaluation would be helpful.

_____ Identify specific items to be reviewed that will be helpful to organize prior to the site visit by forwarding the program version of pre-site visit checklist.

Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS)

~

Program Previsit Checklist

Dear program participant,

The following questions may take some time to consolidate. It is our intention that we provide you with ample time to gather this information and not create an undue impostion to your program. While this information is important and will eventually need to be completed as part of the program evaluation, it is not necessary to have all the information gathered for the evaluators to begin the evaluation of the program.

Thank you!

What is the population of the city / town in which services are received?			
What is the capacity of the program (e.g. number of beds, average program caseload)?			
Total number of clients currently being served by program?			
Number of clients currently with a substitute decision maker (Guardian, Payee, Attorney, etc.)			
Number of clients with a deferred or withheld adjudication status (NGRI, NRRI, etc.)			
Number of clients under civil commitment?			
Number of clients with mental health advance directives?			
What is the total number of clinical staff currently working within the program?			
What is the formal educational levels of paraprofessional and professional staff?			
	Less than a high school education		
	High School diploma or equivalent		
	Professional License (LPN, etc.)		
	Associates degree		
	Bachelors degree		
	Masters degree		
	Doctoral degree		
	Other (List)		
Number of training(s) provided / supported by the program (or parent organization) in the past 12 months?			
Hours of training provided/supported by the program or parent organization in the past 12 months?			
	Psychotropic Medication		
	Psychological Treatments		
	Combined Psychopharmocological Treatment		
	Psychiatric (Psychosocial) Rehabilitation		
	Recovery		
	Integrated Treatment Modalities		
	Co-occurring Serious Mental Illness & Substance Use		
	Evidence-based practice orientation (process not interventions)		
	Empirically Supported Treatment (specific interventions)		
	Organizational Mission / Improvement		
	Trauma Informed Services		
	Relapse Prevention		
		Psychiatric	
		Substance Abuse	
		Integrated	
	Risk Management		
	Other (List)		

Within the program, what is the current number of positions? Based your answers on a full-time equivalent (FTE) schedule (.25 = 10 hours/week, .50 = 20 hours/week, .75 = 30 hours/week, 1.0 = 40 hours/week, etc)

	Slotted	Filled
Administrator		
Psychiatrist		
Nurse practitioner		
Physician assistant		
Other prescribing professionals		
Psychologists		
Psychology Interns		
Psychology Extens		
Psychometricians		
Other Psychology extenders		
Nursing staff		
Vocational staff		
Substance abuse staff		
Social Workers (Masters level or higher)		
Para-professionals (Technicians, Case Managers / workers, etc.)		
Peer providers (specify position / duties)		
Other (List)		

COMPREHENSIVE INVENTORY OF MENTAL HEALTH AND RECOVERY AND REHABILITATION SERVICES (CIMHRRS)

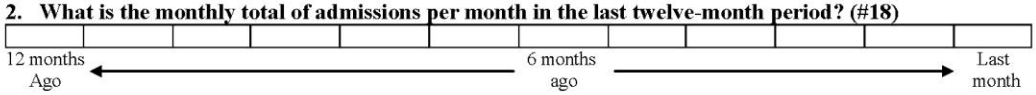
~

PROGRAM ADMINISTRATOR HANDOUT

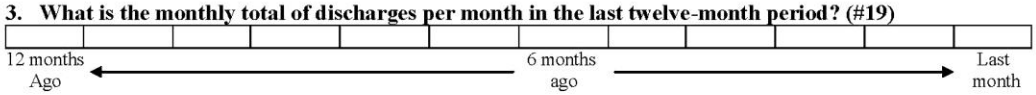
1. Where does the program provide services? (List as percentages. Total should = 100%) (#6)

Inpatient – Locked – Maximum Security	
Inpatient – Locked	
Inpatient – Unlocked	
Residential locked	
Residential – Unlocked	
Residential - 24 Supervision	
Residential – Partial Supervision	
Community Mental Health Center	
Partial Hospitalization Program	
Day Treatment Program	
Job Site	
In home	
In vivo community setting	
Drop-In Center (peer ran)	
In jail / prison (non SMI focus)	
Probation office	
Mental Health Court	
Drug Court	
Substance Abuse Treatment Center	
Other (Please define)	
TOTAL	

2. What is the monthly total of admissions per month in the last twelve-month period? (#18)

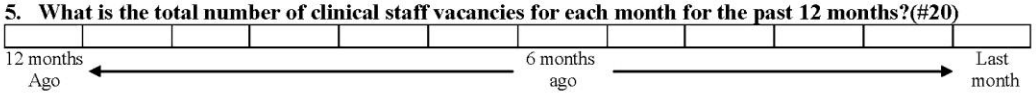


3. What is the monthly total of discharges per month in the last twelve-month period? (#19)

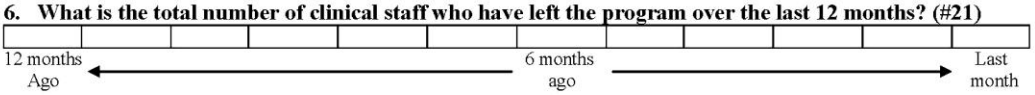


4. What is the number of current clients expected to be discharged in the next twelve months? (#19a)

5. What is the total number of clinical staff vacancies for each month for the past 12 months?(#20)



6. What is the total number of clinical staff who have left the program over the last 12 months? (#21)



7. <u>Who in the program fulfills the roles outlined below? (#28)</u>

<u>Administrator</u> – someone who functions as immediate management and assumes some responsibility in the functioning of the program.

<u>Supervising Independent Practitioner</u> – the staff person who assumes the primary responsibility for the narrative formulation of a treatment plan and provides professional oversight. A prerequisite for this role is some form of professional credentialing that is legally recognized and grants a person to practice "independently."

<u>Case Coordinator</u> – the staff person(s) whose role is to coordinate, manage, or link services to facilitate a client's process through the mental health system.

<u>Skills Trainer</u> – the person whose role it is to teach the acquisition of new skills to clients, through highly developed and systematic training to improve a client's level of functioning (social skills, problem solving, independent living, occupational, illness/wellness management, etc.)

<u>Change Agent Coordinator</u> – the person whose role it is to train direct line staff

<u>Psychopharmacotherapist</u> – the person whose role it is to prescribe psychotropic medications

Consultant – the person who provides ***professional*** expertise in fulfilling an organizational need on a short-term, less than full-time employment, or hired for a very specific activity by the program (i.e. hiring someone to conduct fidelity assessment). While off-site treatment providers may provide professional consultation that informs the treatment process of individuals, (i.e. off-site treatment provider) the definition of this position is specific to services provided on-site directly to the program.

8. Does the program provide or coordinate these services? (#49) (Please circle ONE)

Collaborative Psychopharmacotherapy: There is research evidence that the combination of pharmacotherapy and psychological interventions is more effective than the use of medications alone. This approach is considered standard practice. This approach requires that entire treatment team, including the psychopharmacologist and client work collaboratively to determine the optimal balance between medication regimens and psychosocial treatments to maximize a client's level of functioning.	**Provides**	**Coordinates**	**N/A**
Rehabilitation Counseling: Rehabilitation counseling in SMI populations stem out of the key concepts found in traditional physical rehabilitation. This involves an initial and ongoing meeting with a client and his or her treatment team to identify and integrate issues that require treatment (i.e. rehabilitation), to address a client's concerns and /or desires, and to develop and address these issues. The identified counselor works with the client to assess the objective and subjective processes of treatment to inform the process of rehabilitation.	**Provides**	**Coordinates**	**N/A**
Social Skills Training: Often the functional aspects of serious mental illness is manifested in a reduction in interpersonal effectiveness, making it difficult to establish and maintain relationship or fulfill social roles that are key to a person's individual recovery. Formal social skills training have been shown to improve personal and social functioning. This training typically occurs in a structured group format, includes role-playing, focuses on skill development in the identification of contextual aspects of interactions, and develops social competence via positive reinforcement and repetition.	**Provides**	**Coordinates**	**N/A**
Problem Solving Skills Training: This widely accepted type of social skills training utilizes cognitive-behavioral techniques to teach clients interpersonal problem-solving skills. Following a heuristic model of problem-solving, clients learn how to identify a problem, develop possible solutions, select a solution, and then implement and evaluate the solution	**Provides**	**Coordinates**	**N/A**
Independent Living Skills Training: This training is focused on developing the skills associated with the activities of daily living (e.g. grooming and hygiene, house-keeping, budgeting, cooking, utilization of community supports / resources, etc.). This training typically includes didactic instruction as well as in vivo coaching to solidify a client's knowledge and performance capabilities.	**Provides**	**Coordinates**	**N/A**
Supported Employment: Traditional vocational rehabilitation for people with SMI has resulted in placements in sheltered workshops or in placements that were reserved for people with mental illness. This traditional model is known as the "train-place" model of vocational rehabilitation and averages only 10%-20% of competitive employment placement. Supported employment / occupational skills training is known as the "place-train" model with the result being competitive, "real-world" employment for the client rather than sheltered workshops, etc. Supported employment emphasizes the rapid attainment of work and matching the client's skills and interests to the job rather than teaching new skills for some undetermined job sometime in the future. In this model, the client rather than the	**Provides**	**Coordinates**	**N/A**

program assumes the responsibility for attainment and maintenance of employment. An employment specialist typically serves the client by identifying client preferences, strengths, and previous employment, collaborates with the treatment team, completes vocational assessments, and provides assistance with finding a job and ongoing job support. In addition to the vocational skills learned in supported employment / occupational skills training which are very specific to types of jobs, programs may also provide more generalized training. General occupational skills are those skills that are generalizable to multiple work settings such as showing up to work on time, having a neat and clean appearance, managing work schedule, etc.			
Illness/Wellness Management Skills Training: The ability of a person with SMI to identify, understand, and manage the multiple aspects of his or her mental illness is key in developing strategies to avoid psychiatric relapse. This approach is highly individualized to the person who is in recovery as the functional aspects and range of symptoms of the person's disorder is very heterogeneous. Skills training in this area, examines the idiographic factors of a person's disorder such as symptom presentation, the relationship between symptoms and functional impairments, techniques to control symptoms and improve levels of functioning. Additionally, clients learn to identify "triggers" or "warning signs" of relapse, receive training about psychotropic medications, and develop interpersonal skills to facilitate psychological well-being.	**Provides**	**Coordinates**	**N/A**
Family Consultation, Education, and Therapy: The effects of serious mental illness extend beyond the individual to friends and family members. Often there are unresolved feelings of shame and guilt experienced by family members resulting in a great deal of distress. Additionally, the interactions between friends / family and the person in recovery may increase the potential for psychiatric relapse. Services that include psychoeducational training on mental illness and behavior management, the effects of expressed emotion, and provide support to family members have been shown to reduce recidivism.	**Provides**	**Coordinates**	**N/A**
Contingency Management: Contingency management, rooted in learning and social learning theories utilizes a number of techniques that are important in various psychiatric settings to bring about change in maladaptive behavior (e.g. aggression and polydipsia). In contingency management, a program makes predictions about a client's behavior and through highly specified behavioral approaches and positive reinforcement brings about behavioral change that a client may not otherwise perform (i.e. engagement in rehabilitation activities, learning how to be assertive versus being aggressive, etc.). Contingency management techniques such as token economies have been found effective in inpatient settings and continue to find wider acceptance in community-based settings.	**Provides**	**Coordinates**	**N/A**
Supported Housing: The concept of supported housing is focused on assisting people with SMI living as independently as possible within his or her community, including living in their own home. Programs that follow supported housing ideals work with the individual to identify preferences, resources, and needs and develop flexible services to support the client in successfully remaining in the home and community. This is in contrast to being placed in residential treatment facilities, which is often based on bed availability.	**Provides**	**Coordinates**	**N/A**
Specialized Integrated Treatment for Co-occurring Substance Abuse: The prevalence of a co-occurring substance use problem in those people with serious mental illness is high. The presence of substance abuse issues can have implications for a person's recovery and rehabilitation and serve as a catalyst for psychiatric relapse. This approach is different from a traditional approach to addressing substance abuse in that within an integrated services setting the program provides both mental health and substance abuse service including assessment, treatment planning, and treatment.	**Provides**	**Coordinates**	**N/A**

Cognitive Rehabilitation: As a result of their disorder or the antipsychotic medication used to treat their symptoms, people with serious mental illness often have deficits in their cognitive functioning. Research on cognitive rehabilitation demonstrates the effectiveness of a number of approaches in improving a person's cognitive functioning (i.e. coping with auditory hallucinations, remediation of learning disabilities, executive functioning, developmental delays, attention shaping, generalized improvement in real-world settings). Examples of this type of intervention would include Neuropsychological Educational Approach to Rehabilitation (NEAR), Integrated Psychological Therapy (IPT), Cognitive Enhancement Therapy (CET), Cognitive Adaptation Training (CAT), Attention Shaping, Errorless Learning, and ecologically valid behaviorally supported cognitive interventions.	**Provides**	**Coordinates**	**N/A**
Specialized Models for Service Integration and Provision: Specialized models of integrating and providing services to people who have severe disabilities associated with SMI. Three models that have been developed and are supported by outcome data include: Psychosocial Clubhouse Model, Assertive Community Treatment, and Social Learning Programs.	**Provides**	**Coordinates**	**N/A**
Trauma-based services: Trauma and violence can have a deleterious effect on a person's physical and psychological well being. Trauma-based services seek to address the pervasive impact resulting from violence and trauma, including sexual, physical, and emotional abuse on a person's life and level of functioning. This type of service supports highly individualized treatment and prevention.	**Provides**	**Coordinates**	**N/A**
Peer Support (specify service): Within the context of the literature, the term "peer support" assumes multiple definitions. Within the context of a recovery-oriented system, people with SMI should be included in all aspects of research and service provision; however, the implementation of this concept is varied. Generally speaking, peer support indicates some type of involvement of peers in the management of a person's disorder. This may come in the form of peers being treatment team members as in some versions of assertive community treatment (i.e. peer specialists) or self-help groups / interventions that are based off well-known programs such as Recovery Inc. or Wellness Recovery Action Plan (WRAP). Empirical support for these interventions are limited but are considered to be "promising practices."	**Provides**	**Coordinates**	**N/A**

9. Does program provide OR coordinate these specific Psychotherapies? (#50) (Please circle ONE)

Cognitive Behavioral Therapy: A type of psychotherapy that challenges client attributions of events and their interpretations of how he or she views the world and develops novel approaches to behaving as a result of new cognitions	**Provides**	**Coordinates**	**N/A**
Dialectical Behavior Therapy (DBT) – (Linehan)**:** A psychosocial treatment developed specifically to treat people with borderline personality disorder. Contains individual and group therapy components that seek to develop skills in mindfulness, interpersonal effectiveness, distress tolerance, and emotion regualtion.	**Provides**	**Coordinates**	**N/A**
Psychoanalytic / Psychodynamic: A psychotherapeutic approach that focus early life experiences, basic instincts, and unconscious processes that lead to a person's behavior.	**Provides**	**Coordinates**	**N/A**
Personal Therapy (Hogarty, 2003)**:** A form of individual psychotherapy for chronic psychotic disorders that considers the role that cognition plays but emphasizes personal and social functioning rather than specific symptoms and / or behaviors.	**Provides**	**Coordinates**	**N/A**
Integrated Psychological Therapy (IPT) – (Brenner et. al.)**:** IPT is a highly structured, cognitive behavioral group therapy specifically for people with schizophrenia, which incorporates cognitive retraining. Groups are small, consisting of 5-7 clients with sessions lasting 30-60 minutes three times per week over a period of a few months.	**Provides**	**Coordinates**	**N/A**

COMPREHENSIVE INVENTORY OF MENTAL HEALTH
&
RECOVERY AND REHABILITATION SERVICES

(CIMHRRS)

PROGRAM ADMINISTRATOR INTERVIEW

CIMHRRS ADMINSTRATION NOTES:

- Interviewer needs to review Policies and Procedures manual prior to conducting interviews.
- As the CIMHRRS is designed to be administered to programs with varied staffing and missions, it will be important for the evaluator to determine the number of interviews to complete. However, this sampling should be conducted across clinical staffing ranges (pre-paraprofessional, bachelors-level or nursing, masters-level, doctorate-level). Furthermore it would be important to interview those people within the administrative structure from the highest to lowest available person, which would include any identified "team leader."

PROGRAM MISSION

- What is the "purpose" of the program? (Query for purpose, approach, population, and outcome if not included in response) *(#1)*
  - *Is that purpose documented somewhere?*
- *What is the program's theory or model for reaching that mission?(#2)*

- *Does the program have a process for identifying issues and for making recommendations to the program?(#3)*

- *How does the program monitor its progress in reaching its program mission?(#4)*

- *Does the program have the technology to conduct program monitoring?*

ORGANAZATIONAL BOUNDARIES

Explicit admission criteria (#15)

- *"How does an individual become a client of the program?"*

- *"Does your program have a clearly defined target population with whom you work?"*

- *"Does the program have criteria used to screen potential clients?"*

- *"How do you apply these criteria?"*

- *"Who makes referrals to the program?"*

- *"Who has the final say as to whether or not a person is served by the program?"*

- *"Are there circumstances where you have to take clients?"*

- *"Do you have some clients who you feel do not really fit or need the level or type of services your program provides?"*

Integrated Service Provision (#16)

- *Describe your programs interaction with other programs.*

- *How does the program address a client's multiple treatment needs?*

- *Does the program conduct formal needs assessments?*

- *How do those assessments inform how you provide treatment?*

- *Describe how a client transitions from your program to another setting.*

Responsibility for crisis services (# 17)

- Does the program provide after hours emergency services? **(If "no skip to program functioning).**

- *Describe the program's responsibility in providing handling after hour crises.*

- *Who responds in these situations?*

- *Are there follow up procedures in place?*

PROGRAM FUNCTIONING

- *Has any clinical staff been on leave or an extended absence for more than 3 months?*

Please rate the following:

The organization supports "off-site" training for staff. **(#24)**

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

"Off-site" training facilitates the program's mission or theory/model **(#25)**

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

The program attempts to integrate "off-site" trainings into the current program. **(#26)**

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

TREATMENT TEAM STRUCTURE & PROCESS

Evidence-based practice (#29)

- *Recently, there has been some changing interpretations of the term "evidence-based practice." How does the program interpret the concept of "evidence based practice?" (If needed, explain difference between solitary interventions and process approach).*

- *How does the program utilize the concept of evidence-based practice (process)?*

Recovery Orientation (#30)

- *There are many ways in which the term "recovery" has been utilized in describing treatment and people with serious mental illness. How does your program conceptualize the concept of recovery?*

- *Is there any program policy that supports a recovery-oriented system of care (i.e. policy and procedures manual or internal documents)?*

- *How is the concept of recovery integrated into the services provided by the program? (i.e. person first language, treatment planning, strength based focus, etc.)*

- *How does the program facilitate a client's personal recovery? (i.e. shedding of patient role, integration to community, moving beyond mental health system)*

31. Psychosocial Rehabilitation Orientation

- *Is psychosocial or psychiatric rehabilitation a service option in your program?*

- *Please describe what the program provides to facilitate psychosocial or psychiatric rehabilitation*

- *How does the program foster independence?*

Team Approach (#32, 33)

- *Describe how the team (clinical if available) operates in meeting the treatment needs of the client.*

- *How do team members communicate with each other about treatment planning or the provision of services?*

- *What is the process of resolving conflict between staff? Do you have examples of the process?*

- *Would you say the program operates under a consensus model?*

- *Is there some formal or informal policy in place that identifies outlines how the team functions?*

- *How does the administration support the program's identified mission?*

- *How does the administration support the program's theory or model?*

    - *Are there written statements/ documents of support for the program's mission/ model?*

    - *How well are the program mission / model accepted by management?*

- *Does the program provide any training in the model?*

    - *Is there training for clinicians, mangers, direct-line staff?*

    - *How many are trained?*

- *What percentage is the theory or model fully implemented?*

Role of Consumer on team (#34)

CIMHRRS ADMINSTRATION NOTE: Provide the following definition of consumer prior to beginning this section.

"In this item a consumer, refers to those people who have disclosed a history of psychiatric and / or co-occurring serious mental illness and substance abuse treatment and are not currently receiving services from the program."

- *Does the program have consumers involved in service provision?(If "no" skip to question #35)*

- *What roles do consumers fulfill in the program?*

- *Are consumers considered team members?*

- *Are consumers paid employees? Full-time? Part-time?*

Organizational concept of case management (#35)

- *Who provides case management services?*

- *Is there a person who assumes the primary role of service provision, coordination, or paperwork?*

- *Does the provision of case management services change over time with the client's progress in treatment?*

Approach to Co-occurring SMI and Substance Abuse (#36)

- *Does the program assess substance abuse issues?*

- *Does the program provide substance abuse treatment?*

- *What is the program's approach to dealing with substance abuse problems?(Confrontational, Sequential, Parallel, or Integrated)*

- *What is the goal of substance abuse treatment? (e.g. Abstinence, Harm-reduction (ask for examples))*

- *Are clients referred to:* *How are these programs utilized?*

AA or other 12-step programs	Y / N	
Self-help groups	Y / N	
Detox	Y / N	
Persuasion groups	Y / N	
Psychoeducational programs	Y / N	

- *Does the program utilize stage-wise approaches to substance use treatment? (Ask them to give examples).*

ASSESSMENT PROCESS (#37-45)

	goals	symptoms	neurocognitive functioning	functional behavior	independent living skills	wellness management	social / interpersonal abilities	occupational skills	risk assessment
"Does the program access to or the ability to conduct assessment of client's _____(insert header)?"	NO	NO	NO	NO	NO	NO	NO	NO	NO
If "no" skip to next series of questions	YES	YES	YES	YES	YES	YES	YES	YES	YES
"Is this information collected informally (anecdotally) or formally (formal assessment)?"	Informal	Informal	Informal	Informal	Informal	Informal	Informal	Informal	Informal
If assessment is anecdotal, sporadic, or not associated with systematic monitoring go to next series of questions EXAMPLE: Assessment consists of progress notes anecdotally describing client performance.	Formal	Formal	Formal	Formal	Formal	Formal	Formal	Formal	Formal

	goals	symptoms	neurocognitive functioning	functional behavior	independent living skills	wellness management	social / interpersonal abilities	occupational skills	risk assessment
"Does the program have access to or perform *systematic* formal assessments?"	NO	NO	NO	NO	NO	NO	NO	NO	NO
	YES	YES	YES	YES	YES	YES	YES	YES	YES
"Does the data collected in these formal assessments inform treatment selection AND evaluation of client progress?"	NO	NO	NO	NO	NO	NO	NO	NO	NO
"NO" EXAMPLE: A formal quantitative assessment is administered at intake but not repeated after an intervention.	YES	YES	YES	YES	YES	YES	YES	YES	YES

	goals	symptoms	neurocognitive functioning	functional behavior	independent living skills	wellness management	social / interpersonal abilities	occupational skills	risk assessment
"Does the program conduct in vivo monitoring of performance in a natural environment?" EXAMPLE: Formal functional assessment reveals that client is able to balance a checkbook. Assessment if the client actually keeps his or her checkbook balanced is evidence of in vivo monitoring.	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧
	YES ⇩	YES ⇩	YES ⇩	YES ⇩	YES ⇩	YES ⇩	YES ⇩	YES ⇩	YES ⇩
"Are formal, informal, and in vivo assessment information integrated into treatment planning AND progress evaluation?" **NOTE: Evaluators need to verify this in the chart review process in order to rate the program a "5."**	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧	NO ⇧
	YES ⇧	YES ⇧	YES ⇧	YES ⇧	YES ⇧	YES ⇧	YES ⇧	YES ⇧	YES ⇧

TREATMENT PLANNING (#46- #49)

CIMHRRS ADMINISTRATION NOTE: The questions listed here are meant to facilitate an understanding of the treatment planning process. The primary source of data for this section remains to be the chart review process. Any information gathered in this section must be verified by the chart review process and scored accordingly.

- *Does the program develop treatment plans?* ***(If "no" skip to discharge planning section - #50)***

- *Describe the process of conducting treatment planning(#46-49)*

- *Where does the treatment plan originate? (Inside or outside the program?) (#46)*

  If ***outside*** *the program: "Does program staff have input?" (#46)*

- *What role does assessment play in treatment plan development? (#47)*

- *Would you say the treatment plans are generally the same for all the clients? (#47)*

- *In the process of developing a treatment plan, does the program identify potential barriers to treatment?*

- *What role does the client fulfill in the treatment planning process? (#48)*

- *How are treatment goals identified? (#48)*

- *How are client preferences integrated into the treatment plan? (#48)*

- *Please describe the treatment plan review process (#49)*

    - To what extent does assessment inform the treatment plan review process? (#49)

    - *What facilitates a treatment plan review?(an external funding source (Medicaid, Medicare, etc.), guidelines established by an accreditation body, clinically relevant changes in a client's progress, client request)(#49)*

    - *How often are treatment plans reviewed?(#49)*

- *Does the program have a mechanism for a meeting schedule that exceeds regulatory standards? (#49)*

- Does the program have the capacity to make a quantitative determination of client progress? (#49)

- Does the program have a mechanism and procedure in the policy and procedures manual that directs follow up and documentation on findings of "insufficient progress?" (#49)

- What is the mechanism that alerts the program to insufficient progress? (#49)

- How does the program react to becoming aware of insufficient progress? (i.e. additional meetings, meeting with client, documentation, reassessing interventions, restructuring of treatment plan). (#49)

Tell me about discharge planning.(#50) ***(If program does not discharge or does not discharge plan "no," skip to treatment provision section)***

- *Is discharge expected?*

- *When does discharge planning begin?*

- *Is there written policy outlining the discharge process?*

- *What are the program's criteria for discharge?*

- *Where are clients discharged?*

COMPREHENSIVE INVENTORY OF MENTAL HEALTH
&
RECOVERY AND REHABILITATION SERVICES

(CIMHRRS)

STAFF INTERVIEW

CIMHRRS ADMINSTRATION NOTES:

- Interviewer needs to review Policies and Procedures manual prior to conducting interviews.
- As the CIMHRRS is designed to be administered to programs with varied staffing and missions, it will be important for the evaluator to determine the number of interviews to complete. However, this sampling should be conducted across clinical staffing ranges (pre-paraprofessional, bachelors-level or nursing, masters-level, doctorate-level). Furthermore it would be important to interview those people within the administrative structure from the highest to lowest available person, which would include any identified "team leader."

PROGRAM MISSION

- What is the "purpose" of the program? (Query for purpose, approach, population, and outcome if not included in response) *(#1)*
  - *Is that purpose documented somewhere?*
- *What is the program's theory or model for reaching that mission?(#2)*

- *Does the program have a process for identifying issues and for making recommendations to the program?(#3)*

ORGANIZATIONAL BOUNDARIES

Integrated Service Provision (#16)

- *Describe your programs interaction with other programs.*

- *How does the program address a client's multiple treatment needs?*

- *Does the program conduct formal needs assessments?*

- *How do those assessments inform how you provide treatment?*

- *Describe how a client transitions from your program to another setting.*

Responsibility for crisis services (# 17)

- Does the program provide after hours emergency services? **(If "no skip to program functioning).**

- *Describe the program's responsibility in providing handling after hour crises.*

- *Who responds in these situations?*

- *Are there follow up procedures in place?*

PROGRAM FUNCTIONING (#24-26)

Please rate the following:

The organization supports "off-site" training for staff. **(#24)**

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

"Off-site" training facilitates the program's mission or theory/model **(#25)**

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

The program attempts to integrate "off-site" trainings into the current program. **(#26)**

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

TREATMENT TEAM STRUCTURE & PROCESS

Recovery Orientation (#30)

- *There are many ways in which the term "recovery" has been utilized in describing treatment and people with serious mental illness. How does your program conceptualize the concept of recovery?*

- *Is there any program policy that supports a recovery-oriented system of care (i.e. policy and procedures manual or internal documents)?*

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- *Describe how the team (clinical team - if available) operates in meeting the treatment needs of the client.*

- *How do team members communicate with each other about treatment planning or the provision of services?*

- *What is the process of resolving conflict between staff? Do you have examples?*

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- *How does the administration support the program's theory or model?*

- *Are there written statements/ documents of support for the program's mission/ model?*

- *How well are the program mission / model accepted by management?*

- *Does the program provide any training in the model that is meant to help the program meet its identified mission?*

- *Is there training for clinicians, mangers, direct-line staff?*

- *How many are trained?*

- *What percentage is the theory/model is fully implemented?*

Role of Consumer in service provision (#34)

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- *Does the program provide substance abuse treatment?*

- *What is the program's approach to dealing with substance abuse problems?(Confrontational, Sequential, Parallel, or Integrated)*

- *What is the goal of substance abuse treatment? (e.g. Abstinence, Harm-reduction (ask for examples))*

➢ *Are clients referred to:* *How are these programs utilized?*

AA or other 12-step programs	Y / N	
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Psychoeducational programs	Y / N	

➢ *Does the program utilize stage-wise approaches to substance use treatment? (Ask them to give examples).*

TREATMENT PLANNING (#46- #49)

CIMHRRS ADMINISTRATION NOTE: The questions listed here are meant to facilitate an understanding of the treatment planning process. The primary source of data for this section remains to be the chart review process. Any information gathered in this section must be verified by the chart review process and scored accordingly.

➢ *Does the program develop treatment plans?* ***(If "no" skip to discharge planning section - #50)***

- *Describe the process of conducting treatment planning(#46-49)*

- *Where does the treatment plan originate? (Inside or outside the program?) (#46)*

  *If **outside** the program: "Does program staff have input?" (#46)*

- *What role does assessment play in treatment plan development? (#47)*

- *Would you say the treatment plans are generally the same for all the clients? (#47)*

- *In the process of developing a treatment plan, does the program identify potential barriers to treatment?*

- *What role does the client fulfill in the treatment planning process? (#48)*

- *How are treatment goals identified? (#48)*

- *How are client preferences integrated into the treatment plan? (#48)*

- *Please describe the treatment plan review process (#49)*

- To what extent does assessment inform the treatment plan review process? (#49)

- *What facilitates a treatment plan review?(an external funding source (Medicaid, Medicare, etc.), guidelines established by an accreditation body, clinically relevant changes in a client's progress, client request)(#49)*

- *How often are treatment plans reviewed?(#49)*

- *Does the program have a mechanism for a meeting schedule that exceeds regulatory standards? (#49)*

- Does the program have the capacity to make a quantitative determination of client progress? (#49)

- Does the program have a mechanism and procedure in the policy and procedures manual that directs follow up and documentation on findings of "insufficient progress?" (#49)

- What is the mechanism that alerts the program to insufficient progress? (#49)

- How does the program react to becoming aware of insufficient progress? (i.e. additional meetings, meeting with client, documentation, reassessing interventions, restructuring of treatment plan). (#49)

- *Tell me about discharge planning.*(#50) ***(If program does not discharge or does not discharge plan "no," ask any remaining questions and end the interview)***

- *Is discharge expected?*

- *When does discharge planning begin?*

- *Is there written policy outlining the discharge process?*

- *What are the program's criteria for discharge?*

- *Where are clients discharged?*

APPENDIX B

Disclosure to Participate Form

Disclosure for Research Participation

Introduction to the Study:
We are inviting you to participate in a research study that focuses on the continued psychometric development of the Comprehensive Inventory of Mental Health and Recovery and Rehabilitation Services (CIMHRRS), an instrument that assesses programs that provide services to people with serious mental illness (SMI). The CIMHRRS (pronounced "simmers") is used in the programmatic evaluation of individual service providers (programs) by examining structural and organizational components and the processes of assessment and treatment provision to individuals with SMI. This project is funded by the National Institute of Mental Health (Award number: 1F31MH079771-01A2).

Purpose:
The purpose of this project is to evaluate the interrater reliability and feasibility of the CIMHRRS to evaluate programs that provide services to people with serious mental illness. In addition, the fidelity of programs to particular service models will be assessed, to quantitatively and qualitatively characterize programmatic differences in service settings. This project is expected to serve the purposes of both services research (e.g. research on characteristics of effective service programs) and program evaluation (assessing the performance of specific programs in the real world).

Procedures:
As part of the program evaluation, a review of program policy and procedure manuals, internal program documents, progress notes, assessments, and treatment plans will be conducted. Interviews with program staff and administrators will also be conducted.

Interviews with administrators will take approximately an hour whereas staff interviews will take approximately 30 minutes. During the interview, you will be asked to provide information about the program's policies and procedures. You will not be asked to rate the program. The data to be examined will reflect institutional performance not the performance of human subjects (i.e. yourself or others). The data collected will contain no individual subjects or identifying information.

After you complete the interview, we can talk about the questions if you like. At any time during the process you may ask questions or stop participating. This research is not part of your employment, and your employment will not be affected in any way, whether you decide to participate or not. You do not have to do any of the activities, although we think your participation will greatly inform the continued development of the CIMHRRS.

Risks and/or Discomforts:
Although it is helpful to us if you answer all questions, you DO NOT have to answer.
As key informants about the performance of the program, the inherent risk of the project is uncovering sources of information, which might be considered embarrassing to the site management. To reduce this risk, the investigator will take great care in reporting the study's data such that the identities of the informants cannot be easily inferred by those individuals who run the service programs. Should you experience any problems resulting from participation in the study, please contact Robert W. Johnson at (402) 202-8069 or your Human Resources Director.

Benefits:
The proposed project is an extension of the mandates and recommendations for the treatment of people with SMI as outlined in the President's New Freedom Commission on Mental Health

(2003) and the Surgeon General's report on Mental Health (1999). This project corresponds with the mission of the National Institute of Mental Health's (NIMH) Division of Services and Intervention Research (DISR) service research goals that focus on services organization, interventions to improve the qualities of outcome care (including treatment and rehabilitation services), enhancing capacity for conducting services research, and the dissemination and implementation of evidence-based interventions into service settings. Unfortunately, program administrators and regulatory bodies have lacked an instrument to measure the comprehensive integration of these concepts into services settings. The CIMHRRS will provide a format in which those mandates can be systematically measured, subjecting the concepts of recovery and rehabilitation to scientific rigor; providing a useful yet meaningful instrument to compare SMI service programs.

Confidentiality:
We will make every effort to protect your privacy. We will not use your name in any of the information we get from this study. Any information we get from the study will be identified only with a numerical code; any identifying information will be removed or destroyed after the information is collected. In addition, the interviews will be conducted in a private room. All records will be secured in a locked office and seen only by the investigators or their designees during the study and for five years after the study is complete. The information obtained from this study may be shared with program administrators in an aggregated form. In addition, the information obtained in this study may be published in a scientific journal or presented at scientific meetings but the data will be reported as aggregated data and will not include individual names or other identifying information.

Opportunity to Ask Questions:
You may ask questions concerning this research and have those questions answered before agreeing to participate or during the study or you may call the investigators at the number listed below.

Freedom to Withdraw:
You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigators, the University of Nebraska-Lincoln, or your place of employment. Your decision will not result in any loss of benefits to which you are otherwise entitled.

Consent, Right to Receive a Copy:
You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

_____ _____
Signature of Research Participant Date

Name and Phone number of investigator(s):
Robert W. Johnson, Principal Investigator (402) 202-8069
William Spaulding, Secondary Investigator (402) 472-3811

APPENDIX C

Exit Questionnaire

COMPREHENSIVE INVENTORY OF MENTAL HEALTH & RECOVERY AND REHABILITATION SERVICES (CIMHRRS)

~SITE REVIEW EXIT QUESTIONNAIRE~

Please do not identify your organization or put your name on this form.

We are asking program administrators to take a few moments to complete this questionnaire and share experiences of having the CIMHRRS administered at their program. We ask that you fill-out the questionnaire shortly after completion of the actual site visit so that the experience is still fresh in your mind.

Your responses will provide valuable insight into what it is like for a program to be evaluated with the CIMHRRS and have the potential to improve the quality of administration and scoring of the instrument. Your participation is greatly appreciated. A self-addressed envelope has been included.

Prior to the Site Visit:

1. The site visit was well coordinated.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

2. The goal of the research was thoroughly explained.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

3. The evaluation process was clearly explained to the program administrator.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

4. The potential risk involved in participating in the project was explained.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

5. The steps to reduce the risk involved were discussed.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

6. The program was notified the site evaluation would take approximately 6-8 hours.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

7. The program was notified staff would be interviewed.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

8. The program was notified a review of internal documents would be conducted as part of the site evaluation.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

9. The program was notified a review of treatment processes (e.g. assessment, treatment planning, team functioning, etc.) would be conducted as part of the site evaluation.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

10. The program was provided sufficient time to gather demographic and programmatic information prior to the actual site visit.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11. Adequate instruction and support were provided to complete the pre-site handouts.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

12. The CIMHRRS forms were user friendly.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

During the Site Visit:

13. Administration of the CIMHRRS was efficient.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

14. The CIMHRRS staff made effective use of staff members' time.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

15. The CIMHRRS staff attempted to minimize detractions from clinical care (i.e., staff were able to perform clinical duties with little to no impediment).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

16. CIMHRRS staff were professional in their appearance.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

17. CIMHRRS staff were professional in their actions.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

18. The questions asked in the interview sessions appeared sensitive to the type of services your program provides.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

19. The CIMHRRS collected information that is **NOT** typically gathered in "traditional" program evaluations (i.e., clinical outcomes studies).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

20. The CIMHRRS collected information that is **NOT** typically gathered in accreditation reviews (i.e., CARF, JCAHO).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

General Questions:

21. Please describe your general experience with the CIMHRRS evaluation.

22. What were the perceived weaknesses of the CIMHRRS evaluation?

23. What were the perceived strengths of the CIMHRRS evaluation?

24. How might the CIMHRRS more efficiently gain access to the information that informed the evaluation process?

25. How does the utility of the CIMHRRS differ from the utility of other review processes?

26. What additions might compliment the CIMHRRS instrument?

27. Additional Comments:

Thank you for your time and effort!