Emotion Regulation and Impulse Control (ERIC) Evaluation

Background

Difficulties in emotional regulation can be considered a transdiagnostic mental health challenge (i.e., a core challenge across many diagnostic presentations) (Sloan et al., 2017). It is a particular concern for clients living with complex emotional needs (also known as Borderline Personality Disorder)(Trevillion et al., 2022). Therefore, addressing emotional regulation provides effective care for a wide range of clients as well as targeted assistance for clients with complex emotional needs. PARCS/SUSD settings can find these approaches particularly relevant given their client cohort.

Patterns of emotional regulation have been suggested, such as 'ruminators/avoiders', associated with the most severe symptoms of psychological distress, 'active regulators' having relatively high engagement of emotional regulation strategies, and 'low regulators' demonstrating low use of emotional regulation across the board (Sloan et al., 2019).

Emotion Regulation and Impulse Control (ERIC) (Sloan et al., 2018) is an evidence-based approach to enhancing emotional regulation and impulse control, although there is limited research on the ERIC program to date. It has been designed, researched and licensed by Deakin University. It is a modular program which includes a cognitive behavioural with appealing visual materials and worksheets.

Preliminary evidence suggests that the Emotional Regulation and Impulse Control (ERIC) program may be effective in YRR settings (n=10, (Sloan et al., 2018) although this is a single trial with a very small sample size; results are therefore likely to be unreliable. Improvement in emotional regulation was associated with reduced symptoms including depression and anxiety after an ERIC program (Hall et al., 2021; Sloan, Bos, Graeme, & Hall, 2020) but this research did not include control group comparisons. Further trials are clearly warranted.

Preliminary evidence also suggests that ERIC is implementable and acceptable to clients, but a trial at Hunter YRR reported challenges with staff uptake and acceptance (Sloan et al., 2020). The evaluation identified three practitioner approaches to implementing ERIC, the first two being barriers to implementation:

- Staff saw relationship building as key and ERIC and other skill building approaches as outside of their role
- Staff were resistant to a new intervention and thought the complexity and vulnerability of their client was a barrier to implementing ERIC.
- The third group saw ERIC as a useful tool and adopted seamlessly to practice.

Research questions

Given reported challenges with implementation of ERIC at other organisations, the shorter format ERIC being implemented at YPARC, (possibly associated with lower impact), and licensing costs, this evaluation sought to understand the best ways to implement ERIC and to establish the impact of ERIC on client wellbeing and mental health. Therefore, this evaluation took a hybrid effectiveness/Implementation approach with the research questions being:

1. What implementation activities occurred? How effective was our implementation? What were the barriers and enablers of implementing ERIC?

2. Was ERIC effective in helping our clients?

Understanding implementation of ERIC at Mind

Implementation framework

A high level ERIC implementation approach us summarized in Figure 1. This schema created the conceptual framework for the evaluation of implementation. The schema outlines four key phases to implement ERIC with outcomes and indicators for each phase.

The four phases were: Firstly, Preparation phase, with activities such as basic training staff to deliver ERIC as well as "train the trainer" activities so Mind built the capacity to deliver training in ERIC in house. At the end of this phase, a sufficient number of staff should have basic skills and knowledge of ERIC practice. In Phase Two, staff began using ERIC, with support such as "hot house" seminars[1] and Community of Practice[2] discussions. The ERIC developers suggested 6-8 months of fortnightly individual supervision to implement ERIC. The use of Hot House seminars and Community of Practice sessions was a practical solution to providing this supervision more efficiently via groups. The training aimed to build confidence in using ERIC in the field.

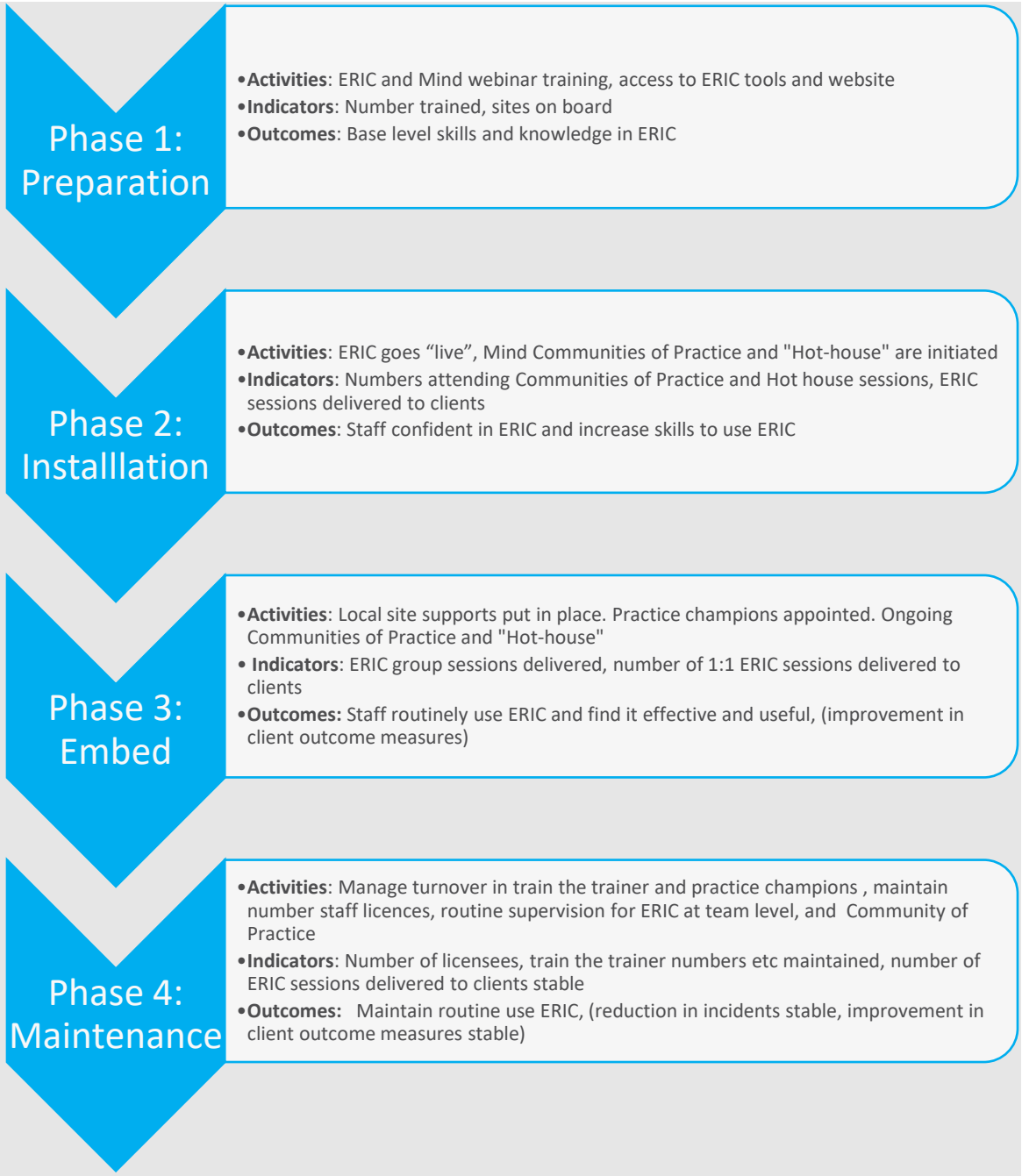
In the third "Embed" phase, the aim was for the practice and use of ERIC to become routine, with measurable outcomes for clients. Enablers and barriers were systematically addressed through appointment of practice champions and site level support is in place.

In the final phase, ERIC practice is maintained, building on the achievements of the previous three phases. Staff turnover can be managed through regular training of new staff and skills maintained and enhanced by systematic supervision. Client benefits continue.

In real life, the phases are not distinct, and there will be cycling between phases to keep momentum and re-activate ERIC if the practice lapses. Preparation started in March and April 2022, and Installation occurred in April and May 2022. The "Embed" phase started in June. The current evaluation report will review these three activity phases and considers if ERIC practice is now in a "maintain" phase.

[1] Learning and development webinars that include opportunities for triad practice (one practitioner plays a client, one a plays a practitioner and a third one observes and gives feedback to the practitioner).
[2] Regular meetings that bring together staff working in similar services to discuss practice challenges, practice wins and other relevant matters.

Figure 1: Implementation schema linked to indicators and outcomes



Preparation phase

- **Activities**: ERIC and Mind initial webinar training and licensing, access to ERIC tools and website
- **Indicators**: Number trained, sites on board
- **Outcomes**: Base level skills and knowledge in ERIC

ERIC was implemented at selected youth program sites at Mind Australia from March 2022. Mind implemented a two week program at YPARCS and a longer program at YRR, both based on the original 12 week ERIC program. The initial sites where ERIC was implemented were:

- Townsville YRR (2 sites)
- Bendigo YPARC
- Apollo YRR and YORS
- Clifton Hill YRR (Sandridge)
- SIL Queensland

ERIC was implemented under licence from Deakin and there is a cost for training staff and licencing and creating “train the trainer” capacity. For the initial implementation of ERIC, 100 licenses were purchased and four staff were trained as ERIC trainers to build and maintain internal capacity.

Deakin University trained 40 staff members and Mind trainers trained 49 staff giving 89 total trained staff. As of October 2022 86 staff retained ERIC licenses. An ERIC license gave access to online ERIC resources. Some staff had trouble accessing the website but Deakin were responsive in resolving these technical problems.

Installation phase

- **Activities**: ERIC goes “live”, Mind Communities of Practice and "Hot-house" are initiated
- **Indicators**: Numbers attending Communities of Practice and Hot house sessions, ERIC sessions delivered to clients
- **Outcomes**: Staff confident in ERIC and increase skills to use ERIC

Hot House sessions

Bookings at Hot House sessions steadily rose, as did attendance.

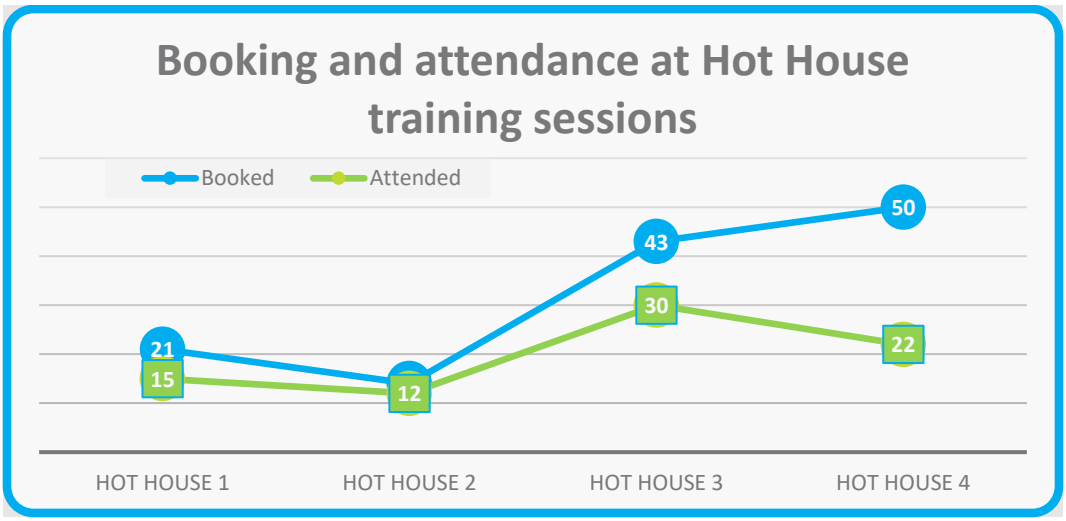


Figure 2: Booking and attendance at Hot House sessions

Attendees at the Hot house sessions were from all service sites except SIL in Queensland and Apollo YRRs (some missing data on where attendees were from).

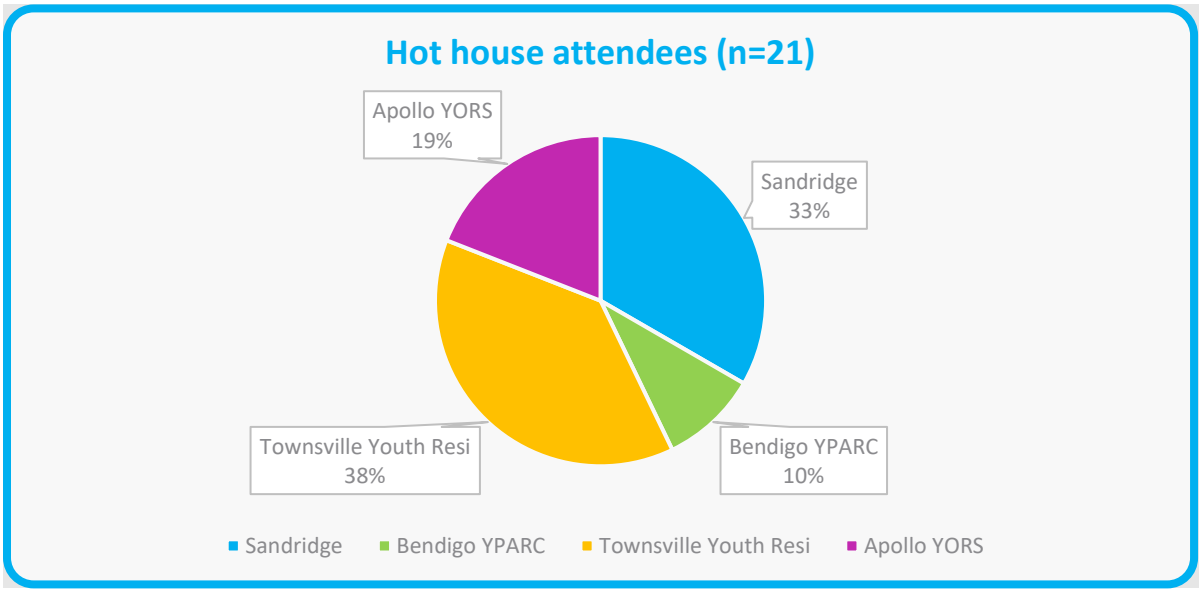


Figure 3: Staff service at Hot House sessions

The impact of the Hot House sessions on staff learning was assessed via an exit survey after each session (see Table 1 below).

The Hot House approach was successful in increasing skills and confidence in using ERIC. Eighty nine percent of attendees felt more confident after Hot Houses and 76% felt the feedback improved their practice. Many rated the skills practice component very positively (100% positive rating in Hot House 4 for instance)(see Figure 3). Attendees also learnt specific applications for ERIC such as using it for MBL goal setting, using it to structure case notes and how Acceptance and Commitment practices could be combined.

Attendees commented that the training made things more simplified and removed the "jargon" that may have been an initial barrier. Some felt the sessions were too long and took them away from duties, but others felt the two hours were a perfect length. Attendees felt the practical activity was useful, and the feedback given was very supportive and useful. Clearly there is a tension between brevity to minimize demands on staff time and providing the required depth of understanding across the ERIC curriculum. Smaller group sessions appeared to allow better time management, share feedback and ask questions with less time pressure.

Table 1: Learning, skills and confidence in ERIC after attending Hot House sessions

	Hot House 1	Hot House 2	Hot House 3	Hot House 4	Average
	Percent who agreed or strongly agreed				
After the Hot House, attendees felt more confident in delivering ERIC worksheets	100%	90%	86%	83%	89%
Feedback in Hot House helped improve practice (% who found it extremely/very helpful)	71%	44%	79%	100%	76%
Increased awareness of using ERIC for MBL	100%	-	-	-	-
Increased awareness of ACT^ supporting ERIC	-	89%	-	-	-
Increased knowledge of writing case notes with ERIC	-	90%	71%	-	-
Increased knowledge of overcoming barriers to using ERIC	75%	-	-	-	-
Supports in place for using ERIC	88%	90%	93%	100%	93%
Supported or encouraged by line manager			83%	92%	88%
ERIC useful in my work	100%	100%	86%	92%	93%
ERIC is effective in my work	88%	90%	71%	92%	84%
Had used ERIC at least once	63%	88%	71%	75%	74%
***Blank cells indicate that question wasn't included in that survey**					
^Acceptance and Commitment Therapy					

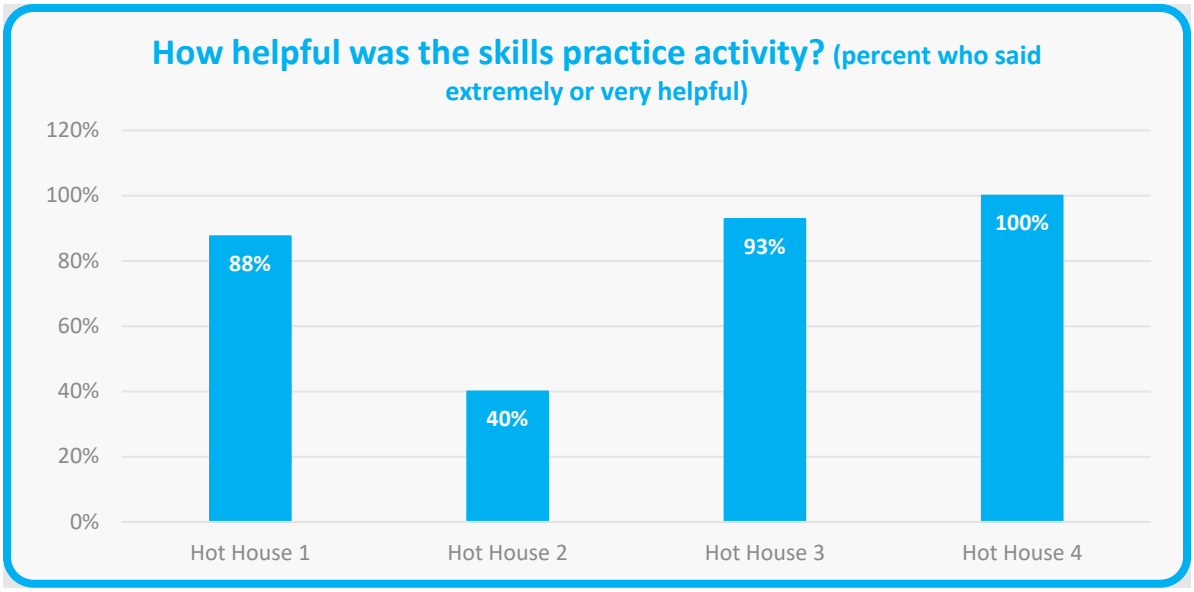


Figure 4: Staff rating the skills practice activity in Hot House sessions

Community of Practice sessions

The attendance pattern for enrolment shows a generally increasing interest peaking in mid August then tailing off. Actual attendance was fairly steady with an average of about 12 attendees, which appeared to be reducing by September. Reasons given for reducing numbers included staff being busy, being time poor, roster gaps, with the feeling there was still interest, but staff were too busy to attend (as reported in an implementation workshop in October). Attendance was also affected by low "buy in" from team leaders and service managers. Buy in was low because team leaders and services managers had not been trained in ERIC due to reluctance to use up licenses.

Community of Practice was perceived as good for sharing expertise across streams as a 'problem solve' in one stream could assist another service. However, sometimes practitioners felt ERIC was used quite differently across services and learnings were not applicable. For instance, adult services didn't run groups so any discussion of ERIC in groups wasn't useful to them.

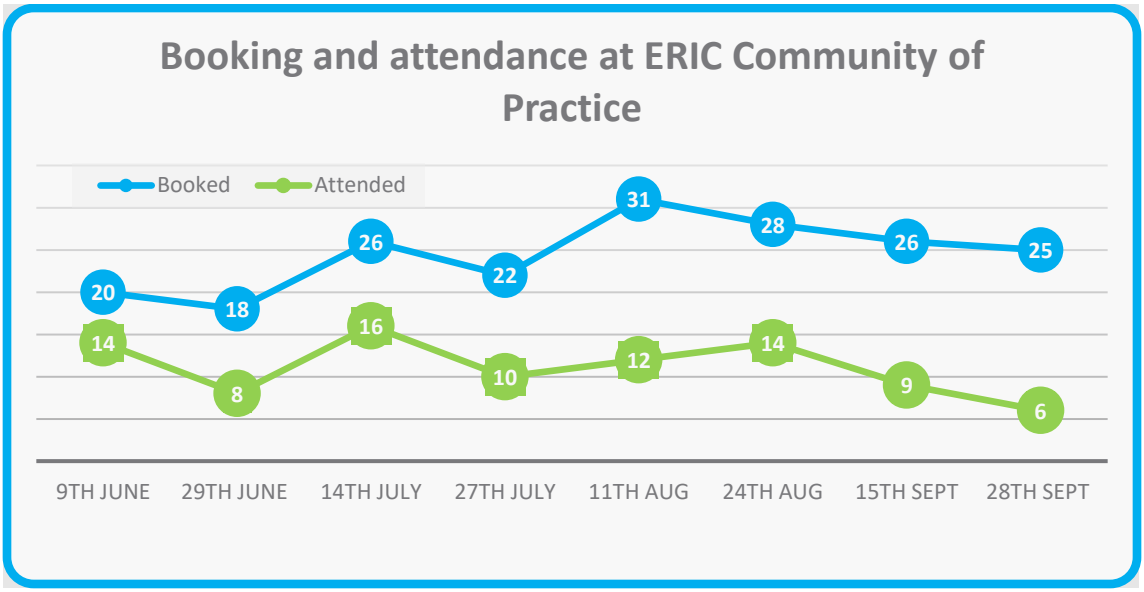


Figure 5: Booking and attendance at Community of Practice sessions

Attendees at Hot House 4 were asked to rate Community of Practice, and 36% found it extremely or very useful and 64% found it somewhat useful.

Embedding phase

- **Activities**: Practice champions appointed, Ongoing Communities of Practice and "Hot-house" per month, local site supports in place
- **Indicators**: ERIC group sessions delivered, number of 1:1 ERIC sessions delivered to clients
- **Outcomes:** Staff routinely use ERIC and find it effective and useful, (improvement in client outcome measures)

Team leaders and managers made local plans to support ERIC practice, making it an agenda item in team meetings, client reviews and in staff supervision.

Data from Hot House exit surveys indicated that staff generally felt that they were supported on site by line managers and had other supports in place. Staff also rated ERIC as effective and useful in their work (see Table 1).

"Clients are generally finding ERIC handouts I've used helpful"

However, the number of staff who attended Hot Houses that had actually used ERIC remained at an average of 74% (see Table 1).

A survey at an August Community of Practice meeting found that only one site (Townsville YRR) was regularly running ERIC group sessions. Sandridge YRR had run one group on mindful breathing. Townsville was also the only site to have used ERIC in one to one sessions with clients regularly. There had been a single session with a client at Sandridge and another single session at Yandina/MHAPD. Some attendees said they intended to use ERIC in "less formal ways".

Although attendees found the training very helpful, many still felt they needed more time to familiarize themselves with the ERIC materials to build confidence.

"[Need] time at work to be able to review the handouts and practice with colleagues"

They also felt they needed local support and problem solving

"[Need] someone just available to discuss creative ideas to put the worksheets into practice".

Getting sheets printed was a challenge for outreach practitioners and sites without a printer:

"with no office space copies of printed worksheets would be helpful"

Another challenge was to feel confident to introduce ERIC to clients:

[Need} Reflection on how to positively invite clients in towards using the ERIC tools

Having examples / role play scripts how how ERIC is introduced to the client may help new staff members be more confident and in time will help staff members create their own script

At an implementation workshop in October a number of enablers, barriers and suggestions were discussed. There appeared to be more use of ERIC by this time.

Attendees at the workshop suggested the following were enablers of ERIC practice:

<u>Local structures to support ERIC practice:</u>

- Including a section on daily notes on ERIC
- Promote a particular ERIC module for a fortnight including have resources for the module provided and discussion at weekly meeting
- One site had an ERIC table that had ERIC resources set up that were easy to access (e.g. the worksheets and other visual material

<u>Enablers related to the "use-ability" of ERIC in practice</u>

- Being able to use ERIC in the moment was encouraging – for instance using work sheets to assist a client "de-escalate" at the moment when the client was "heightened". This could highlight to staff the outcome/benefit at staff level – staff feel confident and have tool to use in difficult moments
- able to tailor it to client/situation - so not just for psychoeducation but for actively supporting a client in resolving a current emotional state.
- appeared to be a succinct tool that didn't need hours of discussion to assist people.

Attendees at the workshop suggested the following were challenges or barriers to ERIC practice:

<u>Staff acceptance and application</u>

- Staff familiarity with ERIC had a variable impact on uptake, one site reported a staff member had done it at University and loved the sheets and the structure – brought familiarity to it and that worked. Another staff member did Acceptance and Commitment Therapy and found an overlap, considered training not so useful in this context so brought familiarity that didn't work in this instance
- Staff still uncertain how to apply in practice – hard to take the leap from training to using in field and identifying key moments to use.

- May be some concerns about using “manualised techniques” which seems to devalue hard won and subtle skills of practice. Could feel prescriptive to experienced staff.
- Some negative feedback from specific professional groups that they didn’t find it useful

Practical barriers

- Staff need permission to resolve practical issues e.g. tech issues like can’t open web site, print worksheets
- Only staff who had licenses/been trained in ERIC were able to access the resources, resulting in a) resources being unable to be saved in a central electronic space for team members b) if new staff who have not been trained in ERIC onboard, they will not be able to use the interventions that their colleagues are completing with clients
- Staff turnover had occurred so need to retrain staff, had lost one “train the trainer” in Qld already. Staff turnover also meant that staff were “thrown in” to Hot Houses and Community of Practice without the introductory training.
- Team leaders not being trained meant they couldn’t fully support the implementation (they worried about taking up a license that someone else could have)

This suggests that in spite of extensive training that was well regarded by attendees, there still remains a gap between staff knowledge and skills leading to actual staff behavior change. Clearly some practical issues could be resolved relatively easily. It is realistic to expect embedding for ERIC is still ongoing, and the team was perhaps over-optimistic to expect to “take the foot off the pedal” at this stage and move into “maintenance”. It is notable at this stage that the intervention seems very usable and practical to staff.

Maintenance phase

- **Activities**: Manage turnover in train the trainer and practice champions , maintain number staff licences, routine supervision for ERIC at team level, and Community of Practice
- **Indicators**: Number of licensees, train the trainer numbers etc maintained, number of ERIC sessions delivered to clients stable
- **Outcomes:** Maintain routine use ERIC, (reduction in incidents stable, improvement in client outcome measures stable)

Findings of this evaluation will be used to determine if Mind will continue with ERIC and then move to a maintenance phase. The foregoing suggests that ERIC needs further embedding before a maintenance phase could be introduced.

Was ERIC effective in helping our clients?

Data analysis of client impacts will be completed in December 2022. However, given the low intensity of ERIC sessions delivered, the client impacts could be minimal at this stage. We want to understand more about the consumer experience of ERIC and will conduct a focus group with clients at services where ERIC has been used most intensively.

Discussion and recommendations

Preparation and installation were successfully delivered as planned, requiring substantive skilled work, effort, thinking and strategizing. Over 80 licenses were taken up in a short period of time and Hot House training provided a large number of practitioners with follow-up skills enhancement. Community of Practice also created a forum for discussion of practice challenges and sharing solutions.
Embed processes are still underway, as would be expected. Sites are gradually integrating ERIC into daily practice and supervision. Until ERIC is more thoroughly embedded then introducing a maintenance phase is unlikely to sustain the practice in the long term. It seems adaptations and local level efforts will support further "embedding" and enable the translation of skill and knowledge into practice change.

Where one or two services edge towards maintenance phase, many others remain clearly in embedding phase with staff still developing confidence and capacity to introduce ERIC into their practice. For those services who edge towards maintenance, having Team Leaders remaining untrained acts as clear challenge to embedding into service BAU.
Additionally, issues with licensing limitations act as clear barrier to services embedding ERIC as new onboarding staff will not have access to ERIC resources and will not be able to participate in ERIC conversations in team or with clients

The sites that have progressed the most with adopting ERIC appear to be sites with a stable well trained workforce who have been able to build skills in ERIC consistently, have Team Leaders and Service Managers who have championed ERIC in their service, provided resources (such as an ERIC table for printouts and materials) and regularly included ERIC in staff discussions.

One significant enabler of implementation are the characteristics of the innovation itself – does the new practice solve a problem for the user and make work easier (e.g. like moving from fax to email)? Staff have described ERIC as a "succinct tool" which supports the client to do the work, the sheets are already available, it's effective and "time efficient". On this criterion then ERIC should be fairly "implementable".

Another outcome that was observed was the enhanced confidence for staff, who feel better informed about managing emotions with/for clients. For some staff (e.g. new staff) ERIC was structuring and helpful. This combines with the benefit from the client point of view as ERIC provides a concise support that assists clients feeling calmer and more in control. This suggests that a key message going forward is that ERIC is useful tool from both the client as well as all staff point of view.

Recommendations and next actions

Continue with:

- Regular training, Hot House training sessions and Community of Practice to continue as they were seen as making a significant impact on staff skills, knowledge and confidence with ERIC. Recommend six ERIC training plus six hothouses per year with training embedded into Mind BAU for staff to sign up to through usual processes.
- Monitoring implementation through regular review of indicators such as surveying sites for ERIC activities, reviewing outcomes, and further exit surveys of Hot House and Community of Practice.
- Maintain an ERIC leadership group to support implementation and monitoring.

Resolve practical barriers

- Meet with Deakin to look at ways to increase the ease of use of ERIC resources and discuss our findings over the feasibility of supervision requirements.
- Provide the timetable for regular training for the full year ahead, so staff can be rostered accordingly.
- Determine optimum length for Hot House training sessions and Community of Practice
- Determine how much on going training is needed for staff with established ERIC skills
- Develop a checklist to support sites with the practical side of implementation (I.e 1. Train all new staff, 2. Determine how printing will be managed 3. Set up staff meeting agenda items etc}

Improve local level enablers

- Local managers need to be involved in training as a necessity - all Service Managers and Team Leaders should be trained so they can effectively lead activities on site to embed ERIC
- ERIC training for Service Managers and Team Leaders to include skills for encouraging staff to use ERIC more often
- Staff turnover is inevitable so clear plans to manage staff turnover should be made.
    - Train the trainer capacity should stay within Learning & Development to ensure capacity to train new staff remains available in-house.
    - New Service Managers and Team Leaders should do ERIC training as part of their early orientation to their job
    - ERIC training is mandatory for all new Youth staff
    - Resources allocated for Learning & Development to deliver all the training sessions for staff throughout the year
- Consider consistent promotion to staff about ERIC – e.g. promote the client point of view- it supports the client to do the work, the sheets are already available, its effective and "time efficient", consider messages for staff who "don't need it"
- ERIC as ongoing agenda item in Youth Stream Service Manager meeting
- Consider development of group structure support in CoP and Hothouses

Appendix 1: Annotated bibliography

Sloan, E., K. Hall, R. Moulding, S. Bryce, H. Mildred and P. K. Staiger (2017). "Emotion regulation as a transdiagnostic treatment construct across anxiety, depression, substance, eating and borderline personality disorders: A systematic review." Clinical psychology review 57: 141-163.

Summary: This paper is a SR of emotion regulation (ER)(67 papers) and its links to a variety of mental health diagnoses. Authors found that a range of IVs could reduce ER in a range of mental illness (depression, anxiety, substance use, eating disorders, and Borderline Personality Disorder). Parallel to the improvement in ER was reduction in symptoms for the diagnosed mental illness (association, not causal). This suggests that ER is a transdiagnostic construct, that is, it is a challenge that is present across a range of mental health concerns.

Unhelpful strategies for ER include rumination, suppression and avoidance

Sloan, E., K. Hall, A. Simpson, G. J. Youssef, R. Moulding, H. Mildred and P. K. Staiger (2018). "An emotion regulation treatment for young people with complex substance use and mental health issues: A case-series analysis." Cognitive and Behavioral Practice 25(3): 427-441.

Trial of ERIC for N=10 in a Youth Residential Rehabilitation(YRR) setting, 16-20 year old. Complex AOD and mental health issues for client group. 4-6 sessions.

Qual feedback at end suggested suitable, useful and viable intervention according to participants and the metaphors and experiential exercises meaningful and memorable. Clinically meaningful reduction depression and anxiety, and Emotional dysregulation.

Hall, K., G. Youssef, A. Simpson, E. Sloan, L. Graeme, N. Perry, R. Moulding, A. L. Baker, A. K. Beck and P. K. Staiger (2021). "An Emotion Regulation and Impulse Control (ERIC) Intervention for Vulnerable Young People: A Multi-Sectoral Pilot Study." Frontiers in psychology 12: 1011.

N=79, 12 week ERIC program. By 21 practitioners from youth and community health services plus TAU. 20% Aboriginal and Torres Strait Islander.

Reduction of Emotional Dysregulation (moderate effect size), plus depression, anxiety, stress and experiential avoidance. No reduction in mindfulness. Time sequence patterns showed that greater improvement in ED matched greater improvement in symptoms, and conversely, increase in ED associated with increased symptoms. However, require more study to show that ER is the key mediator and mechanism of change.

Sloan, E., K. Hall, G. J. Youssef, R. Moulding, H. Mildred and P. K. Staiger (2019). "Profiles of emotion regulation in young people accessing youth mental health and drug treatment." Cognitive Therapy and Research 43(4): 769-780.

N=306, young people using youth advocacy and support or mental health services in Australia. Study involved recalling and emotional arousing event and score of 14 different types of ER responses, as well as MH symptoms and AOD use.

3 groups emerged: Ruminators/Avoiders (higher use of rumination, avoidance and suppression, and low use of ER) most severe symptoms, not AOD) Active regulators (relatively high engagement of ER strategies) and low regulators (low use of all ER strategies, lowest severity of symptoms) (very approx. 1/3 each, low regs predominate).

Sloan, E., R. Moulding, C. Weiner, R. M. Dowling and K. Hall (2020). "A qualitative examination of the relationship between rumination, distress, and dysregulated behaviours in vulnerable young people." Psychology and Psychotherapy: Theory, Research and Practice.

N=12, young people. Examine links between rumination, distress and "dysregulated behaviours" (substance misuse, deliberate self-harm, binge eating and purging. Qual interviews and thematic analysis.

Sequence identified:

- Trigger (stressful situation or other difficult emotion arising)
- Rumination – continuous intrusive negative thoughts, often progressing to global negative self-judgements and overgeneralisations
- Experience of intensive negative emotions
- Behaviour – ineffective attempts at regulating rumination/distress (some relief, but not sufficient)
- Unhelpful behaviour (substance use, self harm etc)
- Some of the unhelpful behaviour offering sufficient distress relief for a number of hours)
- Long term lowered mood and return to rumination

Sloan, E., J. Bos, L. Graeme and K. Hall (2020). ERIC (Emotion Regulation and Impulse Control): A sustainable program for Vulnerable young people with AOD and Mental health issues., Deakin University, The University of Newcastle Hunter and New England Local Health District.

N=57, vulnerable young people with AoD in Hunter. Implementation barriers so that ERIC delivered in low 'dose'. Mild improvement in social engagement and well being. No change in school or vocational engagement. Mild improvement in ER, reduction symptoms and reduction in AOD use (small).

Implementation challenges: Practitioners had 3 approaches to implementing ERIC .1. Saw relationship building as key and ERIC and other skill building approaches as outside of their role, 2 Adopt seamlessly to practice 3. Resistance to new intervention and thought complexity and vulnerability of their client as barrier to implement ERIC.

Appendix 2: Research objectives

Objectives for the evaluation

Implementation:

- What were our implementation activities?
- What supervision and training was provided?
- How many staff were trained?
- Were staff satisfied with the training, supervision and support?
- How effective were the implementation actions in increasing staff skills and confidence with ERIC?
- What were the enablers and barriers to implementation and what were the most effective implementation strategies?
- How did the staff rate the usefulness, relevance and effectiveness of ERIC in practice?
- How many ERIC sessions were delivered?
- How many clients participated in ERIC groups?

Effectiveness:

- Was the ERIC program effective in improving mental health for Mind clients over and above treatment as usual (TAU)?
- Were other outcomes achieved (such as reduction in incidents)?
- Were there outcomes for staff (such as increased confidence for instance) or other levels?
- How did outcomes for the 2 week YPARC program compare to the YRR ERIC format?

Results will be used to:

- Provide evidence to inform decision-making about broad implementation of ERIC.
- Provide evidence of impact for monitoring, practice improvement, staff feedback, practice insight and innovation
- If the ERIC intervention is effective, provide evidence for funders and potential funders of positive impact to promote ERIC in tenders.
- If the ERIC intervention is effective, provide evidence for marketing to potential clients.
- Contribute to literature in youth mental health, particularly in relation to brief interventions and transdiagnostic approaches.

Appendix 3: Methodology

Measuring Indicators

Project leaders, project coordinators, service managers and team leaders at implementation sites collected a range of indicators each month to forward to the evaluation team, set out in **Table 1: Indicators** below Indicators focus on "quantity" measures regarding how much activity occurred in that phase (e.g. numbers of staff trained, number of clients supported using ERIC).

Table 2: Indicators

Implementation phase	Activity measure	Informant	Details	How collected
Preparation	Number trained	Project coordinators/Learning and development	Numbers who complete ERIC led training per month Numbers who complete supplementary Mind training per month	Data noted at training sessions and reported and collated at project meetings
Preparation	Sites on board	Project coordinators		Reported and collated at project meetings
Installation and Embed	Number of Community of Practice and Hot house sessions	Project coordinators/Learning and development	Per month	Data noted at training sessions and reported and collated at project meetings
Installation and Embed	Number of staff attending Community of Practice and Hot house sessions	Project coordinators/Learning and development	Per month	Data noted at training sessions and reported and collated at project meetings
Installation and Embed	Number of ERIC group sessions delivered	Service managers/team leaders at implementation sites	Can monitor site level implementation	Sessions monitored on site and collated at project meetings
Installation and Embed	Client attendee numbers	Service managers/team leaders at implementation sites	Can monitor site level implementation	Sessions monitored on site and collated at project meetings

Installation and Embed	number of 1:1 ERIC sessions delivered to clients		Can monitor site level implementation This is a challenging indicator as sessions may occur in ad hoc manner. Would require a lot of documentation effort	Sessions monitored on site and collated at project meetings
Maintenance	Number of licenses	Project coordinators/Learning and development	Net number (numbers trained less numbers resigning/redeployed)	Monitored by Project coordinators/Learning and development and reported and collated at project meetings
Maintenance	Train the trainer numbers	Project coordinators/Learning and development	Net number (numbers trained less numbers resigning/redeployed)	Monitored by Project coordinators/Learning and development and reported and collated at project meetings

Measuring Implementation outcomes for staff

The impact and effectiveness of implementation will be measured by staff outcomes such as an increase in staff knowledge and changes in confidence. This will be examined via a brief staff survey at exit from Hot House sessions. All staff who have received training will be surveyed. The survey will be forwarded to staff at the conclusion of training and twice more at three months[3] intervals (i.e. 3 times over 6 months) while ERIC is initially implemented. At the end of 6 months decisions about further ERIC implementation will occur. If further surveys are required it can be determined at this six month time point.

The survey will be anonymous and staff will be encouraged to participate in the survey. The in-house survey will be completed via Microsoft Forms/Lime survey. The staff survey can be supplemented by manager interviews if resources allow, and if the extra data would be useful. Outcome questions will be interspersed with questions about the types of ERIC training and supervision the staff member completed. See **Table 2: Staff questionnaire** below.

Table 3: Staff questionnaire

[3] Or every 6 months and only do 2 surveys?

Domain	Question	Implementation phase where this outcome is relevant*
Practice maturity	Have you attended to ERIC training with the ERIC trainers? Yes/No If yes, how many months ago?	Preparation
Practice maturity	Have you attended the Mind training webinar about ERIC? Yes/No If yes, how many months ago?	Preparation
Barriers and Enablers	What did you think of the training? [open response]	Preparation
Barriers and Enablers	How can it be done better? [open response]	Preparation
Practice maturity	How many ERIC community of practice sessions have you attended? [0, 1 2 3 4,5]	Installation
Practice maturity	How many ERIC "hot house" sessions have you attended over the past 6 months? [0, 1 2 3 4,5]	Installation
Barriers and Enablers	What did you think of the ERIC supervision? [open response]	Installation
Barriers and Enablers	How can it be done better? [open response]	Installation
Knowledge	I understand the ERIC program *	Preparation
Skills	I know how to use ERIC in my practice*	Preparation
Confidence	I feel confident using ERIC with my clients*	Installation
Support	I feel supported and encouraged to use ERIC*	Installation
Barriers	I find it challenging to use ERIC in my work*	Installation and Embed
Enablers	There are practical things in place to support using ERIC (e.g. printed practice sheets available, access to the website, supervision)*	Installation and Embed
Barriers and Enablers	Can you tell us about which supports you find most helpful? [open response] Can you tell us more about the challenges? [open response]	Installation and Embed
Relevant	I find ERIC a really *useful* approach in my work (e.g. it meets the needs of my clients, it sits well with other activities)*	Embed
Positive impact	I find ERIC a really *effective* approach in my work*	Embed
Skills	I have used ERIC in one-to –one sessions with _____clients in the past month	Embed
	Are there any final comments you would like to share with us? [open response]	
	What site do you work at [drop down options]? (Your responses will be aggregated when reported)	
***RESPONSE SET: Strongly disagree, Disagree, Neither agree or disagree, Agree, Strongly Agree**		* Positive response in all domains to support maintenance

References

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Sloan, E., Hall, K., Moulding, R., Bryce, S., Mildred, H., & Staiger, P. K. (2017). Emotion regulation as a transdiagnostic treatment construct across anxiety, depression, substance, eating and borderline personality disorders: A systematic review. *Clinical Psychology Review, 57*, 141-163.

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PDFS of all papers are available for review if interested.