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# *Stakeholder Perspectives on Mental Health Performance Indicators*

*Working Papers Prepared for the MHSIP Phase II Task Force on the Design of the Mental Health Component of a Healthcare Report Card*

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## *Section I*

## *A Compilation of the Literature on what Consumers Want from Mental Health Services*

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## *Section II*

## *Performance Indicators for a Consumer-Oriented Mental Health Report Card: Literature Review & Analysis*

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**A Brief Historical Note on System Reform**

> In July, 1788, the embattled King of France commissioned a nationwide research project to discover records and documents bearing on reform of the political system. This call for documents lent legitimacy to a voluminous body of political literature far in excess of the research project originally requested by the King (Shapiro and Markoff, 1994). The "Cahiers de Doleance" of 1789 are a compilation of public desires for political change. They address a central concern that is as pertinent to the current reforms in mental health services as it was to the more general political debate preceding the French Revolution. What do people want from a system of public services?

## INTRODUCTION

This report was prepared to facilitate the work of the Phase II Task Force on the National Consumers' Mental Health Report Card. This report summarizes written documents that express concerns of consumer groups regarding assessing mental health services they receive. The particular focus of this review is on what consumers want from their mental health services. The review is restricted solely to the consumer point of view. The ultimate goal of the Task Force is to select and/or construct a set of performance indicators that express what consumers want from mental health services. This work is one component of a larger literature review on performance indicators. At the time of this writing, we are unaware of any compilation of consumer-generated documents on performance indicators. Consequently, this is an initial attempt to inform members of the Phase II Task Force about existing sets of statements of consumers' concerns. Only after some form of prioritization involving a broad, representative group of consumers occurs, should work proceed to operationalize these selected concerns into quantifiable performance indicators to be used in a National Consumer Mental Health Services Report Card.

Readers are referred to the Phase I Task Force Report, issued in June of 1994 for a full discussion of the background work of the Phase I Task Force. In its suggestions to the Phase II Task Force, the MHSIP Advisory Group offered the following guidance:

1. Domains of indicators from Phase I should be used as a guide, rather than a constraint, in constructing the Report Card.
2. Phase II work should address the needs of State Mental Health Authorities (SMHA's).
3. Selection of indicators need not to be constrained by immediate concerns over reliability and validity in the initial construction process.

With these suggestions in mind, the Phase II Task Force commissioned a selective review of the literature relevant to mental health services' performance indicators. The present document summarizes work completed on one component of the relevant literature—documented, empirical studies involving consumers' (persons with serious and persistent mental illness) expressions of what they want from their MH services.

## WHAT IS INCLUDED IN THIS LITERATURE REVIEW

Much of the material relevant to this review has emanated from small group discussions among consumers regarding their desires and preferences. Some of these discussions result in written reports that vary in detail and level of analysis. Few of these reports have been published in the professional literature. Most exist as reports prepared for the agency asking for and/or funding the work. These local expressions of concern are one good source of information regarding what mental health consumers want from mental health services.

This review represents a first attempt to assemble some broad set of these documents and to catalog the concerns. It is not based on an exhaustive or systematic search. Rather, we relied on

channels known to us and other members of the task force to "get the word out" about what we were looking for and where contributions could be sent.

**How Documents Were Obtained:** We contacted consumer groups, state Offices of Consumer Affairs, and other sources nationally whom we knew to be aware of reports and other relevant documents. We also examined consumer newsletters as possible sources. A request for submissions was posted on several national computer bulletin boards: 1) one operated by consumers, 2) the Policy Resource Center's PIE ONLINE network, and 3) Internet Listservers related to MH program evaluation. We also directly contacted several groups representing consumers and staff in mental health research, policy, and service-provision positions. Consumer groups unaffiliated with state or local mental health agencies, and those not producing newsletters having national circulation are not represented in this review. We make no claims for representativeness of this literature. Our purpose is exploratory, and the generalizations offered from this analysis should be examined with all due consideration of the scope and limitations of this enterprise.

A list of individuals and groups contacted to obtained documents is provided following the reference section of this document. We are indebted to those persons who took the time to assist us.

**Other Sources:** We were also aware of efforts involving other methods that could yield useful information about consumer outcome concerns. These included results of some surveys that have been published in the literature. In addition, we knew of works in progress asking consumers to prioritize what was important to them. Finally, we included the two existing reports on concept mapping of consumer preferences.

**CRITERIA FOR SELECTION DOCUMENTS FOR REVIEW**

We collected a set of 40 documents. Sources are listed at the end of this report. Some referenced sources contributed multiple documents which are identified only once in the *Reference* section.)

The following criteria were used to select documents for detailed review.

1. The document reflected an organized attempt to get at consumer preferences for what they want from the MH system.
2. The number of consumers involved was greater than one (e.g., personal accounts and one-person testimonies were not included in this review).
3. The document listed specific concerns about what consumers want (e.g., symptom relief, social support, choice of service, rights to refuse treatment, information about drugs, etc.).
4. The document reported on empirical data—qualitative and quantitative—and provided information about the sample size, method, probes used to define tasks or generate discussion, sponsoring agency, and other descriptive information.

Of the 40 documents obtained, only a small number met these criteria and were abstracted in detail. This small set resulted from a conscious winnowing of the harvest of documents. We excluded consumer evaluations of specific programs. Needs-assessment surveys regarding particular types of service consumers and others (family members, providers and administrators) believed were needed were also excluded due to their idiosyncratic and provincial nature.

We included brief annotations of documents that were not submitted to full analysis because they fell outside our criteria. These documents are included in order to call attention to their existence and potential significance for readers whose interests are broader than our self-imposed criteria for detailed abstraction.

**ORGANIZATION FOR ABSTRACTIONS AND ANNOTATIONS**

For each project that met criteria for inclusion, we present the following information:

**Source**: - information about the author(s). The complete citation is provided in the "reference section".

**Sponsor**: - a description of the auspices and/or resources used to enable the project.

**Sample Size**: - the number of consumers involved in the study. Some studies/projects involved multiple sample groups and when possible, we abstracted each "subgroup" as a separate study.

**Sample Description**: - information about demographic and clinical status characteristics for the persons involved in the study.

**Method** - a brief description of the procedures used in the study. Three general methods were encountered. The majority of the projects involved focus groups. These involve convening groups of consumers, providing a probe or series of probe questions, and recording consumer responses. A second method involves surveys wherein consumers were asked to respond in writing to questions about what they wanted. The third method presents consumers with a priori closed-end lists of concerns and requests they indicate their relative preference for each concern. Many of the latter types of studies also request consumers to group items according to their similarity (concept mapping procedures) or importance. These groupings are then submitted to statistical clustering or factor analytic procedures in an attempt to establish a structure (label) for groups of concerns.

**Probe**: - the stimulus or request defining the task consumers were requested to complete.

## FULL ABSTRACTIONS

**Source**: Coursey, R.D., Farrell, & Zahniser (1991)
**Sponsor**: University based researchers with input from consumers on survey design and analysis
**Sample size**: 204 consumers
**Sample Description**: Adults with severe and persistent mental illness; East Coast of U.S. including mix of urban, suburban and rural areas; 14% black, 84% white, 2% other; 46% female; mean age = 37.4; 94% of respondents were clients receiving mental health services. Surveys were administered in four rehabilitation centers (N=77), two self-help groups (N=20), two consumer advocacy groups (N=62), and a mental health center, or a day treatment program, or a medication center (combined N = 45). No description provided for sampling methodology - probably a convenience sample. Other demographics: 56% not working; 72% on SSI; 82% receiving treatment for at least three years; 92% taking medication with 40% indicating trouble side-effects; 43% had or were living in supervised housing; 79% were satisfied with current living arrangements; 54% had been involuntarily committed with 58% of these feeling the commitment was justified.
**Method**: Forced-choice scaled-response (some checklist) items on a written survey constructed by authors (with input from consumers regarding readability and format as opposed to content) to explore "how consumers felt about their lives within the context of their illness, the consequences of the illness and the services that they received". Consumers were involved in distributing and administering an unspecified percentage of the surveys. Fifteen consumers involved in a test-retest (2 week interval) reliability estimate that showed 82% of the time consumers provided the same answers. The average amount of missing data (blank answers) for the entire sample was less than 1%. The data presented below are from one checklist item on a 41+ item questionnaire.
**Probe**: Which of the following topics do you want help with (check all that apply)?

| Concern | Percent Positive Response | Authors' Label |
|---|---|---|
| 1. Gaining self-confidence | 65 | |
| 2. Living a more normal life | 61 | |
| 3. Obtaining a job | 61 | |
| 4. Lessening anxiety | 58 | |
| 5. Cultivating friendships | 56 | |
| 6. Controlling weight | 48 | |
| 7. Controlling symptoms of illness (voices, moods) | 46 | |
| 8. Finding a companion of the opposite sex | 46 | |
| 9. Participating in recreation and sports | 42 | |
| 10. Going back to school | 39 | |
| 11. Living independently of supervised housing | 38 | |
| 12. Controlling smoking | 30 | |
| 13. Owning a pet | 19 | |
| 14. Living independent of family | 18 | |
| 15. Controlling drugs and/or alcohol use | 11 | |

**Source**: Coursey, R.D., Farrell, & Zahniser (1991) continued
**Probe**: Assorted additional items (mostly Likert-type ratings)

| Concern | Percent Positive Response | Authors' Label |
|---|---|---|
| 1. Fear that either doctors and MH professionals or family members would place them back in the hospital | 31 | |
| 2. People overreacting to their mental illness and were too quick to place them in a hospital | 48 | |
| 3. MH workers have too much power over consumers' lives | 46 | |
| 4. Parents have too much power over consumers' lives | 24 | |
| 5. People don't listen to consumers or treat them with respect once they know the consumer has been seen by a psychiatrist or been in a hospital | 61 | |
| 6. Not treated fairly by MH staff | 28 | |
| 7. Were angry about their mental illness | 53 | |

**Source:** Dumont, J. & Campbell, J. (1994) - (Lake Lanier, GA.) - Draft as of 2/20/94
**Sponsor**: Center for Mental Health Services
**Sample size:** 16
**Sample Description:** Adult MH service consumer/survivor leaders and advocates - nearly all involved in self-help/advocacy movements. Some are administrators of recipient affairs. Five persons serve on boards/committees of MH agencies. Few are actual public MH agency clients.
**Demographics:** 25% black, 75% white; 56% female; median age = 45; 5 have advanced degrees, 3 have B.A.'s, 4 have some college and the remaining 4 are high school graduates; most currently employed; income range of $6,000 to $50,000.
**Method:** A consumer/survivor led a structured group process. Participants brainstormed a list of 81 concerns. Participants were then asked to sort these concerns into between two and 80 piles with no pile for miscellaneous permitted. Participants were encouraged to have 10-25 piles. Additionally, as a separate, second task, participants were given a list of the concerns and asked to rate the importance of each relative to the other concerns using a 5 point Likert-type scale (1 = relatively unimportant, 2 = somewhat important, 3 = moderately important, 4 -= very important, and 5- extremely important). Trochim's concept mapping software was then used to generate clusters and concept maps which were then used to generate cluster labels.

The data presented below include only those concerns that received an mean importance rating equal to or greater than the median (= 3.50) calculated for the total set of items. The range of mean ratings for the total set was 2.56 - 4.63. The item numbers shown in the first column of the table correspond to the item numbering scheme used in the original study to enable the exploration of items which are not presented here. The mean item importance rating is shown in the second column. The labels shown in the third column are the cluster (concept) names for the corresponding item.
**Probe:** "Generate statements that describe specific consumer/survivor-defined individual and/or system-outcome indicators or measures that should be part of mental health system measurement".

| | Concern | Mean Importance Rating | Authors' Label |
|---|---|---|---|
| 49. | Move from patienthood to personhood | 4.63 | Person Defined Paths to Healing |
| 33. | Effects of force as a studied variable in all mental health research | 4.19 | Force Invol. Intrusive "Treatment" |
| 18. | Recognizing and utilizing natural healing processes of people | 4.13 | Person Defined Paths to Healing |
| 32. | Reclaiming of identity | 4.13 | Person Defined Paths to Healing |
| 15. | Opportunity to define one's own role in the system | 4.06 | Consumer Powerl essness & Sys. Oppression |
| 63. | Relationship between mental health system & perpetuation of shame, stigma & separateness | 4.06 | System's Role in Perpetuation Oppression |
| 68. | How well the system reflects values of: mutuality, respect, holism, acceptance inclusion,... | 4.06 | Values & Quality |
| 40. | Education of consumers about their healing | 4.00 | Person Defined Paths to Healing |
| 46. | Evaluate DSM from the point of view of people who receive the diagnosis | 4.00 | Person Defined Paths to Healing |

| | | | |
|---|---|---|---|
| 57. | Negative and positive effects of going off medication | 4.00 | Damaging Effects of Medicat. & ECT |
| 67. | Impact of involuntary treatment procedures on subsequent therapeutic & family relationships | 4.00 | Force: Invol. Intrusive "Treatment" |
| 73. | Impact of consumer/provider involvement in public policy making activities | 4.00 | Consum. Impact on Policy Making |
| 48. | Relationship between family history of abuse & subsequent diagnosis & treatment | 3.88 | Negative Effects of Labeling, Dx., & Tx. |
| 66. | Pathways of and barriers to accessibility of self help for people on hospital wards | 3.88 | Consumer Powerl essness & Sys. Oppression |
| 1. | Measure the barriers imposed by racism | 3.81 | Barriers due to Racism & Oth. Prejudices |
| 29. | Effect of language and labeling on consumers in hospital wards | 3.81 | Negative Effects of Labeling, Dx. & Tx. |
| 45. | Knowledge of state & local level decision makers about reality of consumers/survivors | 3.81 | Consum. Impact on Policy Making |
| 4. | Staff's cultural competence | 3.75 | Barriers due to Racism & Oth. Prejudices |
| 35. | Contrast differences in quality of life/recovery issues for people who identify themselves as consumers v. survivors v. those who don't identify with either | 3.75 | Consumer Control led Self Help Alternat. |
| 65. | Accessibility & availability of alternative/practitioners & setting to consumers in crisis | 3.75 | Consumer Control led Self Help Alternat. |
| 13. | Effect of negative terminology, e.g., slow functioning, on recovery | 3.69 | Negative Effects of Labeling, Dx., & Tx. |
| 14. | What is the availability and accessibility of legal representation | 3.69 | Legal Issues |
| 19. | Degree of client agency/active control of their situation | 3.69 | Consumer Control led Self Help Alternat. |
| 25. | Number of quality employment opportunities for individual talents | 3.69 | Models of Employment |
| 34. | Dollars spent on MH programs with outcomes achieved (by consumers) if any | 3.69 | System as Parent |
| 38. | Number of educational opportunities give to consumers regarding medication & life style change | 3.69 | System as Parent |
| 50. | Model held by practitioners of a mentally healthy person, how they think you get there & how they convey this to their clients | 3.69 | Values & Quality |
| 51. | Degree of assertiveness consumers feel they have with caregivers in the MH system | 3.69 | Person Defined Paths to Healing |

| | | | |
|---|---|---|---|
| 55. | Differential effects of people with daily structure imposed by MH program vs. people who self generate meaningful activities | 3.69 | Person Defined Paths to Healing |
| 61. | Difference in self defined outcomes for voluntary v. involuntary patients | 3.69 | Values & Quality |
| 30. | Amount and negative effects of ECT | 3.63 | Damaging Effects of Medicat. & ECT |
| 39. | Educate consumers about their healing | 3.63 | Person Defined Paths to Healing |
| 60. | Validity of psychiatric diagnoses by periodic blind reevaluation & comparison | 3.63 | Negative Effects of Labeling, Dx., & Tx. |
| 74. | Effects of unfree access to information, e.g., no patient access to own records | 3.63 | System as Parent |
| 76. | Outcome of commitment law | 3.60 | Legal Issues |
| 72. | Effects of a focus by providers, family members & others on possibilities v. disabilities | 3.57 | Consumer Powerl essness & Sys. Oppression |
| 5. | Number of black males diagnosed with paranoid schizophrenia and other | 3.50 | Stereotyped Dx. Due to Racism & Oth. Prejudices |
| 9. | Number of people misdiagnosed | 3.50 | Negative Effects of Labeling, Dx., & Tx. |
| 16. | Different outcomes of people treated and not treated with psychiatric drugs | 3.50 | Force: Invol. Intrusive "Treatment" |
| 36. | How to measure the condition of forced versus voluntary treatment | 3.50 | Force: Invol. Intrusive "Treatment" |
| 56. | Effects of medication causing seizures | 3.50 | Damaging Effects of Medicat. & ECT |
| 58. | Effects of psychotropic medications on deaths | 3.50 | Damaging Effects of Medicat. & ECT |
| 69. | Impact of insurance parity: increased funding for forced treatment | 3.50 | Legal Issues |
| 71. | Factors influencing rates of restraints & seclusion | 3.50 | Force: Invol. Intrusive "Treatment" |

**Source:** Richard Heine, Ph.D., (1994) Kentucky Department of Mental Health. - Working Papers
**Sponsor:** Kentucky Department of Mental Health and Statewide Consumer Advisory Council
**Sample size:** 20 consumers
**Sample Description:** Adult service recipients with severe and persistent mental illness; 10% black, 90% white; 50% female; mean age = 35; approximately equally split between rural and urban places of residence.
**Method:** DMH staff member and consumer ran a focus group session. The labels in the table that follow represent the interpretations of the group's (non-statistical, inductive) construct interpretations for the items. Groups latter rated the importance of the constructs (as opposed to individual concerns). We present the first five categories and their associated concerns. The other five either were irrelevant, or consisted of very few concerns. The construct labels not included are: "Be attuned to external reality", "Being in tune with internal reality", "Helping others as evidenced by being all I can be to others:, "Self understanding of mental illness", and "Document and do research about mental illness". Consumers prioritized the constructs (but not the individual concerns). The priority rating for the construct is presented in the second column.
**Probe:** "What specific objectives are essential to a consumer's personal success?"

| Concern | Priority Rating | Authors' Label |
|---|---|---|
| 1. Supportive housing | 1 | Being able to live alone |
| 2. Money | " | " |
| 3. Access to community resources | " | " |
| 4. Defining success is my right - my responsibility | 2 | Achieve individual personal goals |
| 5. A day when I have choices | " | " |
| 6. A place to live with dignity | " | " |
| 7. Gainful employment | " | " |
| 8. Increase in activities | " | " |
| 9. Good will of community | " | " |
| 10. Increase support systems | " | " |
| 11. Reduce anger | " | " |
| 12. Reduce rate of hospitalizations | " | " |
| 13. Movement to less strict environment | " | " |
| 14. Identify need for intervention | " | " |
| 15. Be aware of stressors | " | " |
| 16. Reduction in medications | " | " |
| 17. Goal oriented behavior | " | " |
| 18. Attempt a new task | " | " |
| 19. Be socially active | 3 | Develop and maintain responsible relationships |
| 20. Have successful relationships | " | " |
| 21. Develop accurate understanding of relationships | " | " |
| 22. Accept changing relationships | " | " |
| 23. Don't isolate yourself | " | " |

| | | |
|---|---|---|
| 24. Families free of denial | 4 | Create realistic expectations between family and consumers regarding illness/person |
| 25. Family support with no blame | “ | “ |
| 26. Family therapy is OK when consumer requests it | “ | “ |
| 27. Eliminate blame | “ | “ |
| 28. Family must let go | “ | “ |
| 29. Reduce anger between family and me | “ | “ |
| 30. Reduce co-dependency | “ | “ |
| 31. Teach mental health to others | 5 | Other’s understanding of mental illness |
| 32. Families being informed | “ | “ |
| 33. Demystify mental illness | “ | “ |
| 34. Educate own family | “ | “ |
| 35. Educate community about mental illness | “ | “ |
| 36. Send family to AMI | “ | “ |
| 37. Erase mental illness stigma | “ | “ |

**Source:** Midgley, Gilliland, Rose, Livermore, et. al. & Lemoine & Speier (1994)
**Subgroup:** 1
**Sponsor:** Louisiana Office of MH and Louisiana State U.
**Sample size:** 12
**Sample Description:** Adult service recipients and members of Louisiana's statewide consumer network (CONFIDENT). 67% black, 33% white; 67% female; mean age = 38.2; predominantly rural.
**Method:** Focus group were facilitated by OMH and LSU staff. Four probe questions were used. Three are reported below. The fourth question concerned suggestions for informing the state office about whether consumers are getting what they need. The concerns identified in response to each of the probes incorporated are presented below. The authors constructed labels after collapsing the concerns across groups. Thus no labels are available at the level of the individual concerns for each subgroup. No importance or priority information is shown as the project simply involved eliciting concerns.
**Probe 1:** "What to you want MH services to do for you?"

| | **Concern** | | |
|---|---|---|---|
| 1. | More social workers to talk to | | |
| 2. | Keep giving free medication | | |
| 3. | Ease my family's concerns by telling them how I am doing | | |
| 4. | Believe in me | | |
| 5. | No cost access to social workers and doctors to talk to | | |
| 6. | Home visits | | |
| 7. | Same staff to see me in the hospital and community | | |
| 8. | Support to maintain and obtain my personal, financial goals | | |
| 9. | Let me be more independent | | |
| 10. | State support for Confident (consumer organization) | | |
| 11. | More doctor visits | | |

**Probe 2:** "What two questions would you like to be asked in the future about the MH services you have received?"

| | **Concern** | | |
|---|---|---|---|
| 1. | What (services?) do you go for? | | |
| 2. | Do you get your medicine on time? | | |
| 3. | Are you using alcohol or narcotics? | | |
| 4. | Are you satisfied with the services? | | |
| 5. | What can we do to make life easy for you? | | |
| 6. | What kind of problems do you have? | | |
| 7. | Do you know the side-effects of the medications you are taking? | | |
| 8. | How is your life going for you? | | |
| 9. | Are you getting a lot (of benefit) from the services you receive? | | |
| 10. | Have your relationships improved? | | |

**Probe 3:** "If you could get the one thing you really needed from your mental health services, what would it be?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Permission to drive a car | | |
| 2. | Be free of medication (2 times) | | |
| 3. | Have increased self-confidence | | |
| 4. | A job | | |
| 5. | More income | | |
| 6. | Access to services when I need help | | |
| 7. | Assist other people who need help | | |
| 8. | Publish a newsletter about recovery and education of public | | |
| 9. | More help from case managers in area of housing and supports for independent living | | |
| 10. | More services from psychotherapist rather than so many psychiatrist visits | | |

**Source:** Midgley, Gilliland, Rose, Livermore, et. al. & Lemoine & Speier (1994)
**Subgroup:** 2
**Sponsor:** Louisiana Office of MH and Louisiana State U.
**Sample size:** 12
**Sample Description:** Adult service recipients having severe & persistent mental illness and members of statewide consumer network. 50% black, 8% indian, 42% white; 42% female; mean age = 41.1; 5 rural, 2 urban, 5 unknown.
**Method:** Focus group facilitated by OMH and LSU staff

**Probe 1:** "What do you want MH services to do for you?"

| | **Concern** | | |
|---|---|---|---|
| 1. | To listen to me | | |
| 2. | To help me cope with society | | |
| 3. | Offer more direction | | |
| 4. | Faster access to services | | |
| 5. | Reduce staff turnover | | |
| 6. | More access to clinical services | | |
| 7. | To be called and reminded of appointments | | |
| 8. | Counseling to help me deal with the world in an active way | | |
| 9. | Need more counseling and it cost me too much to get it | | |
| 10. | Cost of service is too high | | |
| 11. | More educated counselors | | |
| 12. | To be more assertive | | |
| 13. | Help me with day-to-day life | | |
| 14. | Counselors need to listen what we say | | |
| 15. | Immediate access to crisis evaluation screening | | |

**Probe 2:** "What two questions would you like to be asked in the future about the MH services you have received?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Are your needs being met? | | |
| 2. | How are you? | | |
| 3. | What are your needs? | | |
| 4. | What are your suggestions for improvement? | | |
| 5. | Do you have one counselor; Are you satisfied? | | |
| 6. | Do you have group counseling? | | |
| 7. | Are you being cared for? | | |
| 8. | Are you being heard? | | |
| 9. | Are your needs being met? | | |
| 10. | Is your counselor addressing your problems? | | |
| 11. | What services are available for children/youth? | | |
| 12. | What other resources can we help provide you with? | | |
| 13. | Are clinicians available to me 5 days a week? | | |
| 14. | Do you need legal aid (i.e., help getting child custody)? | | |
| 15. | Do you need family counseling? | | |
| 16. | Do you support groups? | | |
| 17. | Does your therapist feel intimidated by you? | | |
| 18. | What is working for you? | | |
| 19. | Are family members being listened to in their role as caregiver? | | |

**Probe 3:** "If you could get the one thing you really needed from your mental health services, what would it be?

| **Concern** | | |
|---|---|---|
| 1. More information on what services are available | | |
| 2. Understanding | | |
| 3. 24 hour access | | |
| 4. Teaching/Guidance/Learning | | |
| 5. No "shoulds" | | |
| 6. Choice - not put downs | | |
| 7. Need trained professional staff | | |
| 8. More psychologists/psychiatrists - less plain M.D.s | | |
| 9. Want to eliminate the (staff's) "holier than thou" attitude | | |
| 10. Regarded as people of equal status | | |
| 11. Listen to me when I say what the meds are doing | | |
| 12. Listen to what we say | | |
| 13. Know what meds we are given | | |
| 14. Respect | | |
| 15. Support | | |
| 16. To be normal | | |
| 17. More social workers/ more caring | | |
| 18. Learn skills through workshops (e.g., social skills, etc.) | | |

**Source:** Midgley, Gilliland, Rose, Livermore, et. al. & Lemoine & Speier (1994)
**Subgroup:** 3
**Sponsor:** Louisiana Office of MH and Louisiana State U.
**Sample size:** 12
**Sample Description:** Adult service recipients having severe and persistent mental illness and members of statewide consumer network. 33% black, 8% unknown, 58% white; 58% female; mean age = 36.6; equally split between rural and urban.
**Method:** Focus group facilitated by OMH and LSU staff
**Probe 1:** "What do you want MH services to do for you?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Counseling | | |
| 2. | Therapy from psychiatrists without turnover | | |
| 3. | Continuity of care | | |
| 4. | Stabilization | | |
| 5. | More frequent visits with psychiatrists | | |
| 6. | Doctors and other professionals need to take more time and have more compassion | | |
| 7. | Access to case manager | | |
| 8. | Better crisis intervention | | |
| 9. | Help to become a functioning individual again | | |
| 10. | Speedier services | | |
| 11. | System that cares | | |

**Probe 2:** "What two questions would you like to be asked in the future about the MH services you have received?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Are you satisfied with the services you receive? Y/N | | |
| 2. | Are you effectively served? | | |
| 3. | Is your therapist helpful? | | |
| 4. | Is the medication helpful? | | |
| 5. | Are you informed of new medicines? | | |
| 6. | Do you know the potential side-effects of your meds? | | |
| 7. | Are you satisfied with your social worker? | | |
| 8. | How do you cope with your illness? | | |
| 9. | Do you know your diagnosis? | | |
| 10. | Do you feel involved with formulation of your treatment plan? | | |
| 11. | How are you feeling? | | |
| 12. | Are you getting well-rounded care? (physical and mental) | | |
| 13. | Are you willing to take your medicine as prescribed? | | |
| 14. | Are you provided with transportation? | | |

**Probe 3:** "If you could get the one thing you really needed from your mental health services, what would it be?"

| Concern | | |
|---|---|---|
| 1. More acute care beds | | |
| 2. A job | | |
| 3. More group therapy | | |
| 4. More counseling | | |
| 5. Less paperwork: more time with the consumer | | |
| 6. Transportation | | |
| 7. Monitor facilities better/protection from begging and borrowing | | |
| 8. Financial needs met | | |
| 9. Increase SSI checks | | |
| 10. Safe and secure facilities | | |
| 11. Reduce budget cuts/Better financial backing | | |
| 12. Medication-free evaluation period | | |

**Source:** Midgley, Gilliland, Rose, Livermore, et. al. & Lemoine & Speier (1994)
**Subgroup:** 4
**Sponsor:** Louisiana Office of MH and Louisiana State U.
**Sample size:** 13
**Sample Description:** Adult service recipients having severe and persistent mental illness and members of statewide consumer network. 46% black, 54% white; 62% female; mean age -= 38.2; equally split between urban and rural.
**Method:** Focus group facilitated by OMH and LSU staff
**Probe 1:** "What do you want MH services to do for you?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Keep us functioning | | |
| 2. | Maintain medication | | |
| 3. | Meet with case manager when needed | | |
| 4. | Professionals who care about consumers | | |
| 5. | Separate mental illness from criminal behavior | | |
| 6. | Available services | | |
| 7. | Continuity of care (stable) | | |
| 8. | Access to Dr. and counselor | | |
| 9. | Money to go toward services | | |
| 10. | Access to medication, nutritional and marriage counseling | | |
| 11. | Give us a voice in our treatment | | |
| 12. | Not be blamed for our illness | | |
| 13. | Legal services, psychiatrists and social worker provided | | |
| 14. | Extended hours (p.m.) for crisis work | | |
| 15. | Transportation | | |

**Probe 2:** "What two questions would you like to be asked in the future about the MH services you have received?"

| | **Concern** | | |
|---|---|---|---|
| 1. | How are you doing? | | |
| 2. | Is the medication O.K.? | | |
| 3. | What motivates you? | | |
| 4. | What can we do for you? | | |
| 5. | How is the staff treating you? | | |
| 6. | Are your problems being heard? | | |
| 7. | Is the medication working? | | |
| 8. | How are you doing physically? | | |
| 9. | How is life treating you? | | |
| 10. | Are you being consulted about your meds? | | |
| 11. | Are you treated with respect and dignity? | | |
| 12. | Do you wish to continue with the same workers? | | |
| 13. | Are you having to provide services to the providers? | | |
| 14. | How is your doctor treating you? | | |

**Probe 3:** "If you could get the one thing you really needed from your mental health services, what would it be?"

| **Concern** | | |
|---|---|---|
| 1. Better crisis lines | | |
| 2. Speedier services | | |
| 3. Counselor | | |
| 4. More people to care for consumers | | |
| 5. To be treated like a human being with respect and dignity | | |
| 6. Separate mental illness and criminality | | |
| 7. Better education | | |
| 8. Grant to provide for family | | |
| 9. Toll-free number | | |

**Source:** Midgley, Gilliland, Rose, Livermore, et. al. & Lemoine & Speier (1994)
**Subgroup:** 5
**Sponsor:** Louisiana Office of MH and Louisiana State U.
**Sample size:** 12
**Sample Description:** Adult service recipients having severe and persistent mental illness and ;members of statewide consumer network. 25% black, 8% unknown, 67% white; 67% female; mean age = 35.6; equally split between rural and urban.
**Method:** Focus group facilitated by OMH and LSU staff
**Probe 1:** "What do you want MH services to do for you?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Medication | | |
| 2. | Counseling | | |
| 3. | Group | | |
| 4. | Public Awareness/Stigma | | |
| 5. | Income/Financial Support | | |
| 6. | Housing | | |
| 7. | Education | | |
| 8. | Influence public officials | | |
| 9. | More crisis centers | | |
| 10. | Address problems of homelessness | | |
| 11. | Monitor government agencies | | |
| 12. | Coordinate agencies | | |
| 13. | Use plain language | | |
| 14. | Transportation | | |
| 15. | Companionship - doing things with others would stimulate mind | | |

**Probe 2:** "What two questions would you like to be asked in the future about the MH services you have received?"

| | **Concern** | | |
|---|---|---|---|
| 1. | How are you feeling? | | |
| 2. | Are you feeling better? | | |
| 3. | Am I feeling better after medicine? | | |
| 4. | Are these services helping you? If not, what can we do? | | |
| 5. | Is the medication O.K.? | | |
| 6. | How is the family/friends? | | |
| 7. | How can we help with housing? | | |
| 8. | How can they better meet everyone's needs?* | | |
| 9. | How good are the services? | | |
| 10. | Ask about financial matters - How marriage status affects | | |
| 11. | How is the medication? | | |
| 12. | What else can we do besides medication? | | |
| 13. | Questions about income | | |
| 14. | Is housing permanent or temporary? | | |
| 15. | How long should we have to wait for services? | | |
| 16. | When will we be eligible for services? | | |
| 17. | Do you need any more services? | | |
| 18. | How can we get services quicker? | | |

| | | |
|---|---|---|
| 19. How urgently do you need services? | | |
| 20. Are you on a waiting list for any services? | | |
| 21. Is housing situation stressful? | | |
| 22. What things can you help yourself with? | | |
| 23. What have you done to help yourself? | | |
| 24. What are you doing to get your life together? | | |
| 25. Are you taking your meds? | | |
| 26. Are you able to provide for yourself on a daily basis? | | |

Note: * = occurred twice

**Probe 3:** "If you could get the one thing you really needed from your mental health services, what would it be?

**Concern**

| | | |
|---|---|---|
| 1. Reduction in check | | |
| 2. Hear that you are well | | |
| 3. Help as much as you can-get the right person to help you | | |
| 4. Keep on medicine | | |
| 5. Specific counseling (one on one)/ specialized help | | |
| 6. More socialization | | |
| 7. Get health back and live independently | | |
| 8. Education is very important for independence in the future | | |
| 9. Tutoring | | |
| 10. Learn to live with illness | | |
| 11. Learn to cope/ways of helping** | | |
| 12. Help speed up social security | | |
| 13. Focus spending more on mental illness-from President | | |

Note ** = Occurred three times

**Source:** Midgley, Gilliland, Rose, Livermore, et. al. & Lemoine & Speier (1994)
**Subgroup:** 6
**Sponsor:** Louisiana Office of MH and Louisiana State U.
**Sample size:** 12
**Sample Description:** Adult service recipients having severe and persistent mental illness and members of statewide consumer network. 25% black, 75% white; 67% female; mean age = 45; equally split between rural and urban.
**Method:** Focus group facilitated by OMH and LSU staff
**Probe 1:** "What do you want MH services to do for you?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Support - need to be taken seriously | | |
| 2. | Take part in decision making | | |
| 3. | More information on the system and medicine | | |
| 4. | Legal information and services | | |
| 5. | Delivery of services | | |
| 6. | Fine-tuning of services (transportation) | | |
| 7. | Medication | | |
| 8. | Are services the same in other areas? If not, why different? | | |
| 9. | Allow consumers to volunteer | | |
| 10. | Help make transitions easier | | |
| 11. | Public awareness-educate general public | | |
| 12. | Programs are not used because not publicized | | |
| 13. | Job-finding | | |
| 14. | Better health | | |
| 15. | Family | | |
| 16. | Educating friends and family | | |
| 17. | Provide more counseling that includes family | | |
| 18. | Reduce stigma | | |
| 19. | Help with family issues and concerns (divorce) | | |
| 20. | Educate employers that we're capable of meaningful employment | | |
| 21. | Advertisement-let others know we're like everybody else - improve public relations | | |
| 22. | Better services for adolescents (education) | | |

**Probe 2:** "What two questions would you like to be asked in the future about the MH services you have received?"

| | **Concern** | | |
|---|---|---|---|
| 1. | Do you think you can be independent since you're getting services? | | |
| 2. | Are services lasting too long? | | |
| 3. | Is the medication working? | | |
| 4. | Are you able to work? | | |
| 5. | Do mental health professional make you feel intimidated? | | |
| 6. | Are professionals meeting your needs? | | |
| 7. | How are you feeling? | | |
| 8. | What can I do for you? | | |

| | | | |
|---|---|---|---|
| 9. | How do services fit in with the job? Supportive? | | |
| 10. | Has mental health assisted you with finding/ maintaining job? | | |
| 11. | Are you able to cope with mental illness? | | |
| 12. | Does professional meet your needs? | | |
| 13. | Is confidentiality being maintained? | | |
| 14. | Have you seen the same service provider for an extended period of time? | | |
| 15. | Is it possible to get back into field that person was in before illness? | | |
| 16. | Have services been available for your career advancement? | | |
| 17. | How does your family deal with your condition? | | |
| 18. | Do you feel you are discriminated against? | | |

**Probe 3:** "If you could get the one thing you really needed from your mental health services, what would it be?

**Concern**

| | | | |
|---|---|---|---|
| 1. | Patience | | |
| 2. | Peace of mind | | |
| 3. | Job at MH center | | |
| 4. | Understanding problems | | |
| 5. | Respect | | |
| 6. | Support and security* | | |
| 7. | Medication - insurance to make it affordable | | |
| 8. | Financial help | | |
| 9. | Explore new meds and treatments | | |
| 10. | Better equipped hospitals | | |
| 11. | To be an equal | | |
| 12. | Ability to cope | | |
| 13. | Freedom to say no | | |
| 14. | More rights | | |
| 15. | Spiritual support | | |
| 16. | Be able to stop meds | | |
| 17. | To be cured | | |
| 18. | Having a private Dr. who you choose | | |
| 19. | Choice whether to be in a group or not | | |
| 20. | Maintaining confidentiality | | |
| 21. | More consideration | | |
| 22. | More flexibility | | |
| 23. | Same rules for providers as consumers | | |
| 24. | Advocacy (telethons) | | |

**Source:** Gregory Teague, Ph.D., New Hampshire-Dartmouth Psychiatric Research Center. Data presented below represent a consumer-only subset from a study in progress looking at the relative importance of outcome dimensions from the perspectives of consumers, providers and family members. The data comes from a sub-study of the utility of MH services which is part of a larger study on the cost-utility of MH services provided by continuous treatment teams to persons dually diagnosed with MH and SA abuse disorders.
**Sponsor:** R01 NIMH Services Research Grant to Dr. Teague
**Sample size:** 49 consumers
**Sample Description:** Adult service recipients with severe and persistent mental illness (some dually diagnosed with S.A.); 28.6% black, 71.4% white; 49% female; mean age = 36.9; consumers residing in N.H. and Washington, D.C.
**Method:** Pool of 74 items were constructed by Dr. Teague based upon a review of literature and focus groups conducted with consumers, family members and providers. A priori domains of potential MH outcomes included: clinical, functional and experiential areas plus linkage to supports and services. The a priori domains included items sampling: MENTAL AND PHYSICAL HEALTH (i.e., access to health care, MH treatment engagement, MH treatment outcomes, self-management of MH treatment); SUBSTANCE ABUSE (treatment engagement, self management, and level of abuse/dependence); HOUSING (alternatives, choice; physical characteristics/setting; social characteristics); LEGAL (public safety, legal involvement as alleged perpetrator, victimization); INDEPENDENCE/SELF-SUFFICIENCY (self-care, care of others, care of home; optimal independence; financial independence & self-management); WORK (work status, vocational skills, access; independence, satisfaction); SOCIALIZATION (family relations, friends, social support network, interactions between self and others); EMPOWERMENT/GROWTH/EDUCATION (self-esteem and self-confidence, education opportunities, religious/spiritual expression); and LEISURE/RECREATIONAL ACTIVITIES (physical activity; hobbies/other activities). A caucasian, non-consumer research assistant individually assisted MH consumers (and other constituents too) through a Q-sort of the items. Ten factors were statistically identified that accounted for approximately 50% of the variance across all respondent types. The labels in the table that follows represent the author's interpretations for the loadings when considering only the consumer respondent groups. Items are listed in descending order of rated importance. We present only those items having an (adjusted) importance rating equal to or greater than the mean for all items. Blank entries in the 2nd column signify no clear factor loading.
**Probe:** Please sort these statements into one of five piles based on your perception of their importance for persons with severe and persistent mental illness. (Note that the task really consisted of a series of smaller, highly structured tasks - e.g., 1. "pull out the most important...,", 2. "pull out the least important...", etc.).

| **Importance Concern** | **Mean Authors' Rating** | **Label** |
|---|---|---|
| 1. Having stable housing ( having a place to live and not having to move every few days/weeks) | 70.6 | Self Care (-)* |
| 2. Having a sense of self-confidence and self-esteem | 68.7 | Health/Survival Resource; Self-Confidence |
| 3. Living in decent housing (a place that's structurally sound, has electricity, heat, plumbing kitchen and furniture) | 68.6 | Symp. & Medic. Minimization; Decent Housing |
| 4. Having enough money for necessities like food, clothes and transportation | 68.3 | Health/Survival Resource; Self-Confidence |
| 5. Having a sense of hope | 67.4 | Illness self-mngmt. & hope |

| | | | |
|---|---|---|---|
| 6. | Knowing when to ask for help | 65.4 | Health/Survival Resource; Self-Confidence |
| 7. | Receiving mental health services (as needed) | 64.9 | MH/SA Service Engagement |
| 8. | Being able to get medical care (general physical healthy care) | 64.5 | Health/Survival Resource; Self-Confidence |
| 9. | Staying out of psychiatric hospitals as much as possible | 64.3 | Health/Survival Resource; Self-Confidence (-) |
| 10. | The consumer recognizing his/her mental illness | 62.7 | Illness self-mngmt. & hope |
| 11. | Being as physically healthy as possible | 61.8 | Wellness |
| 12. | Having a good relationship with mental health treatment providers | 60.7 | Coping with stigma (Personal Acceptance) (-) |
| 13. | Being able to have fun and enjoyment in life | 60.4 | MH/SA Service Engagement (-) |
| 14. | Having a purpose in life | 60.4 | Wellness |
| 15. | The consumer understands how to use medication properly | 60.4 | MH/SA Service Engagement |
| 16. | The consumer taking an active role in managing his/her mental illness | 59.6 | Illness self-mngmt. & hope |
| 17. | Following through with mental health treatment plans (e.g., attending treatment groups, taking prescribed medication) | 59.5 | MH/SA Service Engagement |
| 18. | Staying out of jail | 59.4 | Legal |
| 19. | Keeping overall symptoms of mental illness to a minimum | 58.6 | Symp. & Medic. Minimization Decent Housing |
| 20. | Being able to get dental care | 58.2 | Health/Survival Resource; Self-Confidence |
| 21. | Being able to manage his/her own money | 57.7 | Self Care |
| 22. | Having someone with whom to share private thoughts, feelings and concerns (other than a MH care professional) | 57.4 | Independent Community Living |
| 23. | Having his/her own place to live (e.g., his/her own apartment) | 57.4 | Independent Community Living |
| 24. | Having health insurance, or being able to pay for medical care | 57.3 | |
| 25. | Dressing and bathing in ways that other people generally accept | 56.9 | Self Care |
| 26. | The consumer understands how to manage his/her stress | 56.5 | Illness self-mngmt. & hope |
| 27. | Not being a victim of physical or sexual assault | 55.3 | Health/Survival Resource; Self-Confidence |

| | | |
|---|---|---|
| 28. Feeling satisfied with treatment for mental illness and/or substance abuse | 55.3 | Work & Career (-) |
| 29. Not using any drugs (except for medications as prescribed or recommended) | 55.0 | Independent Community Living (-) |
| 30. Having a choice about where to live | 54.7 | Independent Community Living |
| 31. Living in a safe neighborhood | 54.6 | Health/Survival Resource; Self-Confidence |
| 32. Being able to cope with setbacks | 54.3 | Wellness |
| 33. Having a good relationship with family members | 54.1 | Self Care (-) |
| 34. Being satisfied with life overall | 53.8 | Wellness |
| 35. Being satisfied overall with his/her living arrangements | 53.7 | Independent Community Living |
| 36. Understanding nutrition and food preparation, and eating 2-3 nutritious meals per day | 53.6 | Self Care |
| 37. Being able to take care of his/her home or apartment (e.g., keeping it clean) | 52.8 | Self Care |
| 38. The consumer understanding how to manage symptoms of mental illness | 52.6 | MH/SA Service Engagement |
| 39. Being able to manage time and set priorities | 52.2 | Independent Community Living (-) |
| 40. Keeping suicidal thoughts and behaviors to a minimum | 51.4 | MH/SA Service Engagement |
| 41. Keeping prescribed medication to a minimum | 51.2 | Symp. & Medic. Minimiz; Decent Housing |
| 42. Having enough privacy where he/she lives | 50.5 | Independent Community Living |
| 43. Having regular contact with friends (people who are | 50.5 | Independent Community Living |

*Note: (-) = item is scored negatively

**Source:** Trochim, W., Dumon, J. & Campbell, J. (1993) - (Wakefield, MA)
**Sponsor:** NASMHPD Research Institute under a contract from CMHS's Div. of State & Community Systems Development
**Sample size:** 17
**Sample Description:** Adult MH service consumer/survivor leaders and advocates - nearly all involved in self-help/advocacy movements. Many are connected with the MH system as providers of services, MH researchers or administrators. All have diagnoses classifiable as a major mental illness. The average number of psychiatric admissions was 10.1. Most are not receiving services from public MH system. Demographics (only 15 persons supplied demographics for what follows): 100% white; 60% female; median age = 42; nine have advanced degrees, 3 have B.A.'s, 3 have some college; most currently employed with income in range of $6,500 to $75,000 (median income = $27,500).
**Method:** Consumer/survivors and William Trochim co-led structured group process. Participants brainstormed a list of 98 concerns. Participants were then asked to sort these concerns into between two and 97 piles (with no pile for miscellaneous permitted and participants encouraged to have 10-25 piles). Additionally, as a separate, second task, participants were given a list of the concerns and asked to rate the importance of each relative to the other concerns using a 5 point Likert-type scale (1 = relatively unimportant, 2 = somewhat important, 3 = moderately important, 4 = very important, and 5 = extremely important). Trochim's concept mapping software was used to generate clusters and concept maps which the participants then used to generate cluster labels.
The data presented below include only those concerns that received an mean importance rating equal to or greater than the median (=- 4.0) calculated for the total set of items. The range of mean ratings for the total set was 2.47 - 4.73. The item numbers shown in the first column of the table correspond to the item numbering scheme used in the original study to enable the exploration of items not presented here. The mean item importance rating is shown in the second column. The labels shown in the third column are the cluster (concept) names for the corresponding item.
**Probe:** "Generate statements that describe specific consumer/survivor- defined individual and/or system-outcome indicators or measures that should be part of mental health system measurement".

| | Concern | Mean Importance Rating | Authors' Label |
|---|---|---|---|
| 35. | Trauma due to psychiatric modalities including involuntary commitment, seclusion, restraints, etc. | 4.73 | Damaging Effects of System |
| 49. | Recognition and enforcement of civil rights and patient rights | 4.60 | Legal System Issues |
| 89. | Measures of involuntary treatment as system failures | 4.60 | Autonomy versus Coercion |
| 91. | Absolute right to engage in any legal or law-abiding behavior regardless of psychiatric label or lack of one | 4.60 | Legal System Issues |
| 23. | Access to and choices RE: food, shelter and clothing | 4.53 | Quality of Life |
| 46. | Informed consent regarding treatments and information dissemination | 4.53 | Consum. Impact on System Developmt. |
| 8. | Impact of poverty on quality of your life | 4.47 | Inner Process of Healing |
| 10. | True citizenship (free agency in society) | 4.47 | Citizenship |
| 34. | Recognizing the uniqueness, dignity, worth and potential of all consumer/survivors | 4.47 | Self Actualiz ./Personal Sovereignty |
| 85. | Development of small, non-hospital residential crisis facilities as alternatives to involuntary hospitalization | 4.47 | Alternatives to System |

| | | | |
|---|---|---|---|
| 98. | Measurement of effects of impoverishment or support of one's life expectations, hopes and dreams | 4.47 | Inner Process of Healing |
| 45. | All treatments should be evaluated with respect to their effects on the recipients rather than convenience for staff | 4.43 | Consum. Impact on System Developmt. |
| 72. | Widespread availability of a variety of methods of helping individuals deal with crises | 4.43 | Alternatives to System |
| 3. | Voluntariness of services delivered | 4.33 | Degree of Voluntariness & Control Over Tx. |
| 37. | Capacity to support healing from abuse (e.g., physical, sexual, emotional trauma) | 4.33 | Inner Process of Healing |
| 48. | Full access to services for physical health needs | 4.33 | Quality of Life |
| 58. | Physical and emotional safety including right to be protected from victimization | 4.33 | Citizenship |
| 60. | Educational and employment opportunities for client/ survivors in both mainstream and alternative settings | 4.33 | Quality of Life |
| 64. | Enhancement of quality of life through personal choices for meaningful work or education as opposed to earmarking to food, filth and filing | 4.33 | Self Actualiz. /Personal Sovereignty |
| 80. | When choosing treatment, that it be with the consumer/ survivor, not to, at, or for | 4.33 | Autonomy versus Coercion |
| 92. | Expeditious access to rights protection, lawyers, other legal advocacy | 4.33 | Consum. Impact of Serv. Delivery |
| 18. | Potential for forming significant personal/love/sexual relationships | 4.29 | Quality of Life |
| 40. | Systematic measurement of iatrogenic effects of medical treatments | 4.29 | Damaging Effects of System |
| 44. | Self-definition of need/want | 4.27 | Identity |
| 59. | Efforts to recruit and hire consumers/survivors at all levels | 4.27 | Citizenship |
| 41. | Ability to opt out of all mental health treatment if you choose treatments | 4.20 | Degree of Voluntariness & Control Over Tx. |
| 69. | Deference to wishes of primary consumers of MH care even when those wishes conflict with wishes of a family member | 4.20 | Degree of Voluntariness & Control Over Tx. |
| 73. | Living in an integrated setting with non-psychiatrically labeled people and having regular contact with them | 4.20 | Quality of Life |
| 79. | Removal of a psychiatric diagnosis as the determinant of human growth and potential | 4.20 | Identity |
| 83. | Consumer control over consumer's treatment record including destruction thereof | 4.20 | Degree of Voluntariness & Control Over Tx. |
| 95. | Feelings of increased authenticity with one's identity (sense of self-definition, self-ownership, personal efficacy) | 4.20 | Identity |
| 6. | Ability to transform painful situations into positive life experiences | 4.13 | Inner Process of Healing |

| | | | |
|---|---|---|---|
| 11. | Access to desired services not contingent upon using undesired services | 4.13 | Degree of Voluntariness & Control Over Tx. |
| 26. | Effective means for professionals to incorporate consumer feedback | 4.13 | Consum. Impact on System Developmt. |
| 29. | Crisis as opportunity for change rather than recovery to former status | 4.13 | Self Actualiz. /Personal Sovereignty |
| 42. | Ability to retain custody of one's children | 4.13 | Citizenship |
| 47. | Creation of a network of sanctuaries, oases of healing where nutritious food, comfortable peaceful surroundings, and affirming people are available | 4.13 | Alternatives to System |
| 88. | Long-term effects of ECT-induced memory loss on quality of life | 4.13 | Damaging Effects of System |
| 93. | Credentials and licensure of MH professionals shall be contingent upon having consumers/survivors as faculty at every level/stage of training | 4.13 | Consum. Impact of Serv. Delivery |
| 4. | How closely person's life approximates where they want to be | 4.07 | Identity |
| 12. | Name and experience one's emotions | 4.07 | Identity |
| 15. | Medical treatment focuses on consumer presented problem | 4.07 | Identity |
| 61. | Freedom to reclaim cultural & ethnic identity & autonomy | 4.07 | Identity |
| 62. | Violent action is the only basis for inferring "dangerousness to oneself or others" – not fear that it might happen | 4.07 | Legal System Issues |
| 77. | Recognition of competing interests of clients, family, professionals with client being final arbiter of what constitutes beneficial outcomes | 4.07 | Consum. Impact on System Developmt. |
| 90. | Individual takes responsibility for that which is her/his responsibility | 4.07 | Identity |
| 9. | Ability (or lack thereof) to change one's circumstances | 4.00 | Identity |
| 13. | Being able to live one's life independently - no supervision or interference | 4.00 | No label |
| 17. | Self mastery over emotional life | 4.00 | Self Actualiz. /Personal Sovereignty |
| 27. | Non-compliance to forced treatment is seen as a healthy choice | 4.00 | No label |
| 31. | Elimination of status hierarchies & dichotomies between staff and consumers | 4.00 | Consum. Impact on System Developmt. |
| 55. | Degree to which your life choices and behavior are limited by your fear of forced treatment/commitment | 4.00 | Autonomy versus Coercion |
| 57. | Satisfactory resolution of complaints from viewpoint of complainer | 4.00 | Consum. Impact on System Developmt. |
| 71. | De-medicalization of crisis so people are better able to seek out support at times as defined by them | 4.00 | No label |

| | | | |
|---|---|---|---|
| 74. | Money allocated to services be reallocated to individuals to sue as they choose | 4.00 | Consum. Impact on System Developmt. |
| 97. | Measures of satisfaction with one's ability to participate in the civic, democratic, and policy-making arena in one's community | 4.00 | Quality of Life |

**BRIEF ANNOTATIONS**
(listed alphabetically)

**Source:** Abramczyk, L.W. (1995) South Caroline SHARE Americans with Disabilities Act Project SHARE Evaluation: Consumer Perspective.
**Sponsor:** Bazelon Center for Mental Health Law by grant funds from the U.S. Depart. of Justice.
**Sample:** Three related samples - total 399 participants (some question regarding duplicated cases within and between samples).
**Sample:** 1) Focus Groups (n=42) estimated 10 participants (average) in each of four groups. Mean age 43 yrs; 52% male; 74% African American. Most were high school educated and living with others; most often in a house with family. Most frequent diagnoses: schizophrenia and depression. 2) Survey (n=350). Mean age was 40 yrs; 44% males and 57% African American. Most were high school educated, and 73% lived with others in a house, most often with family. Most frequent diagnoses were schizophrenia and depression. 3) Longitudinal Tracking (n=7). Mean age of 37 yrs, 86% male, 57% African American. Most were high school educated, and 71% were living with others, most often in a house with family. Most frequent diagnoses were schizophrenia and [?manic?] depression.
**Method:** The methods used to collect data from consumers currently or formerly active in SC SHARE (South Carolina Self Help Association Regarding Emotions) were focus groups of about 10 consumers each [Annotator's estimate] facilitated by a faculty investigator from USC (Lois Abramczyk, MSSW, Ed.D.). Other methods included mail and telephone surveys and longitudinal tracking of a small set of individual consumers.
**Probe:** [for focus groups only] "Obstacles to receiving services." [taken from report description]
**Commentary:** This project was an extensive study of consumers' perceptions of potential barriers to accessing human services (including MH services). The study is one project within a larger effort to study MH client access to human services in compliance with the Americans With Disabilities Act. Focus group responses were categorized into six groups, as follows:

1) Financial Problems - e.g., "don't have enough money to purchase anything beyond the absolute necessities."
2) Information or Knowledge - e.g., not knowing "that a particular service exists"; "not knowing how to go through the right processes to obtain the service."
3) Unresponsiveness - e.g., "physicians and other service providers don't spend enough time with consumers to really hear and understand them;" "if they don't adhere strictly to their appointments and keep behind (sic) services/providers, the providers will just 'skip over' them."
4) Waiting - e.g., "waiting list to get an appointment;" "you wait after you get to the agency;" "waiting for transportation that may arrive at irregular times."
5) Red Tape, Processes, and Forms - e.g., "everything is a procedure;" "some consumers couldn't fill [forms] out without help."
6) Eligibility Requirements - e.g., "eligibility is arbitrary or providers ignored the law;" "specific ... requirements are barriers to ... benefits", "disregard of consumer life style."

**Source:** Bluebird, Gail (1993) - Consumer Dialogues
**Sponsor:** Florida Health and Rehabilitative Service, District 10 Adult Mental Health Office
**Sample size:** 20 to 28
**Sample Description:** Adult mental health consumers who were frequent users of community mental health services in Florida. Four samples consisting of those volunteering for discussion groups on satisfaction with services. Demographics not given.
**Method:** Adapted the "pioneer dialogue" technique, though only consumers participated.
**Probe:** ""What do you feel good about? What do you see as barriers or problem areas? What are your suggestions for changes or improvements."
**Commentary:** This is primarily an effort to investigate consumer satisfaction with aspects of particular

program operations. Specific issues in social rehab. facilities included need for better supplies, improved safety, and more structured activities; especially in the late afternoon. Residential services needed improved privacy and autonomy for residents (choice of roommates, relaxed ruled about tidiness, choice not to participate in social activities without censure). Hospital-based group noted need for more individual contact with therapists, less control of the wards by lower-level staff, alternatives to hospitalization in cases of crises (i.e., a "safe house"), consistent and detailed oral and written explanations of drug and treatment effects and side effects, among other concerns.

**Source:** Campbell, J. & Schraiber (1989)
**Sponsor:** California Network of MH Clients under contract from California Department of MH
**Sample size:** 331 consumers
**Sample Description:** Adult persons with severe and persistent mental illness who had been (27%), or were currently (83%) at the time of the survey, clients of the public mental health system; client sample was drawn from all over California using a "modified statewide, proportionately representative population of mental health clients" (pg. 4). Sample did not include persons in hospitals. Demographics: 15% black, 69% white, 1.9% asian, 4.7% latino, 3.4% native american, and 5.6% other; 48% female; 10% married; 38% have children; median age of approximately 42; 62% had received education beyond high school, 20% completed college, 13% had post graduate education; 80% report no work-related income; 68.1% were receiving V.A. benefits, SSI or other federal/state support; 21% were living in supervised housing; 66% reported having been involuntarily committed at least once.
**Method:** Consumers were responsible for item generation and selection, design, interviewing, analysis and report writing. The focus of the project was on consumers' self-reports regarding issues relevant to their well being. The instrument included amongst its 151 questions, items on demographic information, information related to stigma, isolation, security, control; authority, dependence, trust, and information about creative forms of expression, skills, and learning. Item format was forced choice with five-point Likert-type scales for items other than the demographics. Parallel forms were also used with family members and MH professionals. Consumer surveys were administered using one of three techniques: individual face-to-face interviews (75%), group interviews and mailed surveys.
**Probe:** Please mark all the things in the list below that you believe are <u>essential</u> for your well-being?
**Commentary:** This study has become well known. Amongst its other contributions, it presents consumers' rating of things important to their well-being - a concept coterminous with quality of life. Sixteen closed-end items were rated for importance. The items (and the percentage of consumers indicating a positive response for each included: 1) Health (86%), 2) Good food/decent place to live (85%), 3) Adequate income (84,%), 4) Happiness (78%), 5) Meaningful work/achievement (74%), 6) Privacy (73%), 7) Safety (73%), 8) Basic Human Freedoms (72%), 9) Satisfying social life (69%), 10) Warmth/intimacy (65%), 11) Comfort (64%), 12) Adequate resources (63%), 13) Satisfying spiritual life (62%), 14) Creativity (61%), and 15) Satisfying sexual life (55%).

**Source:** Elbeck Matt (1992)
**Sponsor:** Centracare St. John, Inc., Saint John, New Brunswick, Canada.
**Sample size:** 21 subjects in three focus groups of 6, 5 and 10, respectively
**Sample Description:** Adults with mental illness drawn from the population of voluntary admissions in an inpatient psychiatric unit. All were diagnosed with schizophrenia. There were 9 males and 12 females. Ages and ethnicity were not described.
**Method:** Three focus group interviews, each interview lasting approximately 90 minutes. Setting for the interviews was not mentioned. Subsequent questionnaire was administered to 40 voluntary inpatients by the nursing staff.
**Probe:** "Describe the ideal psychiatric hospital".
**Commentary:** A total of 50 items drawn from the focus group interviews was converted into a 50-item questionnaire with fixed-choice responses on a seven-point Likert-scale (1=critical; 7=irrelevant). The

ten most important items describing patient satisfaction included: hospital resources devoted to curing the patients, staff interest in patients, clear communication from doctor, doctor must clearly explain my illness, need more time with the doctor, discharge to be cleared by my doctor, need to make friends with staff and other patients, relatives need to know patient's diagnosis, and need for a patient visitor area.

**Source:** Knight, Ed and Forquer, Sandy. (1993)
**Sponsor:** New York Office of Mental Health
**Sample size:** 12
**Sample Description:** Persons admitted to psychiatric inpatient units of general hospitals in New York State (termed "Article 28" clients). No demographics given.
**Method:** Focus groups led by Ed Knight and Sandy Forquer with open discussion on negative and positive impressions of satisfaction with hospital stay.
**Probe:** "Describe your experience in your last hospitalization. Describe conditions there [at the hospital]".
**Commentary:** Transcriptions from the group discussions were examined, and a list of 102 items scorable on a Likert-type five-point scale, was constructed. The resulting instrument was piloted on a sample of 150 consumers with recent psychiatric admissions. Results of the pilot study were not available at the time of this review. This work has resulted in a draft "Satisfaction with Inpatient Services" questionnaire available from the authors.

**Source:** Meek, Carmen (1991)
**Sponsor:** Mental Health Association of Southeastern Pennsylvania
**Sample size:** 188
**Sample Description:** Members attending five drop-in centers in the Philadelphia area operated by Project SHARE. Sample was 68% male; 50% white, 44% African American, and 7% other. Of those attending the drop-in center, 29% were not receiving mental health services at the time. Of the 71% receiving services, most used a combination of community, private, and in-patient providers.
**Method:** A four-page questionnaire was distributed during a one-week period to each person visiting the drop-in centers. The method biased responses in terms of more frequent visitors. Responses were summarized and a list of concerns presented.
**Probe:** "What do you like most about the center? What do you like least about the Center? What would you like to change about the center? What activities would you like to have?"
**Commentary:** Participants used the drop-in centers primarily for recreation and socializing. They most liked the informal atmosphere, the people and friends at the centers, the informal recreation, and the snacks. Least liked aspects included need for expanded hours, and problems with the behavior of other consumers. Most frequently, respondents disliked nothing about the centers. Most frequently, respondents wanted no changes at the centers. For those suggesting changes, increase hours and days of operation, and more activities were suggested. A copy of the full questionnaire is available from the author.

**Source:** McGuirk, F., Zahniser, J. Bartsch, D. & Engleby, C. (1995)
**Sponsor:** WICHE MH Program and Colorado Division of Mental Health
**Sample size:** 76 consumers plus administrators, family members and providers (total N=249)
**Sample Description:** Adult MH service recipients, including both inpatients at the state hospital and members of Colorado's Statewide Consumer Network (S.C.C.O.R.E.) Demographics were only presented for the total group.
**Method:** Each constituency group was presented with a paired-comparison task that involved all possible comparisons of ten "outcome" dimensions. The ten included: 1) Community tenure, 2) Consumer involvement, 3) Consumer satisfaction, 4) Family involvement, 5) Family relief, 6) Improved social function, 7) Personhood, 8) Safety, 9) Skilled coping, and 10) Symptom reduction. The dimensions are broadly defined and include some non-traditional groupings of items typically treated

individually (e.g., the dimension of “safety” includes public and family safety, consumer danger to self, and consumers as victims). Each of the four constituency-groups’ sample members individually completed the paired-comparison task using a written survey format.
**Probe:** “Which outcome in the pair is the more important outcome of mental health services?”
**Commentary:** Data were analyzed to determine similarities and differences in the preferences between each of the constituency groups for the ten “outcome” dimensions. High agreement (correlations in excess of .80) was found between the groups although some differences in group preferences were found. If group membership is ignored, the skilled coping, safety, and symptom reduction dimensions were rated the most important. The reader should study the definitions of these ten dimensions carefully before drawing any conclusions because of the non-traditional nature of the dimensions’ definitions.

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**Insert these 5 pages after page 38 of the first chapter**

*the Evaluation Center@HSRI*

# Performance Indicators for a Consumer-Oriented Mental Health Report Card:

*Literature Review & Analysis*

*Prepared by*
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*April 11, 1995*

# INTRODUCTION

This document is the second version of a working paper compiled for use by the Mental Health Statistics Improvement Program (MHSIP) TAsk Force on the Development of a Mental Health CAre REport Card. The earlier document listed indicators and measures related to five very broad domains: Access, appropriateness, outcomes, satisfaction, and prevention/promotion. Data for that report came from a variety of sources including: a survey of state MHSIP Coordinators, industry report cards, and relevant monographs.

The current version of this review is considerably more focused and summarizes only those indicators and measures related (sometimes very loosely) to the much smaller set of indicators identified by Task Force members in May, 1995 as candidates for inclusion in a draft report card. Much of the information in this report has already been reported in the earlier version. However, additional sources have also been reviewed for this second report.

The MHSIP Task Force has remained committed to the notion of a mental health report card designed first and foremost to meet the information needs of individuals who use services and who may have the opportunity to choose among various health plans. This orientation gives the MHSIP report card a unique perspective. It also means, however, that much of the literature on performance indicators, monitoring systems, and other report card efforts is not particularly relevant. The majority of indicator systems have been developed primarily to meet the information needs of provider organizations and funders, not consumers. AS a result, they frequently fail to provide the types of information required for this consumer oriented effort.

A number of other specific points are made in this document in our discussion of specific indicators/measures. A brief Executive Summary, abstracting these points is in preparation.

Clearly, additional work remains to be done in terms of a comprehensive literature review to support the development of this report card. The Evaluation Center@HSRI looks forward to continuing collaboration with the Task Force in this important endeavor.

## REPORT CARDS, PERFORMANCE MEASUREMENT AND MONITORING SYSTEMS SURVEYED

1. Florida Dade Co. Status of Children
2. consortium Research on Indicators of System Performance Project
3. HEDIS 2.5
4. Kaiser Quality Report Card
5. United Healthcare P.I.s for Choosing Managed Behavioral Health Care (United Behavioral Health)
6. New Hampshire Outcome Based Pis
7. Vermont Key Performance Indicators
8. Montana Regional Performance Data
9. Colorado Incentive System
10. Hoosier Assurance Plan — Provider Profile System
11. Washington Regional Support Network MIS
12. Texas Strategic Planning/Budgeting Performance Measures
13. Hawaii 1994 Program Evaluation Data Set for CMHCs
14. Minnesota Annual Performance Report
15. Utah Annual Statistical Report
16. California Medi-Cal Inpatient Consolidation Monitoring System
17. California Adult Performance Outcome Survey
18. Oklahoma Mental Health Information System
19. North Carolina Div. MH/DD/SA Outcomes
20. Oregon Quality Assurance for Managed Care Indicators
21. Rhode Island Division of Integrated Mental Health Systems Report Card
22. Healthy People 2000
23. Institute for Behavioral Healthcare Task Force Performance Standards
24. AMBHA: Developing a Collaborative Report Card: The American Managed Behavioral Healthcare Association's Experience. Panzarino, P.
25. National Leadership Council Task Force: Industry Performance Standards and Monitoring: Preliminary Report
26. Performance Indicators for Mental Health Services: Values, Accountability, Evaluation and Decision Support. Final Report of the Task Force on the Design of Performance Indicators Derived from the MHSIP Content. 1993.

27. Digital Equipment Corporation Performance Indicators for HMOs

28. Group Health Association of America's Consumer Satisfaction Survey. A. Ross Davies and J. E. Ware

29. Design of a Survey to Monitor Consumers' Access to Care, Use of Health Services, Health Outcomes, and Patient Satisfaction. Research Triangle Institute. 1/1995

# ACCESS

## CONCERN AC-1: ENTRY INTO MENTAL HEALTH SERVICES IS QUICK, EASY AND CONVENIENT

**Task Force Indicator # AC-1.1:** *Average length of time from first phone call to the first face-to-face meeting with clinician.*

**COMMENT:** Note that some of the indicators/measures identified in the literature are framed in terms of *standards* (i.e., target values), not merely descriptive information (e.g., average time) as in the above indicator. The Task Force should evaluate both the focus of these indicators/measures and the standard.

Our review suggests that standards for the length of time between a request for service and the first contact should vary by the type of service request. For example, one would expect that the Plan should react more quickly to an urgent request than to a routine one. This indicator, then, should be broken down by the type of request. Examples from other report cards and performance indicator systems use categories such as routine, urgent and emergent.

It might also be useful to measure the length of time between the first appointment and the second. Concerns have been expressed that service systems frequently schedule an assessment appointment in a timely manner, but then place individuals on waiting lists for long periods of time before they can be worked into a caseload.

### EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE

**Routine Visits*:***

**Digital Equipment Corporation**

**Indicator:** Non-urgent office visits shall be available within 10 calendar days.
**Measure:** % of non-urgent office visits scheduled within 10 calendar days.

**United Behavioral Services**

**Measure:** % of respondents reporting that waiting time for first appointment was "not a problem."

**Measure:** Average time for all intake appointment.

***Urgent Visits:***

**National Leadership Council Survey**

**Indicator:** High Standard: 100% of urgent appointments should be available within 24 hours.

**Measure:** % of urgent appointments scheduled within 24 hours.

**Indicator:** Low Standard: 95% of urgent appointments should be available within 24 hours.
**Measure:** % of urgent appointments scheduled within 24 hours.

**United Behavioral Services**

**Indicator:** 100% of appointments for crisis visits within 24 hours.
**Measure:** % of appointments for crisis visits scheduled within 24 hours.

***Emergent Visits:***
**National Leadership Council Survey:**
**Indicator:** High Standard: 100% of emergent appointments should be available within 8 Hours.
**Measure:** % of emergent appointments scheduled within 8 hours.

**Indicator:** Low Standard: 95% of emergent appointments should be available within 24 hours.
**Measure:** % of emergent appointments scheduled within 24 hours.

**Indicator:** Responses to requests for psychiatric consult related to suicide attempts should be met within 24 hours.
**Measure:** % of responses to request psychiatric consult related to suicide attempts met within 24 hours.

***2nd Appointment***

**United Behavioral Health Services**
**Measure:** Average time for second appointment

**Task Force Indicator # AC-1.2:** Program provides 24-hour access to professional help.

**COMMENT:** We have not as yet found an ideal measure. For example, neither of the measures below specifically show that professional help is available for a full 24 hours per day. A measure should also include an operational definition of what constitutes an *appropriate* response to an off-hours request for help, e.g., a response by a person with specific qualifications and within a specified period of time.

**EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE:**

**New Hampshire**

**Measure:** Number of "off-peak" (after 5:00 p.m. and weekends) hours or events/total service hours or events provided.

**Minnesota Annual Performance Report**

**Indicator:** Provide prompt attention to persons trying to contact a mental health professional. (Title: Emergency Hotline Access)

**Measure:** # of service providers connecting caller to mental health professional within 30 minutes/ # of service providers surveyed.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** Unknown | |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Observer | Observer |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Other | Other |

**Task Force Indicator # AC-1.3:** *Location of services is convenient and accessible through public transportation.*

## ACCESS

**COMMENTS**: We found no measures in the literature directly related to this task force indicator ("accessible through public transportation"). Three categories of similar indicators/measures were identified in the literature: (1) measures related to geographic distance; (2) measures related to travel time; and (3) self report of travel problems. These measures/indicators are useful for provider or monitoring organizations, but they are less useful for enrollees seeking to determine whether the locations of services are convenient to them. For potential enrollees to evaluate whether services are conveniently located, they need to know service locations and their proximity to public transportation. This type of information is usually provided in marketing brochures. It is an interesting question as to whether this should be part of a report card.

**EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE:**

**National Leadership Council**

**Indicator:** High Standard: 100% of Plan members should live within a 15 mile radius and/or 30 minute travel time.
**Measure:** % of Plan members living within a 15 mile radius and/or 30 minute travel time.

**Indicator:** Low Standard: 85% of members located within 12 miles.
**Measure:** % of Plan members located within 12 miles.

**Indicator:** High Standard: 90% of Plan members located within 30-60 miles (urban vs. rural?) or 45-60 minutes travel time to inpatient facilities.
**Measure:** % of Plan members located within 30-60 miles or 45-60 minutes travel time to inpatient facilities.

**Indicator:** Low Standard: 85% of members located within 30 miles (urban) and 60 miles (rural) of inpatient facilities.
**Measure:** % of Plan members located within 30 miles (urban) and 60 miles (rural) of inpatient facilities.

**Digital Equipment Corporation**

**Indicator:** All zip codes in the HMO's service area shall be within a 15 mile radius and/or 30 minutes of an available adult primary care physician

facility or office. (Could be modified to reflect MH provider).

**Measure:** % of enrollees living in zip codes within a 15 mile radius and/or 30 minutes of an available adult primary care physician facility or office.

**Indicator:** Members shall have a choice of at least two primary care physicians for adults within a 15 mile radius and/or 30 minutes travel time (May be adjusted in rural areas). Note: (Could be modified for MH provider).

**Measure:** % of Plan members with a choice of at least two primary care physicians for adults within a 15 mile radius and/or 30 minutes travel time.

**United Behavioral Services**

**Measure:** % of respondents reporting that clinic location was "not a problem."

**Institute for Behavioral Healthcare Task Force Performance Standards**

**Indicator:** Reduce barriers to access (Title: Access to Clinicians/outpatient services)

**Measure:** # of members within specified range of miles or travel time/ # of members in plan.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | Other |
| **Age Groups** | All Ages |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | Yes |
| **Quality:** | Unknown | Unknown |
| **Respondent:** | N/A | N/A |

## CONCERN AC-6 A FULL RANGE OF MENTAL HEALTH SERVICE OPTIONS IS AVAILABLE

**Task Force Indicator # AC-6.1:** *Proportion of enrollees using each type of service.*

**COMMENT:** This information would be most useful if the data were gender, age and case-mix adjusted. It does little good to know that a high proportion of plan members receive a particular type of service if those members are not "like you". Some of the indicator/measures reported here do break down their data by age and diagnostic categories.

**EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE:**

**Texas Strategic Planning/Budgeting Performance Measures**

**Indicator:** Creation of options as people move toward meeting needs for homes, jobs, and services. (Title: Appropriate services)

**Measure:** # of clients receiving specified service mix in current year/ # of clients receiving specified service mix in prior year.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | SPMI |
| **Age Groups** | All Ages |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | Yes |
| **Quality:** | Good | Good |
| **Respondent:** | N/A | N/A |

**American Managed Behavioral Healthcare Association (AMBHA)**

**Measure:** % of covered lives receiving following services:
Inpatient services
Residential services
Structured outpatient services and partial hospitalization
Outpatient services
Intensive case management services
Psychosocial rehabilitation services
Any service

**Reported for the following categories:**

**Age**
Children under 12
Adolescent (12-18)
Adult (19-64)
Geriatric (65 and +)

**Diagnostic**
Mood disorders (including bi-polar)
Adjustment disorders
Anxiety disorders
Substance related disorders
Substance abuse and other Mental Disorders (dual diagnosis)
Attention deficit and disruptive behavior disorders
Schizophrenia disorders
Other

**HEDIS 2.5**

**Measure:** # of members receiving service X/# of plan members (Title: Percent of members receiving inpatient, day/night, ambulatory).

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Standard Score |
| **Target Population** | Other |
| **Age Groups** | All Ages |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | No |
| **Quality:** | High | High |
| **Respondent** | N/A | N/A |

**Hawaii 1994 Program Evaluation Data Set for CMHCs**

**Indicator:** Monitor and improve outpatient therapy services (Title: Outpatient therapy services outcome IV).

**Measure:** # of consumers admitted to outpatient therapy program/# of consumers requesting service.

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Self Report |
| **In FN 10:** | Yes | No |
| **Quality:** | Low | Low |
| **Respondent** | N/A | Client |

**Task Force Indicator # AC-6.2:** *Rate at which enrollees report that needed services were not available.*

**COMMENT:** Measures related to this indicator that were identified in the literature typically use self report information from consumers to assess whether services perceived as needed were received. Note that the first indicator is a more indirect measure of this indicator and has to do with satisfaction with the Plan's gatekeeper.

Again, this information should be at least gender, age and case mix adjusted. It might also be useful to break this information out by service type. Plans may differ on which services they make available and which they do not. Enrollees will want to choose plans that match their needs.

**EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE:**

**United Behavioral Health Services**

**Measure:** % of respondents answering "Satisfied" or "Very Satisfied" to the question "Overall, how satisfied were you with the services you received from the UBS staff (who provide initial and ongoing authorization)?"

**RTI Mental Health Survey**

**Self Report Question:** "...was there a problem with getting treatment covered by your health insurance plan that you *and your mental health professional* believed was necessary? (Italics added)

## AC-7 ENROLLEES SHOULD HAVE ACCESS TO A PRIMARY MENTAL HEALTH PROVIDER WHO THEY CONSIDER ABLE TO MEET THEIR NEEDS IN TERMS OF ETHNICITY, LANGUAGE, CULTURE AND AGE.

**Task Force Indicator AC-7.1:** *Degree to which direct service staff characteristics represent enrollee characteristics.*

**COMMENT**: The New Hampshire measure is directly related to the task force indicator. The other two measures address the degree to which the Plan honors choice without specifying the criteria service recipients might use in choosing providers. Enrollees will have diverse needs and preferences. A good report card should address this diversity with as much specificity as possible.

**Examples of Related Indicators/Measures Identified in the Literature:**

**New Hampshire**

**Measure:** Number of FTE belonging to ethnic category (or fluent in specified language) / per 100,000 of corresponding group in catchment area.

**United Behavioral Services**

**Measure:** % of respondents reporting that availability of a specific doctor or therapist was "Not a problem."

**National Leadership council**

**Indicator:** 100% of clients should be offered another therapist at first request if first match is unacceptable.

**Measure:** % of clients requesting therapist change who receive such a change.

## CONCERN AC-2 DENIAL OF MENTAL HEALTH SERVICES IS MINIMAL.

**Task Force Indicator AC-2.1:** *Percent of persons denied services by service type.*

**COMMENT**: This indicator needs further specification. The concept of denial needs to be defined. For example, a plan that discourages persons from seeking mental health services may have few denials. Further, this indicator does not specify the desired denominator. The appropriate denominator would be persons requesting and those referred for mental health services.

We found no indicator in the literature that measured percent of persons denied services. The indicators we did find were framed more generally in terms of complaints and grievances. Admittedly, complaints and grievances are easier to measure than the concept of denial. It should also be noted that plans may differ in the number of denials, as well as the number of persons denied one or more services.

**EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE:**

**National Leadership Council**

**Indicator:** informal complaints and written grievances by clients should be less than 2% of individual provider caseload.

**Measure:** % of clients filing informal complaints and written grievances, per provider.

**Institute of Behavioral Healthcare Task Force Performance Standards**

**Indicator:** Percent of client complaints and grievances (Title: same).

**Measure:** # of clients with complaints and grievances/# of active clients during the period.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

### DATA ON INDICATOR

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | Other |
| **Age Groups** | All Ages |

**Data on measure**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | Yes |
| **Quality:** | Unknown | Unknown |
| **Respondent** | N/A | N/A |

**Task Force Indicator AC-2.2:** *Proportion of mental health service recipients (by population and service function) who successfully appealed a denial*

**Comment:** We found no indicators related to the proportion of service recipients successfully appealing a denial. However, we did find one indicator on the percent of **denials** overturned (see above note distinguishing number of persons from number of denials). The remaining indicators/measures are framed in terms of the denial appeals process. These latter measures address whether appeals structures are in place rather than how well they work.

**Examples of Related Indicators/Measures Identified in the Literature:**

**National Leadership Council**

**Indicator:** 100% of denial cases should be reviewed and signed by medical director.
**Measure;** % of denial cases reviewed and signed by medical director.

**Indicator:** 100% cases denied receive instructions for appeals process.
**Measure:** % denied cases receiving instructions for appeal process.

**Indicator:** No more than 25% of denials overturned in appeals process.
**Measure:** % of denials overturned in appeals process.

**Indicator:** 90% of appeals resolved within 30 working days.
**Measure:** % of appeals resolved within 30 working days.

**Institute for Behavioral Healthcare Task Force Performance Standards**

**Indicator:** Individuals appealing denials should receive instructions. (Title: Denial cases)

**Measure:** # of service denial cases that receive instructions for appeal/# service denial cases.

## CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

### DATA ON INDICATOR

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | Other |
| **Age Groups** | All Ages |

### DATA ON MEASURE

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | No |
| **Quality:** | Unknown | Unknown |
| **Respondent** | N/A | N/A |

## CONCERN AC-4: THE COST TO THE ENROLLEE SHOULD NOT BE SO LARGE AS TO DISCOURAGE THE USE OF NECESSARY MENTAL HEALTH SERVICES.

**Task Force Indicator AC-4.1** *The Proportion of service recipients who report cost as an obstacle to service utilization.*

**Comment: D**ata from questions such as the one presented below from the GHAA satisfaction survey provide useful information for the plan in assessing overall tolerance for expenses among all enrollees. However, *potential enrollees* will have a hard time relating the experiences of other enrollees to their personal financial situation in the absence of information about respondents' actual costs and their financial status. It might be more useful for a potential enrollee to know the actual annual out-of-pocket expenses for enrollees with particular conditions. This raises the issue, noted above, about what is appropriate for a *report card as opposed to a marketing brochure.*

### Examples of Related Indicators/Measures Identified in the Literature

**GHAA's Consumer Satisfaction Survey**

**Self-Report Question:** "Overall, considering the value of the care and services you get for what you pay, how would you rate:

- The part of the premium you pay for covered services?

-The amount you pay out-of-pocket (for example, co-payments, deductibles, payments for services not covered by your plan)?"

**Task Force Indicator AC-4.2** *Proportion of enrollees whose financial status requires the use of a sliding scale to calculate service and billing costs. (This should probably be re-worded to indicate the proportion of enrollees in financial need whose fees are calculated on a sliding scale.)*

**COMMENT:** We found no indicators/measures related to this indicator. As with the previous indicator, this indicator may be more useful to the provider organization than it is to the potential enrollee making a choice among Plans. It might be more useful to know what the Plan's eligibility requirements are for a sliding scale or reduced payment arrangement. Given this information, the potential enrollee can make a more informed judgment. Once again, though, this raises the report card vs. marketing brochure issue.

## APPROPRIATENESS

**Comment:** The Task Force identified several indicators related to service appropriateness. Two additional categories of indicators are also frequently associated with service appropriateness. These are readmission rates (frequently used as a measure of continuity of care) and match to need (i.e. the proportion of clients needing a service who actually receive it). Several indicators in these two categories were identified in the literature review and are included at the end of the appropriateness section.

### CONCERN AP-3: THE PLAN OFFERS SERVICES WHICH PROVIDE CONSUMERS AN OPPORTUNITY FOR RECOVERY.

**Task Force Indicator AP-3.1** *Proportion of service recipients who report that their services are oriented toward recovery.*

**COMMENT:** Our review of current report card efforts and the performance indicator literature did not turn up any measures directly related to this indicator. This is not too surprising given that the concept of "recovery" is only now beginning to be taken seriously by the research community. There is, as yet, no consensus about the meaning of the concept nor how to operationalize it for research purposes. Several evaluation research instruments, developed for other purposes, suggest dimensions of services that might imply a "recovery orientation." These service attributes include: client empowerment, vocational emphasis, de-emphasis of psychotherapy, service user participation in program decisions, focus on autonomy/independence and a practical orientation. Two instruments are included in the Appendix to provide Task Force members with some ideas about how others have sought to measure similar concepts. Neither of these is suggested as the perfect solution to the measurement of this Task Force indicator.

**ILLUSTRATIVE INSTRUMENTS:**

Measurement of Program Implementation. William A. Hargreaves

The Ward Atmosphere Scale. Rudolf H. Moos (Note: Moos has also developed a similar community program atmosphere scale)

## CONCERN AP-4: THE PLAN PROVIDES ENROLLEES WITH WELL ESTABLISHED CONTINUITY OF CARE.

**Task Force Indicator AP-4.1** *Proportion of enrollees who are referred to a (key) service and receive that service within X period of time.*

**COMMENT:** The indicators/measures identified in the literature search are all related to the transition between inpatient and outpatient service. The Task Force may want to include additional key services, such as follow-through for crisis/emergency services.

Note that the indicators listed below are of the type that include a standard. The Task Force should evaluate both the focus of the measure and the standard embedded in it.

### Examples of Related Indicators/Measures Identified in the Literature

**National Leadership Council**

**Indicator:** High Standard: Patients will receive aftercare services within 5 days of discharge.
**Measure:** % of patients receiving aftercare services within 5 days of discharge.

**Indicator:** Low Standard: Patients will be seen by MD for medication management at least once within the first 2 weeks of discharge.
**Measure:** % of patients seen by MD for medication management at least once within the first 2 weeks of discharge.

**Institute for Behavioral Healthcare Task force Performance Standards**

**Indicator:** Assure continuity of care between state hospitals and community mental health services.
**Measure:** # of patients receiving aftercare services within 5-14 days of discharge/ # of patients discharged.

## CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

### DATA ON INDICATOR

| | |
|---|---|
| **Consumer Involvement?** | No |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Unknown |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adult & senior |

### DATA ON MEASURE

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | Yes |
| **Quality:** | Unknown | Unknown |
| **Respondent** | N/A | N/A |

**Task Force Indicator AP-4.2** *The proportion of service recipients who maintain the same principal mental health care provider for the year (or for the term of treatment, whichever is less).*

**COMMENT:** No indicators/measures identified.

## CONCERN AP-1: SERVICE RECIPIENTS DEVELOP VOLUNTARY TREATMENT PLANS IN COLLABORATION WITH PROFESSIONALS.

**Task Force Indicator AP-1.1** *The proportion of service recipients who report active participation in decisions concerning their treatment plans.*

**COMMENT:** Two relevant indicators/measures were identified. Neither one reflects quit as much of a pro-active stance as the above indicator.

### Examples of Related Indicators/Measures Identified in the Literature

**RTI Mental Health Survey**

**Self Report Question:** "How would you rate your mental health professional in getting you involved in decisions about your care?"

**New Hampshire**

**Measure:** # of treatment plans completed and signed within a specified number of days from intake/total # of clients referred.

**Task Force Indicator AP-1.2** *The proportion of involuntary inpatient psychiatric admissions.*

**COMMENT:** There are many different types of involuntary commitments. The Task Force may wish to specify the measurement by type.

## CONCERN AP-9: ENROLLEES HAVE MEANINGFUL INVOLVEMENT IN PROGRAM POLICY AND PLANNING.

**Task Force Indicator AP-9.1:** *Proportion of (policy and planning group) board members who are consumers.*

**COMMENT:** This indicator should specify the types of consumers who would be counted in this measure. Presumably, the indicator refers to mental health consumers. Does consumer refer to primary consumers only or would secondary consumers (e.g. family members) qualify? Also, some organizations have claimed that professionals who used services many years ago quality as consumer representatives.

## CONCERN AP-7: SERVICE RECIPIENTS SHOULD RECEIVE INFORMATION THAT ASSISTS THEM IN MAKING INFORMED CHOICES ABOUT WHICH SERVICES THEY SHOULD SELECT.

**Task Force Indicator AP-7.1:** *Number of patient education information sheets regarding relevant information (e.g. medications, disorders, self-help groups) available for service recipients.*

**Task Force Indicator AP-7.2:** *Proportion of enrollees reporting that they received sufficient information to make informed choices about their selection of mental health services.*

## CONCERN AP-8: SERVICES SHOULD BE DELIVERED IN ACCORDANCE WITH KNOWN AND ACCEPTED BEST PRACTICE GUIDELINES.

**Task Force Indicator AP-8.1** *Services should be delivered according to best practice guidelines.*

**COMMENT:** No specific indicators/measures were identified. However, one might frame an appropriate measure in terms of the proportions of cases in which treatment for specified conditions (e.g. depression) was delivered in accordance with a specified set of accepted practice guidelines.

One might start with depression, and add other conditions in subsequent years as new guidelines are promulgated. Congruence with guidelines can be measured by judges or by computer algorithms that evaluate the match between "condition-treatment" pairs.

## ADDITIONAL INDICATORS/MEASURES RELATED TO CONTINUITY OF CARE

**Indicators/Measures related to Readmissions**

**COMMENT:** The Task Force did not include Readmissions as one of its selected indicators. However, the concept is frequently considered a key indicator when considering continuity of care. Clearly, though, "readmissions" is not an unambiguous concept. Readmissions may be a sign of good access, premature discharge, or poor community service.

The indicators listed below include standards, the content of which should be evaluated.

**National Leadership Council**

**Indicator:** High Standard: 5% or fewer patients readmitted within 90 days.
**Measure:** % of patients readmitted within 90 days.

**Indicator:** Low Standard: Less than 5% of patients readmitted within 30 days.
**Measure:** % of patients readmitted within 30 days.

**HEDIS 2.5**

**Indicator:** Readmissions for major affective disorders (Title: same).
**Measure:** # of members rehospitalized within 90 and 365 days/# of members hospitalized for major affective disorders.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Std. score |
| **Target Population** | Other |
| **Age Groups** | All ages |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | Yes |
| **Quality:** | Good | High |
| **Respondent** | N/A | N/A |

**United Behavioral Health Services**

**Measure:** One year mental health and substance abuse rehospitalization rate.

**Consortium Research on Indicators of System Performance Project**

**Indicator:** Appropriate level of care (Title: Hospital admission rate)

**Measure:** Total hospital readmissions/# of hospital admissions.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | Yes |
| **Quality:** | Unknown | Unknown |
| **Respondent** | N/A | N/A |

**INDICATORS/MEASURES RELATED TO THE MATCH BETWEEN SERVICES NEEDED AND THOSE RECEIVED**

**COMMENT:** One aspect of service appropriateness is frequently conceptualized as the match between services that are considered (either by the clinician or by the individual using services) to be needed and those received by the individual. Obviously, an important issue with such indicators is who judges need. It is also desirable for these measures to be specific with respect to age, gender and diagnosis so that potential enrollees can judge how plan practices might apply to them. Several indicators/ measures identified in the literature search are presented below.

**EXAMPLES OF RELATED INDICATORS/MEASURES IDENTIFIED IN THE LITERATURE**

**Minnesota Annual Performance Report**

**Indicator:** Meeting needs for case management services (title: same)

**Measure:** # of adults with SPMI who receive case management services/ estimated # of adults with SPMI who need case management services.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | No |
| **Quality:** | Good | Los |
| **Respondent** | N/A | N/A |

**Indicator:** Meeting needs for day treatment services (Title: same)
**Measure:** # of adults with SPMI who receive day treatment services/Estimated # of adults with SPMI who need day treatment services.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Unknown |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | No |
| **Quality:** | Good | Low |
| **Respondent** | N/A | Low |

**Indicator:** Unmet need for services will decrease (Title: SED children receiving needed service).

**Measure:** # SED children served who needed the targeted service/# of SED children who needed the targeted service.

## CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

### DATA ON INDICATOR

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SED Children |
| **Age Groups** | Children |

### DATA ON MEASURE

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | Yes |
| **Quality:** | Good | Unknown |
| **Respondent** | N/A | N/A |

**Healthy People 2000**

**Indicator:** Reduce morbidity of depression (Title: Treatment rates for depressive disorders).

**Measure:** # of persons with major depressive disorder who receive treatment/# of persons with major depressive disorder.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | No |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Unknown | Unknown |
| **In FN 10:** | No | No |
| **Quality:** | Unknown | Good |
| **Respondent** | Client | Client |

# OUTCOMES

## CONCERN O-1: ENROLLEES WITH MENTAL ILLNESS SHOULD HAVE EQUAL ACCESS TO EFFECTIVE GENERAL HEALTH CARE (RELATIVE TO GENERAL POPULATION).

**Task Force Indicator O-1.1** *Same indicators for adequate health care as general population, including self-report (e.g. BASIS-32. SF-36).*

**COMMENT:** The relationship between this concern and indicator is somewhat unclear. The concern speaks to *access to health care* but the indicator (if it is to be measured by instruments like the SF-36 or the BASIS-32) reflects *health status.*

### Examples of Related Indicators/Measures Identified in the Literature

**Consortium Research on Indicators of system Performance Project**

**Measure:** SF-36 Total Score/Total survey respondents (Title: General Health Index)

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | Other |
| **Age Groups** | All ages |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | No |
| **Quality:** | Unknown | Unknown |
| **Respondent** | Client | N/A |
| **Internal Consistency** | >8 | -.9 |
| **Retest Reliability** | >.75 | |
| **Factorial Reliability** | Good | |

**California Adult Performance Outcome Survey**

**Indicator:** Receive health care from MD or nurse (Title: same)

**Measure:** Received medical service, current wave/Received medical service, prior wave.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary & Secondary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Other |
| **Target Population** | SPMI |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Client | Client |

## CONCERN O-2: THE LEVEL OF PSYCHOLOGICAL DISTRESS FROM SYMPTOMS SHOULD BE MINIMIZED.

**Task Force Indicator O-2.1** *Average change in symptom scores over course of treatment (for particular populations).*

**COMMENT:** The concern covered in this section relates to psychological distress associated with symptoms. This indicator however, refers to changes in symptomatology. Psychological distress may not be perfectly correlated with the level of symptomatology.

Several indicators/measures identified in the literature search relate to symptom reduction or changes in symptomatology. Illustrative indicators/measures are presented below.

Additionally, a few candidate evaluation research instruments that are frequently used to measure symptomatology are identified. Available information on these instruments is included in the Appendix. Copies of these instruments that are not proprietary are also included in the Appendix. A more thorough review of instruments should be conducted prior to final selection.

Finally, this information should be case-mix adjusted. Once again, potential enrollees will want to know , how does this plan work for people like me, not for people in general.

### Candidate Instruments

**Brief Psychiatric Rating Scale (BPRS)**
**Behavior and Symptom Identification Scale BASIS-32**
**Colorado Client Assessment Record (C-Car)**
**Symptom Checklist (SCL-90)**
**SF- 36**

### Examples of Related Indicators/Measures Identified in the Literature

**Colorado Incentive System**

**Indicator:** Level of outcome over time (Title: same)

**Measure:** Change rating in severity between admission and discharge.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Range |
| **Target Population** | SPMI, drugs |
| **Age Groups** | All ages |

**DATA ON ADMISSION/DISCHARGE SEVERITY INDEX**

| | |
|---|---|
| **Available Data** | |
| **Data type:** | Observer |
| **In FN 10:** | Yes |
| **Quality:** | Good |
| **Respondent** | Clinical staff |
| **Internal Consistency** | .6-.9 |
| **Interrater Agreement** | .5-.9 |
| **Factorial Validity** | High |
| **Discriminant Validity** | Good |
| **Sensitivity to Change** | High |

**North Carolina Div. MH/DD/SA Division Outcomes**

**Indicator:** Maintain or improve functioning

**Measure:** Behaviors Subscale, Carolina Alternatives Questionnaire

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | SPMI |
| **Age Groups** | Child & Youth |

**DATA ON MEASURE**

| **Available Data** | **Numerator** |
|---|---|
| **Data type:** | Observer |
| **In FN 10:** | Yes |
| **Quality:** | Unknown |
| **Respondent** | Clinical staff |

**Healthy People 2000**

**Indicator:** Reducing morbidity: injurious adolescent suicide attempts

**Measure:** # of injurious adolescent suicide attempts/Population count of adolescents

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | Other |
| **Age Groups** | Youth |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Count |
| **In FN 10:** | No | No |
| **Quality:** | Good | High |
| **Respondent** | Client | N/A |

**Task Force Indicator O-2.2** *Symptom coping.*

**COMMENT:** In the measure reported below, note that "problems" are not necessarily the same as "symptoms."

**Examples of Related Indicators/Measures Identified in the Literature**

**United Behavioral Systems, Inc.**

**Indicator:** clients reporting improved coping skills

**Measure:** % of respondents responding "I'm more effective in coping with my problems." to the question: "Which of the following statements best describes how the services you received have changed the way you cope with your problems?"

## CONCERN O-3: THE PLAN SHOULD ADDRESS PROBLEMS AS DEFINED BY CONSUMERS (FOR WHICH THEY SEEK HELP).

**Task Force indicator O-3.1:** *Average score on consumer-rated effectiveness/change.*

**COMMENT:** A number of related indicators/measures are presented below. None of them adjust scores for age, diagnosis of stage of treatment. This is a serious omission. Potential enrollees will want to know how do these plans help people like me.

### Examples of Related Indicators/Measures Identified in the Literature

**United Behavioral Systems, Inc.**

**Indicator:** % of clients reporting improved problems.

**Measure:** % of respondents responding "My problems are better." to the question: "Which of the following statements best describes how the services you received have changed *the problems that brought you to the clinic?*" (Italics added.)

**Hawaii 1994 Program Evaluation Data Set for CMHCs.**

**Indicator:** Improve outcomes in outpatient therapy (Title: Outpatient therapy services outcome I).

**Measure 1:** # of outpatient therapy objectives attained/Total # outpatient therapy objectives.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Client | Client |

**Hawaii 1994 Program Evaluation Data Set for CMHCs.**

**Indicator:** Monitor and improve outcomes of biopsychosocial services (Title: Biopsychosocial rehabilitation outcomes I).

**Measure:** # of BPSR therapy objectives attained/Total # BPSR therapy objectives.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality**: | Low | Low |
| **Respondent** | Client | Client |

**Hawaii 1994 Program Evaluation Data Set for CMHCs**

**Indicator:** To monitor and improve the outcome of case management services (Title: Case management services outcome I).

**Measure:** # of case management objectives attained/# of case management objectives set.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Client | Client |

## CONCERN # O-4: ENROLLEES SHOULD EXHIBIT MINIMAL IMPAIRMENT FROM USE OF SUBSTANCES

**Task Force Indicator O-4.1** *Reduction in impairment in service recipients with substance abuse problems (children and adolescents, adults, seriously mentally ill).*

**COMMENT:** Several candidate evaluation research instruments that are frequently used to measure substance use are identified. Available information on these instruments is included in the Appendix. Copies of these instruments that are not proprietary are also included in the Appendix.

**CANDIDATE INSTRUMENTS:**

**Addiction Severity Index (ASI)**
**Clinician Alcohol Use Scale**
**Clinician Drug Use Scale**
**Substance Abuse Treatment Scale**

## CONCERN O-5: RECIPIENTS SHOULD EXPERIENCE MINIMAL LOSS OF PRODUCTIVE ACTIVITY IN WORK OR SCHOOL AS A RESULT OF ALCOHOL, DRUG, OR MENTAL DISORDERS.

**Task Force Indicator O-5.1:** *Proportion of service recipients reporting an increased number of days of performance of productive activity (work/studying/homemaking) in 30 day period: change over time.*

**COMMENT:** A variety of indicators/measures were identified in he literature search. Some report the number of hours worked, other report types of activities in which individuals engaged during a specified period of time.

To be most useful, data should be broken out by age, diagnosis, and stage of illness/ treatment.

### Examples of Related Indicators/Measures Identified in the Literature

**Washington Regional Support Network MIS**

**Indicator:** Increasing employment, self-esteem, independence (Title: same)
**Measure:** # of clients at each level of activity, employment being the highest.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| Available Data | Numerator |
|---|---|
| **Data type:** | Count |
| **In FN 10:** | No |
| **Quality:** | Low |
| **Respondent** | N/A |

**Washington Regional Support Network MIS**

**Indicator:** Increase employment for consumers. (Title: Net change in employment status)

**Measure:** Change in # of clients in each employment category.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Norms |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Child/youth |

**DATA ON MEASURE**

| Available Data | Numerator |
|---|---|
| **Data type:** | Count |
| **In FN 10:** | No |
| **Quality:** | Low |
| **Respondent** | N/A |

**California Adult Performance Outcome Survey**

**Indicator:** All persons should have the opportunity to engage in meaningful daily activities. (Title: Working 1 or more hours)

**Measure:** Work hours, current wave/work hours prior wave.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary & secondary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Other |
| **Target Population** | SPMI |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Client | Client |
| **Retest Reliability** | .9 | .9 |
| **Concurrent Validity** | .94 | .94 |

**New Hampshire Outcome Based Pis**

**Indicator:** Integration into community life, more productive life (Title: Time worked in integrated settings)

**Measure:** Time worked by clients/Total time @ 37.5 hours

## CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

### DATA ON INDICATOR

| | |
|---|---|
| **Consumer Involvement?** | Primary & secondary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

### DATA ON MEASURE

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | No |
| **Quality:** | Varies | Varies |
| **Respondent** | N/A | N/A |

**California Adult performance Outcome Survey**

**Indicator:** All persons should have opportunity to engage in meaningful daily activities (Title: Engaged in productive activity)

**Measure:** Did volunteer activities current wave/Did volunteer activities, prior wave.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary & secondary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Other |
| **Target Population** | SPMI |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Client | Client |
| **Retest Reliability** | .46 | .46 |
| **concurrent Validity** | .13 | .13 |

**Measure:** Educational activities, current wave/educational activities prior wave. (Title: Engaged in productive activity)

**CONTEXTUAL INFORMATION FOR ABOVE MEASURE**

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Good | good |
| **Respondent** | Client | Client |
| **Retest Reliability** | .18-.7 | .18-.7 |

**Measure:** Work hours, current wave/Work hours prior wave. (Title: Engaged in productive activity)

**CONTEXTUAL INFORMATION FOR ABOVE MEASURE**

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Client | Client |
| **Retest Reliability** | .9 | .9 |
| **Concurrent Validity** | .94 | .94 |

**Washington Regional Support Network MIS**

**Indicator:** Increased employment for consumers, increased independence (Title: Net change in employment status).

**Measure:** Change in # of clients in each employment category.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Norms |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Unknown |

**DATA ON MEASURE**

| Available Data | Numerator | |
|---|---|---|
| **Data type:** | Count | |
| **In FN 10:** | No | |
| **Quality:** | Low | |
| **Respondent** | N/A | |

**North Carolina Div. MH/DD/SA Outcomes**

**Indicator:** Gain work skills toward greater independence (Title: Work skills and self sufficiency).

**Measure:** Carolina Alternatives, subscale B.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Norms |
| **Target Population** | SPMI |
| **Age Groups** | Unknown |

**DATA ON MEASURE**

| **Available Data** | **Numerator** |
|---|---|
| **Data type:** | Observer |
| **In FN 10:** | No |
| **Quality:** | Unknown |
| **Respondent** | Clinical staff |

**RTI Mental Health Survey**

**Self-Report Question:** "During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?"

Cut down on the amount of time you spent on work or other activities?

Accomplished less than you would like?

Didn't do work or other activities as carefully as usual?

## CONCERN O-6: ENROLLEES SHOULD FUNCTION IN COMMUNITY SETTINGS OF THEIR CHOICE WITH OPTIMAL INDEPENDENCE FROM FORMAL SERVICE SYSTEMS.

**Task Force Indicator O-6.1** *% seriously emotionally disturbed children placed outside of the home.*

**COMMENT:** no indicators/measures directly related to out-of-home placement were identified.

**Oklahoma MH Information System**

**Indicator:** Assurance of appropriate level of care for children. (Title: Hospital admission rate for children)

**Measure:** Hospital admissions for , 18 years old/Population of service area.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Child/youth |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | Yes | No |
| **Quality:** | High | High |
| **Respondent** | N/A | N/A |

**Hawaii 1994 Program Evaluation Data Set for CMHCs**

**Indicator:** Improve biopsychosocial service outcomes (Title Biopsychosocial rehabilitation service outcome III)

**Measure:** # residential independence objectives attained/ # social residential independence listed in CM plan.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Client | Client |

**Task Force Indicator O-6.2** *Percent of adults with serious mental illness living in independent living situations of their choice.*

**COMMENT:** This indicator has a "double barrel quality. Although there may be only a few individuals who would choose to live in a supervised setting — the issue of "independence" should be separated from "choice." Additionally, independent living situation needs to be defined.

### Examples of Related Indicators/Measures Identified in the Literature

**MHSIP Performance Indicator Report**

**Indicator:** # of individuals with SPMI successfully placed in independent or supported housing/# of individuals with SPMI receiving community-based services for whom housing is identified as an issue in the treatment plan.

**Task Force Indicator O-6.3** *Service recipient level of functioning, self-care/ independent functioning measures.*

**COMMENT:** In addition to the indicators/measures identified in he literature search, this section also lists candidate instruments for measuring level of functioning. Copies of instruments are contained in Appendix A.

### Candidate Instruments

**Global Assessment of Functioning (GAF)**
**Social and Occupational Functioning Assessment Scale (SOFAS)**
**Behavior and Symptom Identification Scale (BASIS-32)**
**SF-36**
**Specific Level of Functioning (SLOF)**

### Examples of Related Indicators/Measures Identified in the Literature

**Oklahoma MH Information System**

**Indicator:** Appropriate and efficient care (Title: Improvement of life skills for intensively case managed clients).

**Measure:** # of clients with LOF scores sine previous assessment/# of clients with change in LOF since previous assessment.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Norms |
| **Target Population** | SPMI |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Observer | Observer |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Clinical staff | Clinical staff |

**North Carolina Div. MH/DD/SA Outcomes**

**Indicator:** Maintain or improve functioning (Title: Level of functioning in life domains)

**Measure 1:** Present Status Rating Scale

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Child/youth |

**DATA ON MEASURE**

| **Available Data** | **Numerator** |
|---|---|
| **Data type:** | Observer |
| **In FN 10:** | Yes |
| **Quality:** | Unknown |
| **Respondent** | Clinical staff |

**Measure 2:** Family Interview

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Child/youth |

**DATA ON MEASURE**

| Available Data | Numerator |
|---|---|
| **Data type:** | Interview |
| **In FN 10:** | No |
| **Quality:** | Unknown |
| **Respondent** | Family |

**Measure 3:** Child Interview

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Child/youth |

**DATA ON MEASURE**

| **Available Data** | **Numerator** |
|---|---|
| **Data type:** | Interview |
| **In FN 10:** | No |
| **Quality:** | Unknown |
| **Respondent** | Client |

**Texas Strategic Planning/Budgeting performance Measures**

**Indicator:** Achievement of optimal human potential (Title: level of functioning).

**Measure:** Levels of functioning of clients in current year/Levels of functioning of clients in prior year.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Range |
| **Target Population** | SPMI |
| **Age Groups** | All ages |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Observer | count |
| **In FN 10:** | Yes | Yes |
| **Quality:** | Good | Unkown |
| **Respondent** | Clinical staff | N/A |
| **Interrater Agreement** | .3-.9 | .3-.9 |
| **Concurrent Validity** | .1-.6 | .1-.6 |
| **Sensitivity to change** | .5-.8 | .5-.8 |

**California Adult Performance Outcome Survey**

**Indicator:** Supervision required in living situation (Title: same)

**Measure:** Staff rating of need for supervision in living situation, current wave/ Staff rating of need for supervision, prior wave.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary & secondary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Other |
| **Target Population** | SPMI |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Clinical staff | Clinical staff |

**Hawaii 1994 Program Evaluation Data Set for CMHCs**

**Indicator:** Monitor and improve outcome of outpatient activities and services (Title: Outpatient therapy services outcome II).

**Measure:** # of consumers showing higher LOF on C-CAR/# of consumers with outpatient therapy objectives.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Observer | Count |
| **In FN 10:** | Yes | Yes |
| **Quality:** | Low | Unknown |
| **Respondent** | Clinical staff | N/A |

**Task Force Indicator O-6.4:** *(elders) Age-adjusted ratio of enrollees in alternative and independent/family settings vs. nursing/institutional settings.*

**Task Force Indicator O-6.5:** *Percent of service recipients in most restrictive settings (e.g. hospital, jail, homeless, nursing).*

**COMMENT:** Is there any reason to make a distinction between general and Psychiatric hospitals? Data on persons in restrictive settings must be adjusted for sociodemographic and case mis characteristics. The number of persons in hospitals will relate to severity of case mix. Numbers of persons in jails and nursing homes will relate to sociodemographic factors.

**Examples of Related Indicators/Measures Identified in the Literature**

**Washington Regional Support Network MIS**

**Indicator:** Housing for homeless (Title: Net change in homeless status).

**Measure:** Number of clients in homeless categories.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Unknown |
| **Target Population** | SPMI/Acute |
| **Age Groups** | All ages |

**DATA ON MEASURE**

| **Available Data** | **Numerator** |
|---|---|
| **Data type:** | Count |
| **In FN 10:** | No |
| **Quality:** | Low |
| **Respondent** | **N/A** |

**Indicator:** Provide appropriate levels of support to maintain SMI in community (Title: Community tenure)

**Measure:** Months in community prior to a readmission/No. of persons readmitted between 1-25 months ago.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Norms |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | Yes |
| **Quality:** | Good | Good |
| **Respondent** | N/A | N/A |

**Texas Strategic Planning/Budgeting Performance Measures**

**Indicator:** Appropriate levels of support to maintain SMI in community (Title: community tenure).

**Measure:** LOS in community prior to a readmission/# of clients readmitted for period.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | None |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Norms |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Count | Count |
| **In FN 10:** | No | Yes |
| **Quality:** | Good | Good |
| **Respondent** | N/A | N/A |

**Minnesota Annual Performance Report**

**Indicator:** Crisis intervention services will divert inpatient admissions (Title: Crisis intervention service diversion form inpatient).

**Measure:** # of clients eligible for inpatient who are diverted with crisis intervention/Total # of clients eligible for inpatient.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Unknown |

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report (?) | Self report (?) |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Clinical staff | Clinical staff |

**Oklahoma MH Information System**

**Indicator:** Treatment efficacy and cost reduction (Title: Adult inpatient hospitalizations per month)

**Measure:** Adult inpatient hospitalization days per month.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | |
|---|---|---|
| **Data type:** | Count | |
| **In FN 10:** | Yes | |
| **Quality:** | High | |
| **Respondent** | N/A | |

**Task Force Indicator O-6.6:** *Percent of (child/adult) enrollees involved in legal system.*

**COMMENT:** Case-mix adjusted data.

### Examples of Related Indicators/Measures Identified in the Literature

**North Carolina Div. MH/DD/SA Outcomes**

**Indicator:** Maintain or improve functioning (Title: legal involvements)
**Measure:** Respondent: N/Carolina Alternatives, Subscale G.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Unknown |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI |
| **Age Groups** | Child/youth |

**DATA ON MEASURE**

| **Available Data** | **Numerator** |
|---|---|
| **Data type:** | Observer |
| **In FN 10:** | No |
| **Quality:** | Unknown |
| **Respondent** | Clinical staff |

## CONCERN O-7: ENROLLEES EXPERIENCE MINIMAL SOCIAL ISOLATION.

**Task Force Indicator O-7.1:** *Proportion of enrollees who report level of satisfactory social support and contacts.*

**COMMENT:** Adjustment factors should include family status, in addition to case mix and sociodemographic factors. One would expect that family status would be an important factor in social support and contacts.

### Examples of Related Indicators/Measures Identified in the Literature

**California Adult Performance Outcomes Survey**

**Indicator:** SPMI should develop and maintain social supports and link to their community (Title: Attend community recreational activities each month)

**Measure 1:** Level of participation in activities, current wave/Level of participation in activities, prior wave.

### CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary & secondary |
| **Used in Funding Decisions?** | Yes |
| **Type of Standard** | Other |
| **Target Population** | SPMI |
| **Age Groups** | Adult & senior |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Client | Client |
| **Retest Reliability** | .17-.48 | .17-.48 |
| **concurrent Validity** | .31 | .31 |

**Measure 2:** Who do you do things with, current wave/Who do you do things with, prior wave. (Title: Attend enjoyable activities with friends)

**CONTEXTUAL INFORMATION FOR ABOVE MEASURE**

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Client | Client |
| **Retest Reliability** | .24-.38 | .24-.38 |
| **Concurrent Validity** | .0-.44 | .0-.44 |

**Measure 3:** Sources of emotional support, current wave/Sources of emotional support, prior wave (Title: Uses non-MH network for emotional support)

**CONTEXTUAL INFORMATION FOR ABOVE MEASURE**

**DATA ON MEASURE**

| Available Data | Numerator | Denominator |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Good | Good |
| **Respondent** | Client | Client |

**Hawaii 1994 Program Evaluation Data Set for CMHCs**

**Indicator:** Improve biopsychosocial service outcomes (Title) Biopsychosocial rehabilitation service outcome II))

**Measure:** # social integration objectives attained/ # social integration objectives listed in CM plan.

**CONTEXTUAL INFORMATION FOR ABOVE INDICATOR/MEASURE**

**DATA ON INDICATOR**

| | |
|---|---|
| **Consumer Involvement?** | Primary |
| **Used in Funding Decisions?** | No |
| **Type of Standard** | Target |
| **Target Population** | SPMI/Acute |
| **Age Groups** | Adults |

**DATA ON MEASURE**

| **Available Data** | **Numerator** | **Denominator** |
|---|---|---|
| **Data type:** | Self report | Self report |
| **In FN 10:** | No | No |
| **Quality:** | Low | Low |
| **Respondent** | Client | Client |

**RTI Mental Health Care Survey**

**Self Report Question:** "During the past 4 weeks to what extent has your emotional problems interfered with your normal social activities with family, friends, neighbors or groups?"

## CONCERN O-8: RECIPIENTS SHOULD TAKE AN ACTIVE ROLE IN MANAGING THEIR OWN ILLNESSES.

**Task Force Indicator O-8.1:** *Mean rating of illness self-management (selected groups: SMI, older adults with mental illness).*

### Examples of Related Indicators/Measures Identified in the Literature

**Kent-Sussex Mental Health Functional Status Assessment**

**Self Report Question:** How easy is it for you to manage your own involvement in a treatment plan?

—Medication management?

—Other self-management?

## APPROPRIATENESS

### CONCERN P-1: CHILDREN AT HIGH RISK FOR BEHAVIOR DISORDERS WILL BE IDENTIFIED IN THE PLAN.

**Task Force Indicator P-1:** *Proportion of children screened for being at risk for behavior disorders.*

## CONCERN P-2: SKILL TRAINING AND PARENTING EDUCATION IS PROVIDED.

**Task Force Indicator P-2.1:** *Proportion of parents of high risk children receiving skill training and parenting education.*

**Task Force Indicator P-2.2:** *Proportion of high risk children receiving services/ education directed toward anger management.*

## CONCERN P-3: PLAN PROVIDES INFORMATION REGARDING SUBSTANCE USE AND DOMESTIC VIOLENCE.

**Task Force I Indicator p-3.1:** *Proportion of primary care physicians who receive education in mental health and substance abuse identification.*

**COMMENT:** It may be necessary to specify type of education. For example would all of the following qualify: professional preparation, continuing education, in-service training?

# SATISFACTION

Two instruments that have been developed to collect information on client satisfaction, clients' self reports of their health care experiences, and self report of health status are included in Appendix A.

# APPENDIX

# CANDIDATE INSTRUMENTS

BRIEF PSYCHIATRIC RATING SCALE
Overall and Gorham

DIRECTIONS: Place an X in the appropriate box to represent
Level of severity of each symptom.

Patient Name _____ Physician _____

Patient SS # _____ UT # _____ HH # _____ Date _____

| | Not Present | Very Mild | Mild | Moderate | Mod. Severe | Severe | Extremely Severe |
|---|---|---|---|---|---|---|---|
| SOMATIC CONCERN - preoccupation with physical health, fear of physical illness, hypochondriasis. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ANXIETY - worry, fear, over-concern for present or future, uneasiness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EMOTIONAL WITHDRAWAL - lack of spontaneous interaction, isolation deficiency in relating to others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CONCEPTUAL DISORGANIZATION - thought processes confused, disconnected, disorganized, disrupted. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| GUILT FEELINGS - self-blame, shame, remorse for past behavior. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| TENSION - physical and motor manifestations of nervousness, over-activation. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MANNERISMS AND POSTURING - peculiar, bizarre unnatural motor behavior (not including tic). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| GRANDIOSITY - exaggerated self-opinion, arrogance, conviction of unusual power of abilities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DEPRESSIVE MOOD - sorrow, sadness, despondency, pessimism. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HOSTILITY - animosity, contempt, belligerence, disdain for others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SUSPICIOUSNESS - mistrust, belief others harbor malicious or discriminatory intent. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HALLUCINATORY BEHAVIOR - perceptions without normal external stimulus correspondence. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MOTOR RETARDATION - slowed weakened movements or speech, reduced body tone. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNCOOPERATIVENESS - resistance, guardedness, rejection of authority. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNUSUAL THOUGHT CONTENT - unusual, odd, strange, bizarre thought content. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BLUNTED AFFECT - reduced emotional tone, reduction in formal intensity of feelings, flatness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EXCITEMENT - heightened emotional tone, agitation, increased reactivity. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DISORIENTATION - confusion or lack of proper association for person, place, or time. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Global Assessment Scale (Range 1-100)** _____

BRIEF PSYCHIATRIC RATING SCALE
Overall and Gorham

DIRECTIONS: Place an X in the appropriate box to represent
Level of severity of each symptom.

Patient Name _____ Physician _____

Patient SS # _____ UT # _____ HH # _____ Date _____

| | Not Present | Very Mild | Mild | Moderate | Mod. Severe | Severe | Extremely Severe |
|---|---|---|---|---|---|---|---|
| SOMATIC CONCERN - preoccupation with physical health, fear of physical illness, hypochondriasis. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ANXIETY - worry, fear, over-concern for present or future, uneasiness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EMOTIONAL WITHDRAWAL - lack of spontaneous interaction, isolation deficiency in relating to others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| CONCEPTUAL DISORGANIZATION - thought processes confused, disconnected, disorganized, disrupted. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| GUILT FEELINGS - self-blame, shame, remorse for past behavior. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| TENSION - physical and motor manifestations of nervousness, over-activation. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MANNERISMS AND POSTURING - peculiar, bizarre unnatural motor behavior (not including tic). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| GRANDIOSITY - exaggerated self-opinion, arrogance, conviction of unusual power of abilities. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DEPRESSIVE MOOD - sorrow, sadness, despondency, pessimism. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HOSTILITY - animosity, contempt, belligerence, disdain for others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SUSPICIOUSNESS - mistrust, belief others harbor malicious or discriminatory intent. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| HALLUCINATORY BEHAVIOR - perceptions without normal external stimulus correspondence. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| MOTOR RETARDATION - slowed weakened movements or speech, reduced body tone. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNCOOPERATIVENESS - resistance, guardedness, rejection of authority. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNUSUAL THOUGHT CONTENT - unusual, odd, strange, bizarre thought content. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| BLUNTED AFFECT - reduced emotional tone, reduction in formal intensity of feelings, flatness. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| EXCITEMENT - heightened emotional tone, agitation, increased reactivity. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| DISORIENTATION - confusion or lack of proper association for person, place, or time. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Global Assessment Scale (Range 1-100)** _____

*EXTENDED FORMAT FOR OUTCOME MEASURE*

| | | |
|---|---|---|
| *A.* | *Identification Section* | |
| *1.* | *Formal name of Measure or Procedure:* | Brief Psychiatric Rating Scale (BPRS) |
| *2.* | *Taxonomy Code (Use to Identify Comparison Measures):* | III-A-4 |
| *3.* | *Principal Author(s) and Key Reference:* | Overall, J. E. and Gorham, D. R. 1 |
| *4.* | *Derivative of/Supersedes Another or Earlier Measure?* | Yes. Factor-analytic derivative of Lorr Multidimensional Scale for Rating Psychiatric Patients (MSRPP) and Lorr Inpatient Multidimensional Psychiatric Scale (IMPS) 1 |
| *5a.* | *Brief Description of Measure or Technique—(Original or Principal Version only) :* | Eighteen symptom areas are rated on 7-point scales following a brief (18 minute 1) unstructured interview of client by a psychiatrist or psychologist. Authors recommend using two clinicians in a joint interview, with independent ratings made afterwards. Ratings are based upon observation of client and client's verbal report. Eighteen ratings are summed to yield a "total pathology" score. Composite "syndrome factor" scores may also be derived 2. Brief descriptions of each symptom area are included in the BPRS form; more detailed definitions are available in 1. |

| | | |
|---|---|---|
| *5b.* | *Variants of Original Procedure (for reference purposes only: remainder of Format Information may not pertain to these Variants) :* | Has undergone a number of revisions since 1962. Earlier versions of BPRS contained 14 and 16 items. Most research has involved the 16-item version 3. |
| *5c.* | *Other Language Versions Available, if any:* | Translations available in French, German, Czechoslovakian, Italian and Spanish 2. |
| *B.* | *Applications Section* | |
| *6.* | *Estimated Frequency of Use (Low, Medium, or High) :* | High |
| 7. | Appropriate "Target" Groups— | |
| a. | Age Groups: Child (5-12), Adolescent (13-17), Adult (18-64), Geriatric (65+) : | Adult (18-64); also seems appropriate for other age groups. |
| b. | Sex: | Both sexes |
| c. | Clinical/Diagnostic/Problem Groups (Groups on which measure was developed are underlined) : | All groups; developed on schizophrenics. |
| d. | Severity Range of Functional Impairment (Normal, Minimal, Moderate, Severe, Incapacitated) : | Minimal to incapacitated. |
| e. | Important Inappropriate Groups (If not already indicated or implied in 7a through 7d) : | Not applicable to non-clients. |

| | | |
|---|---|---|
| *8a.* | *Specific Functional Areas Assessed:* | Eighteen symptom areas: somatic concern, anxiety, emotional withdrawal, conceptual disorganization, guilt feelings, tension, mannerisms and posturing, grandiosity, depressive mood, hostility, suspiciousness, hallucinatory behavior, motor retardation, uncooperativeness, unusual thought content, blunted affect, excitement, and disorientation (latter two not on 16-item version) 1, 4. Composite scores may be derived for four syndrome factors: thinking disturbance (TD), withdrawal-retardation (WR), hostility-suspiciousness (HS), and anxiety-depression (AD) 2. |
| *b.* | *Key Theoretical Construct(s), if any, which the scale purports to measure, for which it is widely used as a measure, or on which it is founded:* | _____ |
| *c.* | *Nature of Assessment (Deficits, Assets/Growth Areas, or Mixed) :* | Deficits |
| *C.* | *Methodology and Procedures Section* | |
| *9.* | *Restrictions on Treatment Settings, Modalities, etc.* | No restrictions |
| *10.* | *"Subject" of the assessment if other than the client (e.g., an entire family):* | _____ |
| *11.* | *Time Span Covered by Assessment (Today, Last 3 Days, Past Month, etc.):* | Day of assessment plus unspecified prior period for client's self-reports. |
| *12.* | *Usual Points of Data Collection (pre- and post-treatment assessment times):* | AT intake, during treatment, at discharge, "follow-up" 4. |
| | *Data Collection Procedure:* | |
| 13. | Initial Assessment: | In-Facility Interview. |
| 14. | Post-Treatment or Follow-Up Assessment: | In-Facility Interview. |

| | | |
|---|---|---|
| *15.* | *Professional Training Level Required for Data Collection Procedure ("None" if Self-Administration by Client or Collateral is used):* | MD or PhD 3 |
| *16.* | *Important Limitations Imposed by Data Collection Procedures:* | Post-Assessments limited to clients still in the facility. |

*D.* *Psychometric Information Section*

| | | |
|---|---|---|
| *17.* | *Scale type (Single items only, Multi-item scale(s), Likert or Guttman-type scale(s), etc.):* | Single-item scales |
| *18.* | *Evidence for Reliability—* | |
| *a.* | *Internal Consistency (alpha, KR-20 or Reproducibility coefficients):* | Not applicable for overall single rating. |
| *b.* | *Inter-rater Agreement:* | Using earlier 14-item version, correlations of two interviewers' scores ranged from .52 to .90 with an average of .77. Correlations on the 16-item BPRS for two raters ranged from .56 to .87 with an average of .78 1. These figures are somewhat higher than similar correlations from the earliest BPRS version (range of .37 to .75, average of .59) 5. In all cases, it was unclear whether the two raters interviewed each client jointly or independently prior to ratings. |
| *c.* | *Test-retest, Alternate Forms Correlation:* | No information available |
| d. | Other Evidence (e.g., Components of Variance Analyses of Obtained Scores): | ———————— |

19. Evidence for Validity—

| | |
|---|---|
| *a. Content Validity (Includes Coverage of Domain, Representativeness of Items):* | Authors believe that BPRS symptom areas are similar to those considered by clinicians in evaluating a patient 1. Excellent coverage of symptom domain, particularly for more severe forms of pathology. Individual scale descriptions 1 are fairly detailed. Scale titles closely parallel common psychopathological constructs. |
| *b. Criterion Validity (Includes Concurrent and Predictive Validity studies):* | In one study (N = 149), the 16-item BPRS scales showed a canonical correlation of .65 with the Katz Adjustment Scales, .71 with the MMPI scales, .63 with the Psychotic Reaction Profile, .54 with global ratings of pathology by nurses, .61 with psychiatric residents' ratings, and .51 with patients' self-ratings. The BPRS was found to be superior at classifying subjects into four diagnostic groups (although diagnoses and BPRS ratings were made by same person, unlike other measures) 6. Canonical correlations of the BPRS with both self- and other-rated Personal Adjustment and Role Skills (PARS) scales yielded R's of only .29 for both 7. The validity of the shorter BPRS as a substitute for the MSRPP in evaluating drug effects is suggested by a correlation of .93 between change scores on the two measures 3. |

| | | |
|---|---|---|
| *19c.* | *Construct Validity (Includes Convergent and Discriminant Validity, evidence of Multidimensionality, expected Relationships and "Behavior" of Scores):* | Using cluster analysis, eight mean symptom profiles (e.g., "anxious depression") have been derived from BPRS scores. Subjects grouped according to profile type have been found to be similar on background data, and to have different pharmacotherapeutic requirements 8. A cross-cultural study revealed that psychiatrists in four countries interpreted these "phenomenological classifications" similarly; correlations between conceptual profiles and empirical cluster profiles ranged from .58 to .91, with a mean of about .80 9. However, others have found that psychiatrists' intuitive concepts of the eight profile types only showed 65% agreement with empirical profiles derived from 2,000 actual cases 10. Basing BPRS scales on the factor-analytically derived MSRPP scales implies relative scale independence. |
| *d.* | *Sensitivity to Change (Evidence of Response of client scores to Developmental or Treatment factors judged likely to cause change):* | One psychopharmacological study (N = 57) reported significant treatment effects on 13 of the 16 scales, in all four syndrome factors, and a mean improvement of 28.0 points in the total pathology score representing "highly significant change" 11. |
| *20.* | *Aids to Interpretability of Scores—* | |
| *a.* | *Target Group (age, sex, diagnosis, etc.) Means, Ranges, etc.:* | *No information available* |

| | | |
|---|---|---|
| *20b.* | *Community or Other Non-Client Norms (national, state, local, or specific groups—e.g., college students):* | Not applicable to non-clients |
| *c.* | *Pre-to Post-Treatment Change Norms:* | No information available |
| d. | Other Factors Affecting Interpretation of Scores: | _____ |
| *e.* | *Typical Shape of the Measure's Score Distributions:* | No information available |

E. Cost Information Section

Direct Data Collection Costs

| | | |
|---|---|---|
| 21. | Respondent Completion Times (Converted to whole and fractions of Hours)— | |
| *a.* | *Initial (Pre-Treatment) Assessment:* | .33 hours |
| *b.* | *Post-Treatment or Follow-Up Assessment* | .33 hours |
| | ***** | |
| *22d.* | *Scoring Costs, if significant:* | $0 |
| | ***** | |
| 26. | Approximate Direct Costs — | |
| *a.* | *Single Small-Sample Study Cost (N = 100):* | $2,100 |
| *b.* | *Larger Annual Program Outcome Survey Cost (N = 400):* | $8,400 |

Measure Acquisition/Training/ Maintenance Costs

| | | |
|---|---|---|
| 27. | Acquisition Costs— | |
| *a.* | *One-Time Purchase or Charter Cost:* | “No charge for forms or processing if done through NIMH’s Early Clinical Drug Evaluation Unit (ECDEU)” 4; other cost-information not available for rev: |
| *b.* | *Materials Costs for 500 Pre-post pairs annually:* | $200 (estimated) |
| | ***** | |
| 28. | Initial Staff Training Costs (Facility Staff costs only)— | |
| *a.* | *Number of Staff that must be Trained in Assessment Procedure in a typical facility:* | 4 |
| *b.* | *Estimated Hours of Training per Staff Member:* | 3 hours |
| | ***** | |
| *29.* | *Other Essential First-Year Costs (see Commentary):* | $0 |
| 30. | Subsequent Yearly Maintenance Costs— | |
| *a.* | *Percentage of Original Training Time Required Annually to Maintain Skills:* | 10% |
| | ***** | |

| | | |
|---|---|---|
| | Total Annual Client Outcome Measure Cost | |
| *32b.* | *Total Annual Measure Cost for N = 400 evaluation survey (Direct Costs plus annualized Acquisition/ Training/Maintenance Costs):* | $8,706 |
| *33.* | *Percentage of an Assumed Agency Budget of $1.5 million:* | 0.6% |
| F. | Utility Section | |
| | ("Yes" responses generally indicate greater utility.) | *Yes, No, or Other* |
| 34. | Selected Aspects of Utility from the Client's perspective: | |
| *a.* | *Would my assessment score indicate directly (without statistical analysis) whether my treatment was a success?* | No |
| *b.* | *Would my score show whether I still needed further treatment?* | No |
| *c.* | *Would previous clients' scores show if I might be harmed by treatment or suffer negative side effects?* | No |
| *35.* | *Selected Aspects of Utility from a client Collateral's perspective:* | |
| *a.* | *Would our relative assessment score indicate directly whether his/her treatment was a success?* | No |
| *b.* | *Would the score show whether he/she needed further treatment?* | No |
| *c.* | *Would the score(s) show how troublesome to the family our relative was likely to be?* | No |
| *d.* | *Would the score(s) indicate the likelihood of a relapse or recurrence of the problem?* | No |
| *36.* | *Selected Aspects of Utility from the perspective of Legislators, Citizen's Groups, and Regulators:* | |
| *a.* | *Are the measure's scores indicative of how the client feels about the treatment and/or his/her current functioning?* | No |

| | | |
|---|---|---|
| *36b.* | *Do the scores show whether the clients have improved to the point of not needing further treatment?* | No |
| *c.* | *Would outcome scores be essentially comparable for clients differing in sex, income, age, education or ethnicity?* | No information available |
| *d.* | *Does the measure assess areas of high social and community importance (e.g., productivity, dangerousness, or self-maintenance) with good face validity?* | No |
| *e.* | *Is a single overall outcome score available (particularly for relating outcomes to costs) and easy to interpret?* | Partially (individual scale scores can be summed, but resulting score may not be easily interpretable). |
| *f.* | *Assuming similar clients, would the scores for different agencies' programs be directly comparable, so that conclusions about relative effectiveness could be drawn?* | No (rater equivalence has not been established) |
| *g.* | *Are pre-post score norms for some identifiable client groups available so I can compare a program's success with these clients to other programs?* | No |
| *h.* | *Are the measure's scores likely to be free from potential distortion by performance pressure, competition for funds, threatened cutbacks in funding, etc.?* | No |
| *i.* | *Are the scores derived from or indicative of the economic benefits of treatment resuming work, stopping welfare payments, etc.)?* | No |
| *j.* | *Is the measure easy to "fake", so that it could be used to cover up poor staff performance? ("No" is preferable.)* | Somewhat |
| *37.* | *Selected Aspects of Utility from the Clinician's perspective:* | |
| *a.* | *Are there separate scores for estimating outcome in important sub-areas of client functioning?* | Partially (limited to symptoms only). |

| | | |
|---|---|---|
| *37b.* | *Is a single overall outcome score available and easy to interpret?* | Partially (see Item 36e) |
| *c.* | *Does the assessment lead directly to a diagnosis and/or suggest a treatment plan (e.g., use or discontinuance of medication, hospitalization or discharge, etc.)?* | Yes (see discussion of “profi8le types” in Item 19c) |
| *d.* | *Does the data collection procedure interfere in any significant way whit routine service operations, extra interview, more time required, etc.? (“No” is preferable.)* | Yes |
| *e.* | *Does the measure assume a “neutral” viewpoint about mental disorder that will not be incompatible with my own views?* | Yes |
| *f.* | *Can the measure be tailored to the problems or issues that my client and/or I select?* | No |
| *g.* | *Is the measure relatively “value-free”, i.e., does not rely on socially approved or conventional behavior to define what is “good” versus “poor” functioning?* | Yes |
| *h.* | *Does the measure lend itself to use as an ongoing indicator (e.g., by session or by week) of client status against which to check my own observations and/or treatment plans?* | No |
| *i.* | *Even though our clients do differ in problem type and severity, can my clients’ outcome scores be compared directly to scores of clients treated by other clinicians, and thus show my relative performance?* | No |
| 38. | Selected Aspects of Utility for Managers: | |
| *a.* | *Is the measure available at a low total annual cost (below 1% of a $1.5 million budget)?* | Yes |
| *b.* | *Is a single, overall outcome score available (particularly for relating outcomes to costs) and easy to interpret?* | Partially (see Item 36e) |

| | | |
|---|---|---|
| *38c.* | *Are separate functional-area scores available that would match up well to specific program outcome objectives?* | Partially (symptoms only) |
| *d.* | *Does the measure assess politically important outcomes (e.g., productivity, dangerousness, self-maintenance) with high "face-validity"?* | No |
| *e.* | *Does the measure lend itself to monitoring the individual effectiveness of each of my clinical staff?* | No |
| *f.* | *Would poor outcome scores help "diagnose" weak treatments or staff deficiencies in our programs?* | Yes |
| *g.* | *Are pre-post score norms for some identifiable client groups available so I can compare our success with these clients to other programs?* | No |
| *h.* | *Are the measure's scores likely to be free from distortion by funding or managerial pressures to improve outcomes?* | No |
| *i.* | *Would this measure be suitable for an in-depth, comparative study of the effectiveness of two alternative treatment procedures?* | Yes |
| *j.* | *Does the measure provide information on criteria commonly required for professional Quality Assurance/Peer Review procedures?* | Three (Current Functional Impairment, Mental Status, Personal Comfort) |
| *k.* | *Is the measure's content or procedure particularly well suited to "spotting trouble", or even helping me avoid scandal?* | No |

G. Critique of Measure Characteristics Section

39. Notable Strengths, Weaknesses, and Remaining Unresolved Issues in Five General Areas

a. Applications

*Notable Strengths:* Good coverage of individual symptomatology; general applicability (i.e., across client types). Translations are available in Spanish and other languages 2

*Weaknesses:* Solely symptom-oriented.

b. Methodology and Procedures

*Weaknesses:* May be difficult to persuade clients to return to facility for follow-up interview.

c. Psychometric Information

*Notable Strengths:* Empirical derivation via factor analysis.

*Weaknesses:* Inter-rater reliability data available only on relatively limited client samples (i.e., “newly admitted schizophrenics” 1-see Item 18b).

*Unresolved Issues:* Data regarding sensitivity to change following treatment were unavailable to this reviewer.

d. Cost Information

*Notable Strengths:* Relatively low cost to agency, particularly for a multi-dimensional scale.

*Unresolved Issues:* Are ratings by a single rater sufficiently reliable and valid to forego use of two raters? (See Items 18b and 20d).

e. Utility for Outcome Information Users

*Weaknesses:* Client, non-client, and pre-/post-treatment norms are not readily available.

*Unresolved Issues:* Are the “global pathology” scores and profile types useful in making comparisons across clients and between programs?

H. References Section

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6 Zimmermann, R. L., Vestre, N. D., and Hunger, S. H. Validity of family informants' ratings of psychiatric patients: General validity. Psychological Reports, 1975, 37, 619-630.

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8 Overall, J. E., and Hollister, L. E. Phenomenological classification of depressive disorders. Journal of Clinical Psychology, 1980, 36, 372-377.

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BASIS 32-A

BEHAVIOR AND IDENTIFICATION SCALE

Name _____ I.D.# _____ Date _____

INSTRUCTIONS

Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, WRITE IN THE BOX THE NUMBER that best describes THE DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA DURING THE WEEK BEFORE ADMISSION.

0 no difficulty
1 a little
2 moderate
3 quite a bit
4 extreme

For every area rated higher than "0" please indicate

HOW LONG HAVE YOU BEEN EXPERIENCING DIFFICULTY IN THIS AREA?

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is NO DIFFICULTY ("0").

Example

To what extent are you experiencing difficulty in the area of FRIENDSHIPS [2]

How long has this been a problem? 6 months

| TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF: | | HOW LONG HAS THIS BEEN A PROBLEM? Specify in weeks, months or years |
|---|---|---|
| 1. MANAGING DAY-TO-DAY LIFE (e.g., getting places on time, handling money, making every day decisions) | ☐ | _____ |
| 2. HOUSEHOLD RESPONSIBILITIES (e.g., shopping, cooking, laundry, keeping room clean, other chores) | ☐ | _____ |
| 3. WORK (e.g., completing tasks, performance level, finding/keeping a job) | ☐ | _____ |
| 4. SCHOOL (e.g., academic performance, completing assignments, attendance) | ☐ | _____ |

WRITE THE NUMBER IN THE BOX

| | |
|---|---|
| 0 | no difficulty |
| 1 | a little |
| 2 | moderate |
| 3 | quite a bit |
| 4 | extreme |

| TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF: | | HOW LONG HAS THIS BEEN A PROBLEM? Specify in weeks, months or years |
|---|---|---|
| 5. LEISURE TIME OR RECREATIONAL ACTIVITIES | ☐ | _____ |
| 6. ADJUSTING TO MAJOR LIFE STRESSES (e.g., separation, divorce, moving, new job, new school, a death) | ☐ | _____ |
| 7. RELATIONSHIPS WITH FAMILY MEMBERS | ☐ | _____ |
| 8. GETTING ALONG WITH PEOPLE OUTSIDE OF THE FAMILY | ☐ | _____ |
| 9. ISOLATION OR FEELINGS OF LONELINESS | ☐ | _____ |
| 10. BEING ABLE TO FEEL CLOSE TO OTHERS | ☐ | _____ |
| 11. BEING REALISTIC ABOUT YOURSELF OR OTHERS | ☐ | _____ |
| 12. RECOGNIZING AND EXPRESSING EMOTIONS APPROPRIATELY | ☐ | _____ |
| 13. DEVELOPING INDEPENDENCE, AUTONOMY | ☐ | _____ |
| 14. GOALS OR DIRECTION IN LIFE | ☐ | _____ |
| 15. LACK OF SELF-CONFIDENCE, FEELING BAD ABOUT YOURSELF | ☐ | _____ |
| 16. APATHY, LACK OF INTEREST IN THINGS | ☐ | _____ |
| 17. DEPRESSION, HOPELESSNESS | ☐ | _____ |
| 18. SUICIDAL FEELINGS OR BEHAVIOR | ☐ | _____ |
| 19. PHYSICAL SYMPTOMS (e.g., headaches, aches & pains, sleep disturbance, stomach aches, dizziness) | ☐ | _____ |

WRITE THE NUMBER IN THE BOX

| | |
|---|---|
| 0 | no difficulty |
| 1 | a little |
| 2 | moderate |
| 3 | quite a bit |
| 4 | extreme |

| TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF: | | HOW LONG HAS THIS BEEN A PROBLEM? Specify in weeks, months or years |
|---|---|---|
| 20. FEAR, ANXIETY OR PANIC | ☐ | _____ |
| 21. CONFUSION, CONCENTRATION, MEMORY | ☐ | _____ |
| 22. DISTURBING OR UNREAL THOUGHTS OR BELIEFS | ☐ | _____ |
| 23. HEARING VOICES, SEEING THINGS | ☐ | _____ |
| 24. MANIC, BIZARRE BEHAVIOR | ☐ | _____ |
| 25. MOOD SWINGS, UNSTABLE MOODS | ☐ | _____ |
| 26. UNCONTROLLABLE, COMPULSIVE BEHAVIOR (e.g., eating disorder, hand-washing, hurting yourself) SPECIFY _____ | ☐ | _____ |
| 27. SEXUAL ACTIVITY OR PREOCCUPATION | ☐ | _____ |
| 28. DRINKING ALCOHOLIC BEVERAGES | ☐ | _____ |
| 29. TAKING ILLEGAL DRUGS, MISUSING DRUGS | ☐ | _____ |
| 30. CONTROLLING TEMPER, OUTBURSTS OF ANGER, VIOLENCE | ☐ | _____ |
| 31. IMPULSIVE, ILLEGAL OR RECKLESS BEHAVIOR | ☐ | _____ |
| 32. FEELING SATISFACTION WITH YOUR LIFE | ☐ | _____ |

33. WHAT IS THE MOST IMPORTANT PROBLEM YOU WOULD LIKE THE HOSPITAL'S HELP WITH?

PLEASE TURN TO BACK PAGE TO COMPLETE QUESTIONNAIRE

PLEASE FILL IN THE INFORMATION BELOW:

1. Age _____

2. Sex ☐ male ☐ female

3. Marital Status ☐ single ☐ married ☐ sep/div ☐ widowed

4. Education (last grade completed) _____

5. Current Occupation (include student or homemaker) _____

6. Were you working any time in the month before admission? ☐ no ☐ yes

7. If so, how many hours a week? _____

8. Were you in school any time in the month before admission? ☐ no ☐ yes

9. If so, was it part-time or full-time? ☐ part-time ☐ full-time

10. If you were in school, what kind of program was it? ☐ non-degree ☐ degree

11. What was your <u>usual</u> living arrangement in the <u>year</u> before admission? ☐ with parents ☐ with spouse and/or children ☐ with friends ☐ alone ☐ dorm

Other, specify: _____

Office Use Only

Facility _____ Interviewer _____

Unit _____ Interview # _____

Interview Type: Narr._____ S-R_____ Mail_____ Tel:_____

Comments:

BASIS 32-B

BEHAVIOR AND IDENTIFICATION SCALE

Name_____ I.D.# _____ Date _____

INSTRUCTIONS

Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, WRITE IN THE BOX THE NUMBER that best describes THE DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA DURING THE WEEK.

0 no difficulty
1 a little
2 moderate
3 quite a bit
4 extreme

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is NO DIFFICULTY ("0").

Example

To what extent are you experiencing difficulty in the area of FRIENDSHIPS [2]

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

1. MANAGING DAY-TO-DAY LIFE (e.g., getting places on time, handling money, making every day decisions) [ ]
2. HOUSEHOLD RESPONSIBILITIES (e.g., shopping, cooking, laundry, keeping room clean, other chores) [ ]
3. WORK (e.g., completing tasks, performance level, finding/keeping a job) [ ]
4. SCHOOL (e.g., academic performance, completing assignments, attendance) [ ]

WRITE THE NUMBER IN THE BOX

| | |
|---|---|
| 0 | no difficulty |
| 1 | a little |
| 2 | moderate |
| 3 | quite a bit |
| 4 | extreme |

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

5. LEISURE TIME OR RECREATIONAL ACTIVITIES ☐
6. ADJUSTING TO MAJOR LIFE STRESSES (e.g., separation, divorce, moving, new job, new school, a death) ☐
7. RELATIONSHIPS WITH FAMILY MEMBERS ☐
8. GETTING ALONG WITH PEOPLE OUTSIDE OF THE FAMILY ☐
9. ISOLATION OR FEELINGS OF LONELINESS ☐
10. BEING ABLE TO FEEL CLOSE TO OTHERS ☐
11. BEING REALISTIC ABOUT YOURSELF OR OTHERS ☐
12. RECOGNIZING AND EXPRESSING EMOTIONS APPROPRIATELY ☐
13. DEVELOPING INDEPENDENCE, AUTONOMY ☐
14. GOALS OR DIRECTION IN LIFE ☐
15. LACK OF SELF-CONFIDENCE, FEELING BAD ABOUT YOURSELF ☐
16. APATHY, LACK OF INTEREST IN THINGS ☐
17. DEPRESSION, HOPELESSNESS ☐
18. SUICIDAL FEELINGS OR BEHAVIOR ☐
19. PHYSICAL SYMPTOMS (e.g., headaches, aches & pains, sleep disturbance, stomach aches, dizziness) ☐

WRITE THE NUMBER IN THE BOX

0 no difficulty
1 a little
2 moderate
3 quite a bit
4 extreme

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

20. FEAR, ANXIETY OR PANIC ☐

21. CONFUSION, CONCENTRATION, MEMORY ☐

22. DISTURBING OR UNREAL THOUGHTS OR BELIEFS ☐

23. HEARING VOICES, SEEING THINGS ☐

24. MANIC, BIZARRE BEHAVIOR ☐

25. MOOD SWINGS, UNSTABLE MOODS ☐

26. UNCONTROLLABLE, COMPULSIVE BEHAVIOR (e.g., eating disorder, hand-washing, hurting yourself) SPECIFY _____ ☐

27. SEXUAL ACTIVITY OR PREOCCUPATION ☐

28. DRINKING ALCOHOLIC BEVERAGES ☐

29. TAKING ILLEGAL DRUGS, MISUSING DRUGS ☐

30. CONTROLLING TEMPER, OUTBURSTS OF ANGER, VIOLENCE ☐

31. IMPULSIVE, ILLEGAL OR RECKLESS BEHAVIOR ☐

32. FEELING SATISFACTION WITH YOUR LIFE ☐

Office Use Only

Facility _____ Interviewer _____

Unit _____ Interview # _____

Interview Type: Narr._____ S-R_____ Mail_____ Tel:_____

Comments:

BASIS 32-C

BEHAVIOR AND IDENTIFICATION SCALE

Name_____ I.D.# _____ Date _____

INSTRUCTIONS

Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, WRITE IN THE BOX THE NUMBER that best describes THE DEGREE OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA DURING THE WEEK.

0 no difficulty
1 a little
2 moderate
3 quite a bit
4 extreme

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is NO DIFFICULTY ("0").

Example

To what extent are you experiencing difficulty in the area of FRIENDSHIPS [2]

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

1. MANAGING DAY-TO-DAY LIFE (e.g., getting places on time, handling money, making every day decisions) [ ]
2. HOUSEHOLD RESPONSIBILITIES (e.g., shopping, cooking, laundry, keeping room clean, other chores) [ ]
3. WORK (e.g., completing tasks, performance level, finding/keeping a job) [ ]
4. SCHOOL (e.g., academic performance, completing assignments, attendance) [ ]

WRITE THE NUMBER IN THE BOX

| | |
|---|---|
| 0 | no difficulty |
| 1 | a little |
| 2 | moderate |
| 3 | quite a bit |
| 4 | extreme |

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

5. LEISURE TIME OR RECREATIONAL ACTIVITIES ☐

6. ADJUSTING TO MAJOR LIFE STRESSES (e.g., separation, divorce, moving, new job, new school, a death) ☐

7. RELATIONSHIPS WITH FAMILY MEMBERS ☐

8. GETTING ALONG WITH PEOPLE OUTSIDE OF THE FAMILY ☐

9. ISOLATION OR FEELINGS OF LONELINESS ☐

10. BEING ABLE TO FEEL CLOSE TO OTHERS ☐

11. BEING REALISTIC ABOUT YOURSELF OR OTHERS ☐

12. RECOGNIZING AND EXPRESSING EMOTIONS APPROPRIATELY ☐

13. DEVELOPING INDEPENDENCE, AUTONOMY ☐

14. GOALS OR DIRECTION IN LIFE ☐

15. LACK OF SELF-CONFIDENCE, FEELING BAD ABOUT YOURSELF ☐

16. APATHY, LACK OF INTEREST IN THINGS ☐

17. DEPRESSION, HOPELESSNESS ☐

18. SUICIDAL FEELINGS OR BEHAVIOR ☐

19. PHYSICAL SYMPTOMS (e.g., headaches, aches & pains, sleep disturbance, stomach aches, dizziness) ☐

WRITE THE NUMBER IN THE BOX

0 no difficulty
1 a little
2 moderate
3 quite a bit
4 extreme

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

20. FEAR, ANXIETY OR PANIC ☐

21. CONFUSION, CONCENTRATION, MEMORY ☐

22. DISTURBING OR UNREAL THOUGHTS OR BELIEFS ☐

23. HEARING VOICES, SEEING THINGS ☐

24. MANIC, BIZARRE BEHAVIOR ☐

25. MOOD SWINGS, UNSTABLE MOODS ☐

26. UNCONTROLLABLE, COMPULSIVE BEHAVIOR (e.g., eating disorder, hand-washing, hurting yourself) SPECIFY _____ ☐

27. SEXUAL ACTIVITY OR PREOCCUPATION ☐

28. DRINKING ALCOHOLIC BEVERAGES ☐

29. TAKING ILLEGAL DRUGS, MISUSING DRUGS ☐

30. CONTROLLING TEMPER, OUTBURSTS OF ANGER, VIOLENCE ☐

31. IMPULSIVE, ILLEGAL OR RECKLESS BEHAVIOR ☐

32. FEELING SATISFACTION WITH YOUR LIFE ☐

PLEASE FILL IN THE INFORMATION BELOW:

1. What is your current living arrangement? ☐ with Parents ☐ with spouse and/or children ☐ with friends ☐ alone ☐ dorm

   Other, please specify _____

2. Marital Status ☐ single ☐ married ☐ sep/div ☐ widowed

3. Are you currently employed? no ☐ yes ☐

4. If so, how many hours per week? _____

5. Current occupation (include student or homemaker) _____

6. Are you currently in school? no ☐ yes ☐

7. If so, is it part-time or full-time? part-time ☐ full-time ☐

8. If you are in school, what type of program? non-degree ☐ degree ☐

9. Are you in individual therapy? no ☐ yes ☐

10. Are you in group therapy? no ☐ yes ☐

11. Are you in family therapy? no ☐ yes ☐

12. Are you attending AA or NA? no ☐ yes ☐

13. Is psychiatric medication currently prescribed for you? no ☐ yes ☐

14. If so, specify your prescribed medication(s) _____

    _____

    _____

15. If so, do you take the medication(s) as prescribed? ☐ usually ☐ sometimes ☐ rarely ☐ never

16. Are you receiving any other psychiatric treatment? no ☐ yes ☐

    Specify _____

17. Have you been rehospitalized at any time in the past six months? (including transfer to another hospital) no ☐ yes ☐

18. If so, where? _____

19. when? _____

20. for how long? _____

Eisen, Susan V., Dill, Diana L., Grob, Mollie C. (March 1994). Reliability and Validity of a Brief Patient- Report Instrument for Psychiatric Outcome Evaluation. *Hospital and Community Psychiatry.* Vol. 45 No. 3.

Ware, Jr.,John E., Sherbourne, Cathy Donald. (June 1992). The MOS 36-Item Short-Form Health Survey (SF-36). *Medical Care.* Vol. 30 No. 6.

McHorney, Colleen A., Ware, Jr, John E., Rogers, William., Raczek, Anastasia E., Lu, J. F. Rachel. (May 1992). The Validity and Relative Precision of MOS Short- and Long-Form Health Status Scales and Dartmouth COOP Charts. *Medical Care*. Vol. 30. No. 5. *supplement*.

AGENCY PROGRAM
CLIENT ID
MEDICAID ID
ADMISSION DATE: mm/dd/yy

VICTIM PROBLEMS Check all that Apply
—Ever Sexual Abuse Victim —Ever Verbal Abuse Victim
—Ever Physical Abuse Victim —Neglect

## CHANGE & PROBLEM SEVERITY

Rate the CHANGE SINCE THE LAST EVALUATION (CHNG)
Rate each area using the following scale:

| Much Worse | Worse | Somewhat Worse | No Change | Somewhat Better | Better | Much Better |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Rate the CURRENT PROBLEM SEVERITY (P-SEV)
Rate each area using the following scale:

None Slight Moderate Severe Extreme
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9

CURRENT P-SEV — Check all that Apply

EMOTIONAL WITHDRAWAL
—Stunted Affect —Underactive — Vacant
—Reticent —Passive — Subdued
—Distant —Reserved — Detached

DEPRESSION
—Depressed —Worthless — Lonely
—Hopeless —Dejected
—Desolate —Sleep Problem

ANXIETY
—Anxious —Fearful — Nervous
—Tense —Panic — Phobic
—Obsessive —Restless — Guilt

HYPER AFFECT
—Mania —Agitated — Overactive
—Sleep Deficit —Mood Swings — Elevated Mood
—Pressured Speech —Accelerated Speech

SUICIDE/DANGER TO SELF
—celceation —Suicide Plan — Suicide Attempt
—Past SuiAttempt —Self Injury
—Self Mutilation
—Danger to Self (CRS 27-10)

THOUGHT PROCESSES
—arre —Delusions — Hallucinations
—Suspicious —Paranoid — Repeated Thought
—Disorganized —Derailed — Loose Associations
—Illogical —Magical Thought — Unwanted Thought

COGNITIVE PROBLEMS
—cry —Confused — Intellect
—crete —ImpairedJudgmnt — Disoriented
—Attention Span —Lacks Self-Awareness

SELF-CARE/BASIC NEEDS (Doesn't)
—for Self —Manage Money — Provide Food
—Provide Housing —Manage Personal Environment
—e Use of Available Resources — Hygiene
—vely Disabled (CRS 27-10)

CHNG CURRENT P-SEV — Check all that Apply

RESISTIVENESS
—Uncooperative — Evasive — Resistive
—Guarded — Wary — Oppositional
—Antagonistic — Denies Problems — Refuses Treatment

AGGRESSIVENESS
—Aggressive — Hostile — Angry
—Belligerent — Threatening — "Notorious"
—Defiant — Intimidating

SOCIO-LEGAL PROBLEMS
—DisregardsRules — Dishonest — Uses/Cons Others
—Legal Problems — Offenses/Prop — Offenses/Persons
—Fire Setter — DestroyProperty — Pending Charges
—Probation — Parole

VIOLENCE/DANGER TO OTHERS Client to Others
—Violent — Assaultive — Physical Abuser
—Sexual Abuser — Homicidal Idea — Homicidal Threats
—Homicide Attempt
—Danger to Others (CRS 27-10)

ROLE PERFORMANCE (Work/School)
—Absenteeism — Performance — Behavior
—Terminations — Learning Disabilities
—Not Employable — Doesn't Read/Write
—Doesn't earn — Unstable Work/School History

FAMILY PROBLEMS Client Problems in Family
—No Family — No Contact w/Family
—w/Partner — w/Relative — w/Child
—w/Parent — Parenting — Acting Out

FAMILY ENVIRON Envir Causes Prob for Client
—Fam Instability — Separation — Custody
—Family Legal — Unstable Home Environment
—Family History of Mental Illness

FAMILY VIOLENCE Toward Client or FamMember
—Sexual Assault — Verbal Assault — Physical Assault

INTERPERSONAL PROBLEMS
—w/Friend — Establishing Relationships
—Social Skills — Maintaining Relationships

SUBSTANCE ABUSE PROBLEMS
—Alcohol — Drug(s) — Dependent
—Addicted — Interferes with Responsibilities
—DUI/DUID — Family History of Substance Abuse

MEDICAL/PHYSICAL
—Acute Illness — Chronic Illness — CNS Disorder
—Nutrition — Eating Disorder — Physical Handicap
—Enuretic — Encopretic — MedicalCareNeeded
—Developmental Disability — Perm Disability
—Attention Deficit Disorder
—Injury by Abuse/Assault

CHNG CURRENT P-SEV

OVERALL DEGREE OF PROBLEM SEVERITY
SECURITY/MANAGEMENT

## SECURITY/MANAGEMENT

CHNG CURRENT P-SEV — Check all that Apply

SECURITY/MANAGEMENT ISSUES

__Restraint __Surveillance __ Close Supervision
__Seclusion __Locked Unit __ BehaviorManagement
__Security __Time Out __ Suicide Watch
__Walkaway/Escape Medication Compliance

## STRENGTHS/RESOURCES

Check all CURRENT STRENGTHS/RESOURCES individual has:

ECONOMIC RESOURCES

__Employment __Housing __ Financial
__Transportation __SSI/SSDI __ Medical Insurance
__Medicaid/Medicare

EDUCATION/SKILL RESOURCES

__Education __Intelligence __ Language Skills
__Job Skills __Interpersonal Skills

PERSON RESOURCES

__Spouse __Parent(s) __ Child(ren)
__Other Family __Friend(s) __ Others

PERSONAL STRENGTHS

__Insight __ Judgment __ Responsibility
__Emot Stability __ Adaptability __ Resourcefulness
__Tolerance __ Appearance __ Health
__Thought Clarity __ Empathy

## LEVEL-OF-FUNCTIONING

Rate the CURRENT LEVEL-OF-FUNCTIONING (LOF) for each area using the following scale:

| Very Low | | Moderately Low | | | Moderately High | | Very High |
|---|---|---|---|---|---|---|---|
| 10 - | 15 - | 20 - | 25 - | 30 - | 35 - | 40 - | 45 - 50 |
| Low | | Slightly Low | | Slightly High | | High | |

FUNCTIONING

CHNG CURRENT LOF

[ ][ ] SOCIETAL/ROLE FUNCTIONING

[ ][ ] INTERPERSONAL FUNCTIONING

[ ][ ] DAILY LIVING/PERSONAL CARE FUNCTIONING

[ ][ ] PHYSICAL FUNCTIONING

[ ][ ] COGNITIVE/INTELLECTUAL FUNCTIONING

[ ][ ] OVERALL LEVEL OF FUNCTIONING

[ ] ACTION TYPE

| | |
|---|---|
| 01-Admission | 11-Correction to Admission |
| 02-Update | 12-Correction to Update |
| 03-Discharge | 13-Correction to Discharge |

[ ][ ][ ] EFFECTIVE DATE: mm/dd/yy

[ ][ ][ ] DATE FORM COMPLETED:mm/dd/yy

[ ][ ][ ][ ].[ ] CURRENT DIAGNOSIS

[ ] QA LEVEL (1,2,3,4)

## DISCHARGE

[ ][ ][ ] DISCHARGE DATE: mm/dd/yy

[ ][ ][ ] LAST CONTACT DATE:mm/dd/yy

[ ] TYPE OF TERMINATION:

| STAFF/AGENCY INITIATED | CLIENT INITIATED |
|---|---|
| 1-Discharged/Transferred | 6-Patient/ClientDied |
| 2-TX Completed/No Referral | 7-Patient/Client Term |
| 3-TX Completed/Follow-up | |
| 4-Evaluation Only | |

[ ] EXPECTED RESIDENCE AFTER DISCHARGE

| | |
|---|---|
| 1-Corrections/Jail | 6-Boarding Home |
| 2-Inpatient | 7-Homeless-in Shelter |
| 3-Nursing Home | 8-Homeless-on Street |
| 4-Residential-Mental Health | 9-Other Independent |
| 5-Residential-Non Mental | Living Arrangement |

[ ] EXPECTED LIVING ARRANGEMENT AFTER DISCHARGE

| | |
|---|---|
| 1-Lives w/Both Parents | 4-Lives Alone |
| 2-Lives w/One Parent | 5-Lives w/Unrelated |
| 3-Lives w/Spouse and/or Other Relative | Person(s) |

[ ] EXPECTED EMPLOYMENT AFTER DISCHARGE

| | |
|---|---|
| 1-Employed-Full Time | 6-Unemployed less |
| 2-Employed-Part Time | than 3 months |
| 3-Homemaker not otherwise Employed | 7-Unemployed 3 months or more |
| 4-Sheltered Employment | 8-Armed Forces Active |
| 5-Not in Labor Force | Military Duty |

[ ] TERMINATION REFERRAL: (See Back of Form)
Note use 61 “Self” if no Referral

[ ][ ][ ][ ][ ][ ][ ][ ][ ] STAFF ID STAFF SIGNATURE/DEGREE _____

[ ] DISCIPLINE: 1-none 2-mh worker 3-nursing 4-social 5-psychology 6-psychiatry 7-other

[ ] DEGREE : 1-none 2-associate 3-bachelors 4-masters 5-PhD/PsyD/EdD 6-MD 7-other

| | | |
|---|---|---|
| | AGENCY | PROGRAM |
| | CLIENT ID | |
| | MEDICAID ID | |
| | ADMISSION DATE: | mm/dd/yy |

VICTIM PROBLEMS Check all that Apply
__Ever Sexual Abuse Victim __Ever Verbal Abuse Victim
__Ever Physical Abuse Victim __Neglect

**PROBLEM SEVERITY**

Rate the CURRENT PROBLEM SEVERITY (P-SEV)
Rate each area using the following scale:

None Slight Moderate Severe Extreme
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9

CURRENT P-SEV — Check all that Apply

EMOTIONAL WITHDRAWAL
— Stunted Affect — Underactive — Vacant
— Reticent — Passive — Subdued
— Distant — Reserved — Detached

DEPRESSION
— Depressed — Worthless — Lonely
— Hopeless — Dejected
— Desolate — Sleep Problem

ANXIETY
— Anxious — Fearful — Nervous
— Tense — Panic — Phobic
— Obsessive — Restless — Guilt

HYPER AFFECT
— Mania — Agitated — Overactive
— Sleep Deficit — Mood Swings — Elevated Mood
— Pressured Speech — Accelerated Speech

SUICIDE/DANGER TO SELF
— celceation — Suicide Plan — Suicide Attempt
— Past SuiAttempt — Self Injury
— Self Mutilation
— Danger to Self (CRS 27-10)

THOUGHT PROCESSES
— arre — Delusions — Hallucinations
— Suspicious — Paranoid — Repeated Thought
— Disorganized — Derailed — Loose Associations
— Illogical — Magical Thought — Unwanted Thought

COGNITIVE PROBLEMS
— cry — Confused — Intellect
— crete — ImpairedJudgmnt — Disoriented
— Attention Span — Lacks Self-Awareness

SELF-CARE/BASIC NEEDS (Doesn't)
— for Self — Manage Money — Provide Food
— Provide Housing — Manage Personal Environment
— e Use of Available Resources — Hygiene
— vely Disabled (CRS 27-10)

RESISTIVENESS
— Uncooperative — Evasive — Resistive
— Guarded — Wary — Oppositional
— Antagonistic — Denies Problems — Refuses Treatment

CURRENT P-SEV — Check all that Apply

AGGRESSIVENESS
— Aggressive — Hostile — Angry
— Belligerent — Threatening — "Notorious"
— Defiant — Intimidating

SOCIO-LEGAL PROBLEMS
— DisregardsRules — Dishonest — Uses/Cons Others
— Legal Problems — Offenses/Prop — Offenses/Persons
— Fire Setter — DestroyProperty — Pending Charges
— Probation — Parole

VIOLENCE/DANGER TO OTHERS Client to Others
— Violent — Assaultive — Physical Abuser
— Sexual Abuser — Homicidal Idea — Homicidal Threats
— Homicide Attempt
— Danger to Others (CRS 27-10)

ROLE PERFORMANCE (Work/School)
— Absenteeism — Performance — Behavior
— Terminations — Learning Disabilities
— Not Employable — Doesn't Read/Write
— Doesn't earn — Unstable Work/School History

FAMILY PROBLEMS Client Problems in Family
— No Family — No Contact w/Family
— w/Partner — w/Relative — w/Child
— w/Parent — Parenting — Acting Out

FAMILY ENVIRON Envir Causes Prob for Client
— Fam Instability — Separation — Custody
— Family Legal — Unstable Home Environment
— Family History of Mental Illness

FAMILY VIOLENCE Toward Client or FamMember
— Sexual Assault — Verbal Assault — Physical Assault

INTERPERSONAL PROBLEMS
— w/Friend — Establishing Relationships
— Social Skills — Maintaining Relationships

SUBSTANCE ABUSE PROBLEMS
— Alcohol — Drug(s) — Dependent
— Addicted — Interferes with Responsibilities
— DUI/DUID — Family History of Substance Abuse

MEDICAL/PHYSICAL
— Acute Illness — Chronic Illness — CNS Disorder
— Nutrition — Eating Disorder — Physical Handicap
— Enuretic — Encopretic — MedicalCareNeeded
— Developmental Disability — Perm Disability
— Attention Deficit Disorder
— Injury by Abuse/Assault

SECURITY/MANAGEMENT ISSUES
— Restraint — Surveillance — Close Supervision
— Seclusion — Locked Unit — BehaviorManagement
— Security — Time Out — Suicide Watch
— Walkaway/Escape — Medication Compliance

OVERALL DEGREE OF PROBLEM SEVERITY

CHANGE IN OVERALL PROBLEM SEVERITY
1=Much Worse 2-=Worse 3=Somewhat Worse 4=No Change
5=Somewhat Better 6=Better 7=Much Better

## STRENGTHS/RESOURCES

Check all CURRENT STRENGTHS/RESOURCES individual has:

ECONOMIC RESOURCES
__ Employment __ Housing __ Financial
__ Transportation __ SSI/SSDI __ Medical Insurance
__ Medicaid/Medicare

EDUCATION/SKILL RESOURCES
__ Education __ Intelligence __ Language Skills
__ Job Skills __ Interpersonal Skills

PERSON RESOURCES
__ Spouse __ Parent(s) __ Child(ren)
__ Other Family __ Friend(s) __ Others

PERSONAL STRENGTHS
__ Insight __ Judgment __ Responsibility
__ Emot Stability __ Adaptability __ Resourcefulness
__ Tolerance __ Appearance __ Health
__ Thought Clarity __ Empathy

## LEVEL-OF-FUNCTIONING (LOF)

Circle ONE Response for Each LOF Area

SOCIETAL/ROLE FUNCTIONING

| Very Low | Low | Moder Low | Slight Low | Slight High | Moder High | High | Very High |
|---|---|---|---|---|---|---|---|

INTERPERSONAL FUNCTIONING

| Very Low | Low | Moder Low | Slight Low | Slight High | Moder High | High | Very High |
|---|---|---|---|---|---|---|---|

DAILY LIVING/PERSONAL CARE FUNCTIONING

| Very Low | Low | Moder Low | Slight Low | Slight High | Moder High | High | Very High |
|---|---|---|---|---|---|---|---|

PHYSICAL FUNCTIONING

| Very Low | Low | Moder Low | Slight Low | Slight High | Moder High | High | Very High |
|---|---|---|---|---|---|---|---|

COGNITIVE/INTELLECTUAL FUNCTIONING

| Very Low | Low | Moder Low | Slight Low | Slight High | Moder High | High | Very High |
|---|---|---|---|---|---|---|---|

OVERALL LEVEL OF FUNCTIONING

| Very Low | Low | Moder Low | Slight Low | Slight High | Moder High | High | Very High |
|---|---|---|---|---|---|---|---|

CHANGE IN LEVEL OF FUNCTIONING
1=Much Worse 2=Worse 3=Somewhat Worse 4=No Change
5=Somewhat Better 6=Better 7=Much Better

[ ] ACTION TYPE
01-Admission 11-Correction to Admission
02-Update 12-Correction to Update
03-Discharge 13-Correction to Discharge

[ ][ ][ ] EFFECTIVE DATE: mm/dd/yy

[ ][ ][ ] DATE FORM COMPLETED:mm/dd/yy

[ ][ ][ ][ ].[ ] CURRENT DIAGNOSIS

[ ] QA LEVEL (1,2,3,4)

## DISCHARGE

[ ][ ][ ] DISCHARGE DATE: mm/dd/yy

[ ][ ][ ] LAST CONTACT DATE:mm/dd/yy

[ ] TYPE OF TERMINATION:

STAFF/AGENCY INITIATED
1-Discharged/Transferred
2-TX Completed/No Referral
3-TX Completed/Follow-up
4-Evaluation Only

CLIENT INITIATED
6-Patient/ClientDied
7-Patient/Client Term

[ ] EXPECTED RESIDENCE AFTER DISCHARGE

1-Corrections/Jail
2-Inpatient
3-Nursing Home
4-Residential-Mental Health
5-Residential-Non Mental
6-Boarding Home
7-Homeless-in Shelter
8-Homeless-on Street
9-Other Independent Living Arrangement

[ ] EXPECTED LIVING ARRANGEMENT AFTER DISCHARGE

1-Lives w/Both Parents
2-Lives w/One Parent
3-Lives w/Spouse and/or Other Relative
4-Lives Alone
5-Lives w/Unrelated Person (s)

[ ] EXPECTED EMPLOYMENT AFTER DISCHARGE

1-Employed-Full Time
2-Employed-Part Time
3-Homemaker not otherwise Employed
4-Sheltered Employment
5-Not in Labor Force
6-Unemployed less than 3 months
7-Unemployed 3 months or more
8-Armed Forces Active Military Duty

[ ] TERMINATION REFERRAL: (See Back of Form)
Note use 61 "Self" if no Referral

[ ][ ][ ][ ][ ][ ][ ][ ][ ] STAFF ID STAFF SIGNATURE/DEGREE

[ ] DISCIPLINE: 1-none 2-mh worker 3-nursing 4-social 5-psychology 6-psychiatry 7-other

[ ] DEGREE : 1-none 2-associate 3-bachelors 4-masters 5-PhD/PsyD/EdD 6-MD 7-other

Definitions for Assessment/Discharge Form

AGENCY (per system requirements)

PROGRAM (per system requirements)

CLIENT ID ( “ )

MEDICAID ID ( “ )

ADMISSION DATE: ( “ )

**VICTIM PROBLEMS**

| | |
|---|---|
| Directions: | Select if client was ever a victim of any of the following abuses. |
| Sexual Abuse Victim | Client was sexually abused, possibly contributing to current psychological difficulties. |
| Verbal Abuse Victim | Client was verbally abused, possibly contributing to current psychological difficulties. |
| Physical Abuse Victim | Client was physically assaulted, possibly contributing to current psychological difficulties. |
| Neglect Victim | Client was ignored, cut-off from family and/or friends, discounted, or not cared-for. |
| Directions: | Rate the CHANGE SINCE THE LAST EVALUATION (CHNG) for each area using the scale. |

The person’s condition may have improved, deteriorated or remained unchanged. To the best of your knowledge,indicate which of these has occurred.

Directions: Rate the CURRENT PROBLEM SEVERITY (P-SEV) for each area using the scale:

GENERAL ABSTRACT ANCHOR GUIDELINES

| | |
|---|---|
| 1 = No Problem | Functioning in the domain is consistently average or better than what is typical for this person's age, sex, and subculture: no problem is present for this person in the domain. |
| 2 = No to Slight | (Use if Severity is between 1 = No and 3 = Slight). |
| 3 = Slight Problem | Person has a problem or problems in the domain. The problem may be intermittent or may persist at a low level. The problem has little or no impact on other domains. The problem is not urgent but may require therapeutic intervention in the future. |
| 4 = Slight to Moderate | (Use if Severity is between 3 = Slight and 5 = Moderate.) |
| 5 = Moderate Problem | The problem or problems may persist at a moderate level or become severe on occasion. Problems in this domain may be related to problems in other domains and do require therapeutic intervention(s). |
| 6 = Modeate to Severe | (Use if Severity is between 5 = Moderate and 7 = Severe.) |
| 7 = Severe Problem | The problem may be acute and severe or subacute but chronic. It almost always extends to other domains and involves other persons in interpersonal and/or social contexts. Hospitalization or some other form of external control is often needed in addition to other therapeutic intervention(s). |
| 8 = Severe or Extreme | (Use if Severity is between 7 = Severe and 9 = Extreme.) |
| 9 = Extreme Problem | The highest level of the scale, suggesting the person's behavior or situation is totally out of control, unacceptable, and potentially life-threatening. The problem is immediate and the need of control is urgent. |

Directions: Check all the ITEMS that apply in the given area. Generally, all the ITEMS grouped under the broad heading describe the given area. However, even though a particular ITEM describes the individual you are rating but doesn't appear to be associated with the heading, you may select the ITEM (for example, Sleep Problem may be present but no in connection with DEPRESSION.)

**EMOTIONAL WITHDRAWAL**

| | |
|---|---|
| Blunted Affect | Lacking in feeling; insensitive; dull; flat affect; slow to express feeling. |
| Underactive | Listlessness, lack of energy, low to no participation in daily activities. |
| Vacant | Lacking expression; blank. |
| Reticent | Inclined to keep on'es thoughts, feelings and personal affairs to oneself; uncommunicative; taciturn. |
| Passive | Relating to or characteristic of an inactive submissive role. Accepting or submitting without objection or resistance; compliant. |
| Subdued | Quiet; less forceful; under control; toned down. |
| Distant | Far removed mentally; remote. |
| Reserved | Marked by self-restraint. |
| Detached | Emotionally unresponsive; an absence of emotional involvement and an aloof, impersonal objectivity; introverted; remote. |

**DEPRESSION**

| | |
|---|---|
| Depressed | Loss of interest in usual activities; hopeless, flat affect, gloomy. |
| Worthless | Feels of no use or value to self or others; lack of self esteem. |
| Lonely | Feelings of isolation; alone, separate or empty. |
| Bored | A sense of lack of challenge, stimulation or change; unmotivated. |
| Hopeless | Having no hope, despairing, bleak. |
| Dejected | Being in low spirits; downcast; discouraged. |
| Sad | Affected or characterized by sorrow or unhappiness; somber. |
| Desolate | Bereft of friends; forlorn; forsaken; wretched. |
| Sleep Problem | Disturbance in frequency, amount or patterning of sleep. |

**ANXIETY**

| | |
|---|---|
| Anxious | Worry, distress, or agitation resulting from concern about something impending or anticipated. |
| Fearful | Unpleasant sensations associated with anticipation or awareness of danger. Includes phobias which are exaggerated, usually inexplicable and illogical, fears of particular objects or a class of objects. |
| Nervous | Jumpy, jittery, easily excited or irritated. |
| Tense | In a state of mental or nervous tension; taut; wired. |
| Panic | A sudden, overpowering fear or terror. |
| Phobic | Of, relating to, arising from, or having a phobia. Consistently reacting in a fearful manner to a circumscribed stimulus. |
| Obsessive | To be excessively preoccupied |
| Restless | Not able to relax or be still; no repose. |
| Guilt | A sense of having committed some breach of conduct; recrimination, blaming, self fault-finding. |

**HYPER-AFFECT**

| | |
|---|---|
| Mania | High level of uncontrolled excitement. |
| Agitated | Moved with violence or sudden force; stirred up; upset. |
| Overactive | Excessive movement, animation, e.g., pacing, incessant talking. |
| Sleep Deficit | Insufficiency in the frequency, amount, or patterning of sleep. |
| Mood Swings | Wide or dramatic shifts or swings from elated, euphoric to depressed, sad. |
| Elevated Mood | Lifted in spirit; elated; high. |
| Pressured Speech | A prolongation of sounds or syllables. |
| Accelerated Speech | Speech which is speeded up; quicker, faster than usual. |

**SUICIDE / DANGER TO SELF**

| | |
|---|---|
| Ideation | To form an idea of, conceive mental images or thoughts of suicide. |
| Plan | A scheme, program, or method worked out beforehand for committing suicide. |
| Attempt | To try to commit suicide. |
| Past Attempt | History of trying to commit suicide. |
| Self Injury | Damage or harm done to oneself. |
| Self Mutilation | To disfigure oneself by damaging irreparably. |
| Danger to Self | Person, as the result of mental illness, appears to be an imminent danger to him/herself. Restricted to behaviors that result in involuntary legal status under CRS 27-10-101, et seq. |

**THOUGHT PROCESSES**

| | |
|---|---|
| Bizarre | Thinking strikingly out of the ordinary; odd, eccentric. |
| Delusions | Belief(s) held in the face of evidence normally sufficient to destroy that belief. |
| Hallucinations | Perceptions which appear real to the client but are not supported by the objective stimuli or social consensus; basis may be organic or functional. |
| Suspicious | Is overly wary and distrustful; lacks confidence in others; questions their motives, doubts their reason. |
| Paranoid | Thinks thoughts or actions by others have reference to self in absence of clear evidence. |
| Repeated Thoughts | Words, phrases, and / or ideas that occur over and over; obsessive thinking. |
| Disorganized | Lacking coherence of thought; broken up system of thoughts. |
| Derailed | Inability to articulate a single, simple train of thought. |
| Loose Associations | A loose mental connection or relation between thoughts, feelings, ideas, or sensations. |
| Illogical | Contradicting or disregarding the principles of logic. Without logic, senseless. |
| Magical Thought | Belief that simply thinking one’s thoughts can cause things to happen. |
| Unwanted Thought | Intrusive, unbidden, possibly disturbing, disruptive, or threatening thoughts that may occur randomly or in connection with external events. |

**COGNITIVE PROBLEMS**

| | |
|---|---|
| Memory | Has loss of recent or remote memory, difficulty concentrating, focusing attention, forgetfulness. |
| Confusion | Unclear, bewildered, perplexed. Feels thigns are disordered, chaotic. |
| Intellect | Has difficulty in conceptualizing, understanding or limited intellectual capacity (IQ). |
| Concrete | Thinks literally, not abstractly; relates to things perceptible by the senses; real. Implication of rigidity; being locked on. |
| Impaired Judgement | Inability to adequately assess the impact of one's actions. Difficulty in self-monitoring. |
| Disoriented | Lack of orientation to time , place, person. |
| Attention Span | Limitation in ability to focus on current task or issues. |
| Lacks Self-Awareness | Not cognizant of one's effect on other people; not conscious of one's own self; can't differentiate oneself from other people or things. |

**SELF-CARE PROBLEMS**

| | |
|---|---|
| Care for Self | Does not maintain diet, clothing, prepare food, and / or keep up residence according to age-appropriate expectations, given the financial support available. |
| Manage Money | Does not allocate available funds according to age-appropriate expectations in order to meet needs. |
| Provide Food | At an age-appropriate level and within available resources, the inability to obtain food. |
| Provide Housing | At an age-appropriate level and within available resources, the inability to obtain housing. |
| Manage Personal Environment | Not maintaining personal living environment to minimum health and safety standards. |
| Make Use of Available Resources | Does not assess and effectively utilize available resources at an age-appropriate level. |
| Hygiene | Does not maintain conditions that promote good health, such as personal cleanliness. |
| Grave Disability | A condition in which a person, as a result of mental illness, is unable to take care of his / her personal needs or is making irrational or grossly irresponsible decisions concerning his / her person and lacks the capacity to understand this is so. Restricted to behaviors that result in involuntary status under the provisions of CSR 27-10-101 et seq. |

**RESISTIVENESS**

| | |
|---|---|
| Uncooperative | Refuses to conform to rules or structure; doesn’t work with others. |
| Evasive | Intentionally vague or ambiguous; equivocal; avoiding by deceit or cleverness. |
| Resistive | Inappropriately counteracting; opposing, withstanding the force or effect of something or someone; can be either active or passive. |
| Guarded | Cautious; restrained. |
| Wary | On guard; watchful. |
| Oppositional | To be resistant to; contrary; contradictory. |
| Antagonistic | One who contends against another; adversarial. |
| Denies Problems | Person does not acknowledge conditions or circumstances noted or defined by others as problems for the person. |
| Refuses Treatment | Person categorically or unconditionally refuses to be treated. |

**AGGRESSIVENESS**

| | |
|---|---|
| Aggressive | Inclined to behave in a overly assertive manner. |
| Hostile | Feeling or demonstrating animosity, ill will, or hatred. |
| Angry | Feeling or showing intense displeasure; incensed or enraged; furious; irate; wrathful. |
| Belligerent | Actively hostile, quarrelsome, contentious. |
| Threatening | Expressing or using threats; menacing; indicating danger or harm. |
| “Notorious” | Known widely and usually unfavorably; infamous. |
| Defiant | Marked by defiance; boldly or actively challening. |
| Intimidating | Coerces or inhibits by or as if by threats. |

**SOCIO-LEGAL PROBLEMS**

| | |
|---|---|
| Disregards Rules | The client does not consider ordinary societal controls as personally applicable, e.g., traffic signs, classroom rules, etc. |
| Dishonest | Deliberate lying, cheating, and / or fraud even though not always criminal. |
| Uses / Consn Others | Deliberately plays upon, manipulates, or controls others by deceptive or unfair means, usually to own advantage. |
| Legal Problems | Legal action is pending to which the client is a party. Does not include mental health commitment. |
| Offenses vs Property | The consequences of illegal and / or anti-social acts involving property are currently a problem. |
| Offenses vs Persons | The consequences of illegal and / or anti-social acts involving other people are currently a problem. |
| Fire Setter | Crime of maliciously, voluntarily, and willfully setting fire to public or private property; arsonist. |
| Destroys Property | Willful or malicious destruction of public or private property; vandalism. |
| Pending Charges | Person has criminal charges open and pending. |
| Probation | Person is in a legal status of probation as the result of criminal proceedings. |
| Parole | Person is in a legal status of parole following conviction, sentencing, and serving time in a criminal case. |

**VIOLENCE / DANGER TO OTHERS** (Client Toward Others - Family or non-Family)

| | |
|---|---|
| Violent | Exhibits extreme emotional or physical force; vehement feelings or expression. |
| Assaultive | Attacks others physically or verbally. |
| Physical Abuser | Person hurts or injures other(s) physically. |
| Sexual Abuser | Person hurts or injures other(s) sexually. |
| Homicidal Ideation | Person forms ideas or thoughts of killing another person or persons. |
| Homicidal Threats | Person expresses the intention to kill another person or persons. |
| Danger to Others | Person, as the result of mental illness, appears to be an imminent danger to others. Restricted to behaviors that result in involuntary legal status under CRS 27-10-101, et seq. |

**ROLE PERFORMANCE** (Work/School)

| | |
|---|---|
| Absenteeism | Frequent/extended/unexplained/unapproved absence from work, school, or training program. |
| Performance | Fails to meet expectations for job/role/school problem performance. |
| Behavior Problem | Nonparticipative, withdrawn, and/or disruptive; acting out in school, training program, or work setting. |
| Terminations | Suspended/fired/expelled from work, school, or training program. |
| Learning Disabilities | Impairment in reception, processing, or utilization of information. |
| Not Employable | At this point in time, given the person's current mental state, work history, and skills not employable without further training and support. |
| Doesn't Read/Write | Does not read or write at age-appropriate levels in any language. |
| Unstable Work/School History | Unpredictable; fluctuating; unsteady work or school experience. |

**FAMILY PROBLEMS** (Client Problems in Family)

| | |
|---|---|
| No Family | Family members are deceased or unknown to the individual. |
| No Contact w/Family | Family is alive and known to the person, however person is estranged from all family members and has no contact with them. |
| With Partner | An interpersonal difficulty involving spouse, mate, or primary partner; legal or common-law. |
| Parenting | Difficulties resulting from the parenting function (applies to children or parents). NOTE: Interpersonal difficulties between parents and child can obviously occur at any age; however, only those related to the parenting function should be reported under this item. |
| Acting Out | Rebellious behavior contrary to family rules or structure. |

**FAMILY ENVIRONMENT** (Environment Causes Problems for Client)

| | |
|---|---|
| Family Instability | Family in crisis; multiple problems, significant discord, lack of cohesiveness. |
| Separation | An agreement or a court decree terminating a spousal relationship. |
| Custody | The act or right of guarding, especially such a right granted by a court. Care, supervision, and control exerted by one in charge. |
| Family Legal | Legal problem between family members of either a civil and/or criminal nature, e.g., divorce, custody, charges of abuse. |
| Unstable Home Environment | Unpredictable; fluctuating family structure; potentially decomposing. |
| Family History of Mental Illness | Mental illness is present in the person's family and/or there is a history of mental illness in the family. |

**FAMILY VIOLENCE** (Family Member(s) toward Client or Between Family Members)

| | |
|---|---|
| Sexual Assault | A sexual attack on the client, a family member or members. |
| Verbal Assault | A verbal attack on the client, a family member or members. |
| Physical Assault | A violent physical attack on the client, a family member or members. |

**INTERPERSONAL RELATIONSHIPS**

| | |
|---|---|
| With Friends | An interpersonal problem involving persons other than close family member(s). |
| Establishing Relationships | Has difficulty making friends, developing close relationships or is so unselective in making friends that client is taken advantage of. |
| Social Skills | Lack of or difficulty in mastering dress, presentation, manners, verbal expression; factors associated with successful interactions w/others. |
| Maintaining Relationships | Difficulty keeping desired friends or relationships. |

**SUBSTANCE ABUSE PROBLEMS**

| | |
|---|---|
| Alcohol | Alcohol use presents a problem in person's life. |
| Drugs | Use of illicit, prescription, over the counter drugs, and / or other substances which presents a problem in the person's life. |
| Dependent | Person relies on alcohol or other substances for self-perceived optimal daily functioning. Performs less than optimally when discontinuing use. |
| Addicted | Person is unable to maintain daily functioning without the use of alcohol or drugs. Experiences withdrawal symptoms when discontinuing use. |
| Interferes with Responsibilities | Use of alcohol or drugs impairs person's ability to perform job, school, or other responsibilities. |
| DUI/DUID | The consequences of the person having been arrested one or more times for driving while intoxicated or under the influence of alcohol or drugs are currently a problem. Includes arrest or conviction for DUI or DUID. |
| Family History of Substance Abuse | Alcohol and / or drugs in the client's family or a history of such abuse. |

**MEDICAL PROBLEMS**

| | |
|---|---|
| Acute Illness | Any non-psychiatric illness / injury (e.g., broken bone, flu, mumps) of short duration, current, or during the past 3-4 weeks. |
| Chronic Illness Disorder | Any non-psychiatric illness / injury (e.g., diabetes, glaucoma) of long or potentially long length which needs to be controlled or contained. |
| Central Neurological | Behavior, cognitive, or effective problems or deficits indicating organic impairment of the brain or central nervous system. Can result from degenerative or traumatic conditions. |
| Nutrition | Client's nutrition (dietary balance, vitamin intake, etc.) or weight (gain or loss) are in need of correction. |
| Eating Disorder | Disruption in what is considered to be a normal eating pattern. |
| Physical Handicap | A physical condition that produces impairment (e.g., difficulty in seeing, hearing) in normal functioning. |
| Enuretic | Lacking normal voluntary control (incontinent) of urine. |
| Encopretic | Lacking normal voluntary control (incontinent) of feces. |
| Medical Care Needed | A physical condition requiring medical services. |
| Developmental Disability | A physical condition (e.g., loss of limb, sensory modality) which produces a permanent loss in normal functioning. |
| Attention Def. Dis. | Hyperactivity disorder. |
| Injury by Abuse/Asslt | Medical/Physical consequences resulting from rape, abuse or assault. |

**SECURITY/MANAGEMENT NEEDS**

Directions: Indicate each of the following currently needed or likely to be needed soon for this client.

| | |
|---|---|
| Restraint | Physical means of restricting movement of a client's limbs in order to prevent self-injury or physical assault on another person. |
| Surveillance | Constant watchfulness or vigilance of staff regarding a client that is otherwise allowed normal access to the milieu. |
| Close Supervision | Direct staff involvement with the client, controlling, directing or otherwise seeing that the client does what is needed or asked. |
| Seclusion | Removal of the client from the milieu to a separate room with the door closed so there is little or no interaction between the client and other persons. Client is closely monitored (approximately every 15 minutes) while in seclusion. |
| Locked Unit | A treatment unit with restricted ingress and egress controlled by locks on doors and windows. |
| Behavior Management | Direct staff involvement with the client, with staff prompting, coaxing, demanding the client perform specific tasks or duties. |
| Security | Assistance of security officers in managing behavior that has gone out of control. |
| Time Out | Removal of the client from the milieu to a separate area or room wtih the door open; usually of shorter duration than seclusion. |
| Suicide Watch | Continuous monitoring of a client in seclusion; specifically when there is high risk of suicide. |
| Walkaway/Escape Risk | Significant potential for physical departure or elopement. |
| Medication Compliance Risk | Significant potential for not taking medications as prescribed by physician. |

**RESOURCES**

Directions: Select any of the following that are currently strengths or resources for the client or likely will be in the near future.

**ECONOMIC RESOURCES**

| | |
|---|---|
| Employment | Performance of a task or tasks for wages, salary, or other remuneration. |
| Housing | A permanent structure providing shelter for the client and his / her belongings. |
| Financial | Monetary support other than from wages, salary. |
| Transport | Means for conveyance of client other than by foot. |
| SSI/SSDI | Federal entitlement benefits. |
| Medical Insurance | Private medical insurance |
| Medicaid/Medicare | Federal medical benefits. |

**EDUCATION/SKILL RESOURCES**

| | |
|---|---|
| Education | Client has skills gained through formal education. |
| Intelligence | Client has good ability to conceptualize and understand; normal or not otherwise limited in intellectual capacity. |
| Language Skills | Especially articulate or fluent in native tongue OR multi-lingual. |
| Job Skills | Special vocational skills that enhance opportunities for obtaining or retaining employment. |
| Interpersonal Skills | Relates well to others: interacts well verbally: makes and keeps friends> |

**PERSON RESOURCES**

| | |
|---|---|
| Spouse | Husband or wife who can and will help client. |
| Parent(s) | Mother or father who can and will help client. |
| Child(ren) | Offspring who can and will help client. |
| Other Family | Other relative who can and will help client. |
| Others(s) | Friend, colleague who can and will help client. |

**PERSONAL STRENGTHS**

| | |
|---|---|
| Own Insight | Understanding of one's own problem(s) sufficient to help in solving them. |
| Judgment | Ability to observe and interpret the consequences of one's own actions. |
| Responsibility | Ability to assume responsibility for one's own actions. |
| Emotional Stability | Person's ability to act and react to ordinary stresses of everyday life without disproportionate affect enhances chances for survival and happy, productive life. |
| Adaptability | Person is able to function effectively under a variety of conditions and in a wide range of circumstances. |
| Resourcefulness | Person uses available resources in constructive, creative ways that enhance functioning. |

Tolerance Person shows ability to accept wide range of persons, situations,.

| | |
|---|---|
| Appearance | Person appears orderly, organized in dress and habits which improves acceptance in society thereby decreasing chances for problems and increasing chances for desirable outcomes. |
| Health | Person enjoys good physical health for age, increasing chances for survival and good functioning. |
| Thought Clarity | Person's reasoning is especially good; has good logic. |
| Empathy | Person is sensitive to feelings, circumstances, difficulties of family or others. |

**LEVEL OF FUNCTIONING**

Directions: For all ratings, consider the person's problems, their severity, and the strengths/resources the person brings to the situation, then determine to the best of your ability, how well the person is currently functioning in each of the five specific areas and overall. A scale ranging from Very High to Very Low, is provided for recording your judgments.

Societal/Role Functioning This rating describes the person's functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules, and strong social mores.

Interpersonal Functioning This rating describes how well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings.

Daily Living/Personal Care This rating describes how well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter, and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, sex and culture.

Physical Functioning This rating describes the person's general physical health, nutrition, strength, abilities/disabilities, and illnesses/injuries.

Cognitive/Intellectual This rating describes the person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, sex and culture. The person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.

Overall Functioning This rating describes the person's global or overall functioning with respect to his/her age, sex and culture.

**ACTION TYPE**

Please indicate whether the data collected on this form describes the person at admission, at an update, or at discharge. This form may also be used for corrections to any earlier form of any of these three types.

**EFFECTIVE DATE**

This is the date the ACTION TYPE became effective. For example, Update or Discharge date.

**DATE FORM COMPLETED:**

Because the date this form is completed may be different from the EFFECTIVE DATE, please record DATE FORM COMPLETED.

**CURRENT DIAGNOSIS**

Please report the person’s current primary diagnosis.

QA Level

The person’s Level of Care (LOC) can be determined from the data collected on this form. If known, report the LOC here.

**DISCHARGE**

Discharge Date: The date the client was terminated from the agency.

Last Contact Date: The date of the last contact with the client, i.e. telephone or face-to-face therapeutic contact.

**Type of Termination**

There are two types of terminations:

Agency-initiated:

(1) Discharge/transfer - Client is being discharged from your agency/ organization and being transferred to another agency/organization. The responsibility for the client has been officially accepted by the receiving organization.

(2) Treatment Completed, No Referral - Client has completed treatment and no referral is made by the agency/organization discharging.

(3) Treatment Complete, Advise Follow-up - Client has completed treatment and additional services are advised by the agency/organization.

(4) Evaluation Only - Client was admitted for the purposes of evaluation only. No treatment services were expected or delivered.

(5) not used

Client-initiated

(6) Patient/Client Died - Occurs when client dies before completing treatment. Use the status of client when last seen to complete termination form.

(7) Patient/Client Ended Services - Occurs when a client terminates service before completing treatment in the opinion of the clinician. Use the status of the client when last seen to complete the termination form.

**EXPECTED RESIDENCE AFTER DISCHARGE:**

Code the appropriate category where the client is expected to live after termination. Use the same basic instructions as described for the PES-7A.

**EXPECTED LIVING ARRANGEMENT AFTER DISCHARGE:**

This item needs to be completed only if the response to place of residence was an 8 or 9 (independent living arrangement codes). Choose the response which best describes the persons with whom the client will share a living unit. If the response to place of residence was 1, 2, 3, 4, 5, 6 or 7 current living arrangement should be left blank.

**EXPECTED EMPLOYMENT STATUS AFTER DISCHARGE:**

Code the appropriate category which best describes the client’s expected employment status after termination from your agency. Use the same basic instructions as described for the PES-7A.

**TERMINATION REFERRAL:**

Refer to the code sheet and report where the client is being referred to upon termination from your agency. Use the same basic instructions as described for the PES-7A. If no referral is made at time of termination, use the code for Self Referral.

draft 03-05-95

dick ellis

*EXTENDED FORMAT FOR OUTCOME MEASURE**

A. Identification Section

| | | |
|---|---|---|
| *1.* | *Formal name of Measure or Procedure:* | Symptom Distress Checklist 90-Revised (SCL-90-R) |
| *2.* | *Taxonomy Code (Use to Identify Comparison Measures):* | III-A-1.<br>Primarily symptoms; Interpersonal Sensitivity scale deals with interpersonal relationships, but solely in terms of client's thoughts and feeling about these. |
| *3.* | *Principal Author(s) and Key Reference:* | Derogatis, L.R. 1 |
| *4.* | *Derivative of/Supersedes Another or Earlier Measure?* | Yes; the SCL-90-R is a revised version of the SCL-90 (2), involving changes in items and wordings; the latter was developed from the Hopkins Symptom Checklist (HSCL) 3. |
| *5a.* | *Brief Description of Measure or Technique—(Original or Principal Version only):* | 90-item, self-administered, self-report inventory measuring symptomatic psychological distress. Clients indicate how much each "complaint" has bothered them over a given time period using a 5-point scale ranging from "not-at-all" (0) to "extremely" (4). The measure is currently hand-scored and interpreted (computer scoring and interpretation are being developed) in terms of nine primary symptom dimensions and three global indices of distress (see Item 8a) 4, 5. |

*This format was prepared wit the assistance of Leonard R. Derogatis, Ph.D.

| | | |
|---|---|---|
| 5b. | *Variants of Original Procedure (for reference purposes only: remainder of Format Information may not pertain to these Variants):* | Authors note that the SCL-90-R was designed as one of a matched series of instruments which includes a 53-item form of the scale, the Brief Symptom Inventory (BSI), as well as two matched clinical observers' scales, the Hopkins Psychiatric Rating Scale (HPRS) and the SCL-90 Analogue Scale, which measures the same nine symptom constructs as the SCL-90-R 5.<br>All information reported below is derived from the SCL-90 literature and may not apply to these variants. Additional review of these variants is suggested prior to selection for use. |
| 5c. | *Other Language Versions Available, if any:* | "At present the SCL-90-R is available in Spanish, Portuguese, German, Italian, Dutch, Czechoslovakian, Japanese, Korean, Chinese, Vietnamese and several other Pacific Island languages." 5 |
| B. | Application Section | |
| 6. | *Estimated Frequency of Use (Low, Medium, or High):* | High |
| 7. | Appropriate "Target" Groups— | |
| a. | *Age Groups: Child (5-12), Adolescent (13-17), Adult (18-64), Geriatric (65+):* | Adults; authors report use with persons 13-70+ 5. |
| b. | *Sex:* | Both sexes (same form, separate norms) 5. |
| c. | *Clinical/Diagnostic/Problem Groups (Groups on which measure was developed are underlined):* | All outpatient or inpatient psychiatric andmedical groups 1, 5. |
| d. | *Severity Range of Functional Impairment (Normal, Minimal, Moderate, Severe, Incapacitated):* | Normal to severe |
| e. | *Important Inappropriate Groups (If not already indicated or implied in 7a through 7d):* | Inappropriate for acutely psychotic, retarded or otherwise severely disoriented clients; for illiterate or handicapped clients the measure may be read aloud in a "narrative mode" 1. |

| | | |
|---|---|---|
| *8a.* | *Specific Functional Areas Assessed:* | The nine primary symptom dimensions are: Somatization (SOM), Obsessive-Compulsive (OBS), Interpersonal Sensitivity (INT), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation (PAR) and Psychoticism (PSY). "The General Severity Index (GSI) combines information on number of symptoms and intensity of distress, while the Positive Symptom Total (PST) reflects only number of symptoms; the Positive Symptom Distress Index (PSDI) is a pure intensity measure, adjusted for number of symptoms present" 5. |
| *b.* | *Key Theoretical Construct(s), if any, which the scale purports to measure, for which it is widely used as a measure, or on which it is founded:* | _____ |
| *9.* | *Nature of Assessment (Deficits, Assets/Growth Areas, or Mixed):* | Deficits |
| C. | Methodology and Procedures Section | |
| *10.* | *Restrictions on Treatment Settings, Modalities, etc.* | No restrictions |
| *11.* | *"Subject" of the assessment if other than the client (e.g., an entire family):* | _____ |
| *12.* | *Time Span Covered by Assessment (Today, Last 3 Days, Past Month, etc.):* | Typically "the past 7 days including today", although other periods may be specified by user 1. |
| *13.* | *Usual Points of Data Collection (pre- and post-treatment assessment times):* | At intake, during treatment, at discharge, post-discharge follow-up 6. |
| 14. | Data Collection Procedure: | |
| *a.* | *Initial Assessment:* | In-Facility Self-Administration 1. |
| *b.* | *Post-Treatment or Follow-Up Assessment:* | In-Facility Self-Administration (although Mail-Out/Back Self-Administration has been used, e.g., in 7). |

| | | |
|---|---|---|
| *15.* | *Professional Training Level Required for Data Collection Procedure ("None" if Self-Administration by Client or Collateral is used):* | None (but clerical staff needed for scoring) |
| *16.* | *Important Limitations Imposed by Data Collection Procedures:* | Post-assessments limited to clients returning to the facility. |

D. Psychometric Information Section

| | | |
|---|---|---|
| *17.* | *Scale type (Single items only, Multi-item scale(s), Likert or Guttman-type scale(s), etc.):* | Multi-item scales. |
| *18.* | *Evidence for Reliability—* | |
| *a.* | *Internal Consistency (alpha, KR-20 or Reproducibility coefficients):* | Alphas ranging from .77 to .90 (average = .84) have been reported for the nine primary symptom dimensions of the older SCL-90 8. Others have computed an overall mean alpha of .95 for the SCL-90 over three repeated testings 9. |
| *b.* | *Inter-rater Agreement:* | Not applicable for self-rating scale; see Item 19c for correlations of SCL-90-R with other-rated versions (e.g., SCL-90 Analogue). |
| *c.* | *Test-retest, Alternate Forms Correlation:* | Test-retest coefficients reported for the nine symptom dimensions range from .78 to .90 (average = .84) based on 94 heterogeneous psychiatric outpatients tested over a one-week interval 1. in 9, test-retest coefficients for two successive two-week intervals are reported to range from .55 to .94 average = .81); average of the coefficients for two subject groups (total N = 92) for the second time interval only is .94. |
| *d.* | *Other Evidence (e.g., Components of Variance Analyses of Obtained Scores):* | The standard error measurement "based on both internal consistency and stability coefficients as estimates of reliability" was 0.085 for the Global Severity Index 9. |

19. Evidence for Validity—

*a. Content Validity (Includes Coverage of Domain, Representativeness of Items):*

Four new symptom dimensions were added to others factorially derived from the HSCL to provide more comprehensive symptom coverage. Both “face validity” and domain coverage appear to be excellent.

*b. Criterion Validity (Includes Concurrent and Predictive Validity studies):*

Studies comparing self-versus -clinician ratings on the nine symptom dimensions (see Item 5b) have reported mixed results. A comparison of cancer patients’ SCL-90 ratings with their treating physicians’ ratings of them on the SCL-90 Analogue Scale revealed “significant differences” in terms of perception of psychological symptoms. Another group, using the “90” to assess the level of agreement between psychiatric ER patients and their doctors, reported high agreement in the areas of depression and anxiety but low convergence in others 5. Correlations between the SCL-90 symptom dimensions and corresponding dimensions on the Hopkins Psychiatric Rating Scale (i.e., “psychiatrist’s version of the SCL-90") range from -.01 to .20, with only four of the nine correlations significant at the .05 level. The two measures’ global scores only correlated .06 7.

Correlations of SCL-90 symptom dimensions with like dimensions of the Middlesex Hospital Questionnaire (MHQ) yielded r’s ranging from .36 to .74 (average = .58); correlations of the SCL-90 Global Severity Index with the MHQ global score was an extremely high .92 1. Other researchers have found high concordance between SCL-90-R scores and those on the CES-D depression scale, Hamilton Depression Rating Scale, Social Adjustment Scale-Self Report, and the Raskin Depression Screen 5. Numerous studies demonstrate the utility of the SCL-90 (and -R) in discriminating between: breast cancer versus other female cancer patients, depressed versus non-depressed methadone users and alcoholics, rape victims from non-victims, and cases of post-traumatic stress disorder 5. A 1981 study (in press, cited in 5) reportedly demonstrates significant differences in SCL-90-R scores between various DSM-III diagnostic groups.

| | |
|---|---|
| *19c. Construct Validity (Includes Convergent and Discriminant Validity, evidence of Multidimensionality, expected Relationships and "Behavior" of Scores):* | One study contrasted the nine symptom dimensions of the SCL-90 with a total of 33 scales derived from the MMPI (i.e., the 13 clinical scales plus the 13 Wiggins content scales and the 7 Tryon cluster scales): "each of the 9 SCL-90...dimensions showed a peak correlation with an MMPI scale representing a highly corresponding symptom construct" 8. These peak correlations ranged from .50 to .75, reflecting good convergence between the two measures. However, some scales appeared to overlap heavily with non-identical constructs (e.g., anxiety, depression, and interpersonal sensitivity).<br>Factor loading of SCL-90 items via Varimax rotation of the nine symptom constructs indicate strong evidence of theoretical-empirical agreement for all dimensions but Psychoticism (only five of ten items loaded significantly), based on a sample of 1,002 heterogeneous psychiatric outpatients 10.<br>Additional construct validation for the Depression scale was shown in a multi-instrument study using unidimensional depression measures 11.<br>In 12, interscale correlations for the HSCL (6 shared dimensions with the SCL-90-R) indicate a fair degree of overlap for physicians' ratings (intercorrrelations range from .18 to .54; N = 320). However, intercorrelations for patients' self-ratings were considerably higher (.47 to .80), indicating considerable overlap, and possibly even a single dimension underlying these conceptually discrete areas. |
| d. Sensitivity to Change (Evidence of Response of client scores to Developmental or Treatment factors judged likely to cause change): | Numerous studies indicate sensitivity to treatment effects in various groups, including chronic anxiety disorders, depressives, schizophrenics, alcoholics, chronic pain patients, and various forms of sleep disturbance 5. The results of an outpatient therapy outcome study (N = 213) showed that both sexes showed improvement on the SCL-90 over four months, with women more improved than men; for both groups, changes on the Global Severity and Positive Symptom Distress Indices were significant at the .001 level 7. |

20. Aids to Interpretability of Scores—

| | |
|---|---|
| a. Target Group (age, sex, diagnosis, etc.) Means, Ranges, etc.: | Comprehensive descriptions of the normative samples are available in the Manual 1. Standard (T-score) norms are available for psychiatric outpatients, psychiatric inpatients, and non-patient normals; separate norms are available for each sex. Mean score profiles are available for specialized clinical groups (e.g., sexual disorders, alcoholics, etc.) 5. |
| b. Community or Other Non-Client Norms (national, state, local, or other specific groups—e.g., college students): | Available for a sample of 974 non-patient normals (separate norms for each sex) 1. Norms for adolescents and industrial executives reportedly will be introduced in 1981 5. |
| c. Pre- to Post-Treatment Change Norms: | “The first of a series of “change” norms will be completed for psychiatric outpatients” during 1981 5. Currently only mean admission and discharge score profiles for 120 female and 77 male psychiatric inpatients are available 1. |
| d. Other Factors Affecting Interpretation of Scores: | One study used the 84th percentile of the “normals” score distribution on the GSI as the criterion for “substandard” outcome, with good outcome scores falling below the 84th percentile 7. |
| e. Typical Shape of the Measure’s Score Distributions: | In 7, it was observed that in nearly every case, the distribution of SCL-90 scores was positively skewed, indicating that scores tend to “bunch up” at the lower or less disturbed end of the scale. |

*E.* *Cost Information Section*

*Direct Data Collection Costs*

| | | |
|---|---|---|
| 21. | Respondent Completion Times (Converted to whole and fractions of Hours)— | |
| a. | Initial (Pre-Treatment) Assessment: | .33 hours 1 (BSI takes .20 hours 1 |
| b. | Post-Treatment or Follow-Up Assessment | .33 hours |
| 22d. | Scoring Costs, if significant: | $1 (estimated) |
| 26. | Approximate Direct Costs — | |
| a. | Single Small-Sample Study Cost (N = 100): | $300 |
| b. | Larger Annual Program Outcome Survey Cost (N = 400): | $1,200 |

*Measure Acquisition/Training/ Maintenance Costs*

| | | |
|---|---|---|
| 27. | Acquisition Costs— | |
| a. | One-time Purchase or Charter Cost: | |
| b. | Materials Costs for 500 Pre-post pairs annually: | $15 (Manual plus Templates) |
| 28. | Initial Staff Training Costs (Facility Staff costs only)— | $270 (Rating Scales plus Score Profiles) |
| a. | Number of Staff that must be Trained in Assessment Procedure in a typical facility: | 2 (clerical scorers) |
| b. | Estimated Hours of Training per Staff Member: | 2 hours |
| 29. | Other Essential First-Year Costs (see Commentary): | $0 |
| 30. | Subsequent Yearly Maintenance Costs— | |
| a. | Percentage of Original Training Time Required Annually to Maintain Skills: | 0% |

*****

| | |
|---|---|
| Total Annual Client Outcome Measure Cost | |
| b. Total Annual Measure Cost for N = 400 evaluation survey (Direct Costs plus annualized Acquisition/Training/ Maintenance Costs): | $1,480 |
| Percentage of an Assumed Agency Budget of $1.5 million: | Less than 0.1% |
| Utility Section | |
| (“Yes” responses generally indicate greater utility.) | Yes, No, or Other |
| Selected Aspects of Utility from the Client’s perspective: | |
| Would my assessment score indicate directly (without statistical analysis) whether my treatment was a success? | No. No standard “cut-off” scores exist (see Item 20d). |
| Would my score who whether I still needed further treatment? | No |
| Would previous clients’ scores how if I might be harmed by treatment or suffer negative side effects? | No |
| Selected Aspects of Utility from a client Collateral’s perspective: | |
| Would our relative’s assessment score indicate directly whether his/her treatment was a success? | No (see Item 34a) |
| Would the score show whether he/she needed further treatment? | No |
| Would the score(s) show how troublesome to the family our relative was likely to be? | No |
| Would the score(s) indicate the likelihood of a relapse or recurrence of the problem? | No |
| Selected Aspects of Utility from the perspective of Legislators, Citizen’s Groups, and Regulators: | |
| Are the measure’s scores indicative of how the client feels about the treatment and/or his/her current functioning? | Yes |

| | | |
|---|---|---|
| 36b. | Do the scores show whether the clients have improved to the point of not needing further treatment? | No |
| c. | Would outcome scores be essentially comparable for clients differing in sex, income, age, education or ethnicity? | Probably (see Item 20a) |
| d. | Does the measure assess areas of high social and community importance (e.g., productivity, dangerousness, or self-maintenance) with good face validity? | No |
| e. | Is a single overall outcome score available (particularly for relating outcomes to costs) and easy to interpret? | Yes, but limited psychometric data available on this score (GSI) |
| f. | Assuming similar clients, would the scores for different agencies' programs be directly comparable, so that conclusions about relative effectiveness could be drawn? | Yes |
| g. | Are pre-post score norms for some identifiable client groups available so I can compare a program's success with these clients to other programs? | Not yet available (see Item 20c) |
| h. | Are the measure's scores likely to be free from potential distortion by performance pressure, competition for funds, threatened cutbacks in funding, etc.? | Yes |
| i. | Are the scores derived from or indicative of the economic benefits of treatment (resuming work, stopping welfare payments, etc.)? | No |
| j. | Is the measure easy to "fake", so that it could be used to cover up poor staff performance? ("No" is preferable.) | No |
| 37. | Selected aspects of Utility from the Clinician's perspective: | |
| a. | Are there separate scores for estimating outcome in important sub-areas of client functioning? | Partially (symptoms only) |

| | |
|---|---|
| Is a single overall outcome score available and easy to interpret? | Yes (but see Item 36e) |
| Does the assessment lead directly to a diagnosis and/or suggest a treatment plan (e.g., use or discontinuance of medication, hospitalization or discharge, etc.)? | No |
| Does the data collection procedure interfere in any significant way with routine service operations, extra interview, more time required, etc.? (“No” is preferable.) | No |
| Does the measure assume a “neutral” viewpoint about mental disorder that will not be incompatible with my own views? | Partially; many scales are linked to traditional psychiatric nosology. |
| Can the measure be tailored to the problems or issues that my client and/or I select? | No |
| Is the measure relatively “value-free”, i.e., does not rely on socially approved or conventional behavior to define what is “good” versus “poor” functioning? | Yes |
| Does the measure lend itself to use as an ongoing indicator (e.g., by session or by week) of client status against which to check my own observations and/or treatment plans? | Probably not; requires 20 minutes of client time. |
| Even though our clients do differ in problem type and severity, can my clients’ outcome scores be compared directly to scores of clients treated by other clinicians, and thus show my relative performance? | No |

Selected Aspects of Utility for Managers:

| | |
|---|---|
| Is the measure available at a low total annual cost (below 1% of a $1.5 million budget)? | Yes |
| Is a single, overall outcome score available (particularly for relating outcomes to costs) and easy to interpret? | Yes (but see Item 36e) |

| | | |
|---|---|---|
| 38c. | Are separate functional-area scores available that would match up well to specific program outcome objectives? | Partially (symptom areas only). |
| d. | Does the measure assess politically important outcomes (e.g., productivity, dangerousness, self-maintenance) with high “face-validity”? | No |
| e. | Does the measure lend itself to monitoring the individual effectiveness of each of my clinical stuff? | No |
| f. | Would poor outcome scores help “diagnose” weak treatments or staff deficiencies in our programs? | Possibly, within symptom areas only |
| g. | Are pre-post score norms for some identifiable client groups available so I can compare our success with these clients to other programs? | Not yet available (see Item 20c) |
| h. | Are the measure’s scores likely to be free from distortion by funding or managerial pressure to improve outcomes? | Yes |
| i. | Would this measure be suitable for an in-depth, comparative study of the effectiveness of two alternative treatment procedures? | Yes |
| j. | Does the measure provide information on criteria commonly required for professional Quality Assurance/Peer Review procedures? | One to two (Personal Comfort, Current Functional Impairment). |
| k. | Is the measure’s content or procedure particularly well suited to “spotting trouble”, or even helping me avoid scandal? | No |

## *Critique of Measure Characteristics Section*

### *Notable Strengths, Weaknesses, and Remaining Unresolved Issues in Five General Areas:*

#### *Applications:*

*Notable Strengths:* A simple form with demonstrated utility over a wide range of client and problem groups; well-suited for use as a repeated measure to assess changes over time.

*Weaknesses:* Only measures a standard set of symptoms, "does not provide for, or enable the client to indicate what special symptom(s) caused him or her to seek treatment in the first place" 4.

#### *Methodology and Procedures*

*Weaknesses:* No established procedure or form for mail-out/back self-administration.

*Unresolved Issues:* Unclear whether scores resulting from technician-assisted administration (as authors recommend 1) and self-administration are comparable.

#### *Psychometric Information*

*Notable Strengths:* Multi-dimensionality is suggested through factor analysis for all symptom dimensions except Psychoticism (see Item 19c); however, substantial scale intercorrelation is also apparent. T-score norms and score profiles are available for a variety of client groups.

*Weaknesses:* Convergence between SCL-90 (-R) and clinician-rating versions (e.g., SCL-90 Analogue) is not well established (see Item 19c); hence them two formats cannot be assumed to measure identical constructs.

*Unresolved Issues:* Remains to be seen whether the soon-to-be-published "change" norms (see Item 20c) will significantly increase the measure's utility as an evaluation instrument.

#### *Cost Information*

*Notable Strengths:* Available at a relatively low cost.

*Unresolved Issues:* Too early to assess the relative cost-effectiveness of scoring and interpreting the SCL-90-R by hand as opposed to via computer (see Item 5a).

#### *Utility for Outcome Information Users*

*Weaknesses:* Would be helpful to have separate norms for important subgroups (e.g., by ethnicity, socioeconomic status) or evidence that the measure is relatively insensitive to such client variables.

## H. References Section


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# SF-36 HEALTH SURVEY

INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

(circle one)

Excellent ..... 1

Very good ..... 2

Good ..... 3

Fair ..... 4

Poor ..... 5

2. *Compared to one year ago, how would you rate your health in general now?*

(circle one)

Much better now than one year ago ..... 1

Somewhat better now than one year ago ..... 2

About the same as one year ago ..... 3

Somewhat worse now than one year ago ..... 4

Much worse now than one year ago ..... 5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

| ACTIVITIES | Yes, Limited A Lot | Yes, Limited A Little | No, Not Limited At All |
|---|---|---|---|
| a. **Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports | 1 | 2 | 3 |
| b. **Moderate activities,** such moving a table, pushing a vacuum cleaner, bowling, or playing golf | 1 | 2 | 3 |
| c. Lifting or carrying groceries | 1 | 2 | 3 |
| d. Climbing **several** flights of stairs | 1 | 2 | 3 |
| e. Climbing **one** flight of stairs | 1 | 2 | 3 |
| f. Bending, kneeling, or stooping | 1 | 2 | 3 |
| g. Walking **more than a mile** | 1 | 2 | 3 |
| h. Walking **several blocks** | 1 | 2 | 3 |
| i. Walking **one block** | 1 | 2 | 3 |
| j. Bathing or dressing yourself | 1 | 2 | 3 |

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

| | **YES** | **NO** |
|---|---|---|
| a. Cut down on the **amount of time** you spent on work or other activities | 1 | 2 |
| b. **Accomplished less** than you would like | 1 | 2 |
| c. Were limited in the **kind** of work or other activities | 1 | 2 |
| d. Had **difficulty** performed the work or other activities (for example, it took extra effort) | 1 | 2 |

5. During the past 4 weeks, have you had any of the following problems with yoru work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(circle one number on each line)

| | | YES | NO |
|---|---|---|---|
| a. | Cut down the **amount of time** you spent on work or other activities | 1 | 2 |
| b. | **Accomplished less** than you would like | 1 | 2 |
| c. | Didn't do work or other activities as **carefully as** usual | 1 | 2 |

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(circle one)

Not at all ..... 1

Slightly ..... 2

Moderately ..... 3

Quite a bit ..... 4

Extremely ..... 5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

None ..... 1

Very mild ..... 2

Mild ..... 3

Moderate ..... 4

Severe ..... 5

Very severe ..... 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

Not at all ..... 1

A little bit ..... 2

Moderately ..... 3

Quite a bit ..... 4

Extremely ..... 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

(circle one number on each line)

| | **All of the Time** | **Most of the Time** | **A Good Bit of the Time** | **Some of the Time** | **A Little of the Time** | **None of the Time** |
|---|---|---|---|---|---|---|
| a. Did you feel full of pep? | 1 | 2 | 3 | 4 | 5 | 6 |
| b. Have you been a very nervous person? | 1 | 2 | 3 | 4 | 5 | 6 |
| c. Have you felt so down in the dumps that nothing could cheer you up? | 1 | 2 | 3 | 4 | 5 | 6 |
| d. Have you felt calm and peaceful? | 1 | 2 | 3 | 4 | 5 | 6 |
| e. Did you have a lot of energy? | 1 | 2 | 3 | 4 | 5 | 6 |
| f. Have you felt down hearted and blue? | 1 | 2 | 3 | 4 | 5 | 6 |
| g. Did you feel worn out? | 1 | 2 | 3 | 4 | 5 | 6 |
| h. Have you been a happy person? | 1 | 2 | 3 | 4 | 5 | 6 |
| i. Did you feel tired? | 1 | 2 | 3 | 4 | 5 | 6 |

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

All of the time ..... 1

Most of the time ..... 2

Some of the time ..... 3

A little of the time ..... 4

None of the time ..... 5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

| | Definitely True | Mostly True | Don't Know | Mostly False | Definitely False |
|---|---|---|---|---|---|
| a. I seem to get sick a little easier than other people | 1 | 2 | 3 | 4 | 5 |
| b. I am as healthy as anybody I know | 1 | 2 | 3 | 4 | 5 |
| c. I expect my health to get worse | 1 | 2 | 3 | 4 | 5 |
| d. My health is excellent | 1 | 2 | 3 | 4 | 5 |

# ADDICTION SEVERITY INDEX

Authors: A.T. McLellan, L. Luborsky, C.P. O'Brien, and G.E. Woody

Assessment Areas Covered: Mental health, physical health, employment, legal, alcohol consumption, drug use, family relations, social relationships, matching patients to treatment, diagnosis, prognosis

Administration: Structured interview is administered by an easily trained technician or counselor (30 to 40 minutes). Instructional materials and videotaped interviews are available for 2-day training sessions. Suitable for both alcohol- and drug-dependent adults (over 16 years of age), male or female, at screening, intake, and followup

Design Features: Utilizes seven independent problem assessments. Suitable for patient screening and "matching" patients to treatments by clinical staff at treatment admission. Suitable for repeated administration by researchers at followup to assess patient improvement.

Abstract: The Addiction Severity Index (ASI) is a clinical/research instrument that has been in wide use since 1979 to assess seven problem areas commonly found in alcohol- and drug-abusing patients. Results of concurrent reliability studies indicate that trained technicians can estimate the severity of patients' treatment problems with an average concordance of .89. Test-retest studies show that the information obtained from the ASI is consistent, even between different interviewers. Comparisons of the ASI severity ratings and composite measures with a battery of previously validated tests indicate strong evidence of discriminant validity. The reliability and validity results were consistent across subgroups of patients divided by age, race, sex, primary drug problem, or type of treatment program. Following 6 years of experience with the instrument, the authors feel that the ASI offers advantages in the examination of important issues such as the prediction of treatment outcome, the comparison of different forms of treatment, and the "matching" of patients to treatments.

Related Published Reports:

McLellan, A.T.; Luborsky, L.; Woody, G.E.; and O'Brien, C.P. An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous and Mental Disorders, 168:26-33, 1980.*

McLellan, A.T.; Luborsky, L.; Woody, G.E.; O'Brien, C.P.; and Kron, R. Are the "addiction-related" problems of substance abusers really related? Journal of Nervous and Mental Disease, 169:232-239, 1981.

McLellan, A.T.; Luborsky, L.; and O'Brien, C.O. Is treatment for substance abuse effective? Journal of the American Meidcal Association, 247:1423-1427, 1982.

McLellan, A.T.; Luborsky, L.; Woody, G.E.; O'Brien, C.P.; and Druley, K.A. Predicting response to alcohol and drug abuse treatment. Archives of General Psychiatry, 40:620-625, 1983.

Woody, G.E.; Luborsky, L.; McLellan, A.T.; O'Brien, C.P.; Beck, A.T.; Blaine, I.; Herman, I.; and Hole, A. Psychotherapy for opiate addiction: Does it help? Archives of General Psychiatry, 40:626-634, 1983.

Kosten, T.R.; Rounsaville, B.J.; and Kleber, H.D. Concurrent validity of the Addiction Severity Index. Journal of Nervous and Mental Disease, 171(10):606-610, 1983.

Availability Source: A. Thomas McLellan, Ph.D., Building 7, Philadelphia JAMC, Philadelphia, Pennsylvania 19104. There is a fee for reproduction and material costs involved in mailing the training materials.

INSTRUCTIONS

1. Leave No Blanks — Where appropriate code items: X = question not answered
   N = question not applicable
   Use only one character per item.
2. Item numbers printed in squares are to be asked at follow-up. Items with a red asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional pertinent information.

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in eac h area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual.

Third Edition

SUMMARY OF

PATIENT'S RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

---

I.D. NUMBER 1 [ ][ ][ ][ ]

LAST 4 DIGITS OF SSN [ ][ ][ ][ ]

DATE OF ADMISSION [ ][ ][ ][ ][ ][ ]

DATE OF INTERVIEW [ ][ ][ ][ ][ ][ ]

TIME BEGUN [ ][ ] : [ ][ ]

TIME ENDED [ ][ ] : [ ][ ]

CLASS: [ ]
1 – Intake
2 – Follow-up

CONTACT CODE: [ ]
1 – In Person
2 – Phone
3 – Mail

ORIGIN: [ ]
1 – PVAMC – DDTS
2 – Carrier Foundation
3 – Eagleville

TREATMENT EPISODE NUMBER [ ][ ]

INTERVIEWER CODE NUMBER [ ][ ]

SPECIAL: [ ]
1 – Patient terminated
2 – Patient refused
3 – Patient unable to respond

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

_____

_____

GEOGRAPHIC CODE [ ][ ]

1. How long have you lived at this address? [ ][ ] YRS. [ ][ ] MOS.
2. Is this residence owned by you or your family? [ ]
   0 – No 1 – Yes
3. DATE OF BIRTH [ ][ ][ ][ ][ ][ ]
4. RACE [ ]
   1 – White (Not of Hispanic Origin)
   2 – Black (Not of Hispanic Origin)
   3 – American Indian
   4 – Alaskan Native
   5 – Asian or Pacific Islander
   6 – Hispanic – Mexican
   7 – Hispanic – Puerto Rican
   8 – Hispanic – Cuban
   9 – Other Hispanic
5. RELIGIOUS PREFERENCE [ ]
   1 – Protestant 4 – Islamic
   2 – Catholic 5 – Other
   3 – Jewish 6 – None
6. Have you been in a controlled environment in the past 30 days? [ ]
   1 – No
   2 – Jail
   3 – Alcohol or Drug Treatment
   4 – Medical Treatment
   5 – Psychiatric Treatment
   6 – Other _____
7. How many days? [ ][ ]

TEST RESULTS

Shipley

C.Q. [ ][ ][ ]

I.Q. [ ][ ][ ]

Beck

Total Score [ ][ ] 62

Card [1] 80

SEVERITY PROFILE

| | PROBLEMS | MEDICAL | EMP/SUP | ALCOHOL | DRUG | LEGAL | FAM/SOC | PSYCH |
|---|---|---|---|---|---|---|---|---|
| 9 | | | | | | | | |
| 8 | | | | | | | | |
| 7 | | | | | | | | |
| 6 | | | | | | | | |
| 5 | | | | | | | | |
| 4 | | | | | | | | |
| 3 | | | | | | | | |
| 2 | | | | | | | | |
| 1 | | | | | | | | |
| 0 | | | | | | | | |

I.D. [1] [ ][ ][ ][ ]

1. *How many times in your life have you been hospitalized for medicalproblems? (Include a.d.'s, d.t.'s, exclude detox.)* [ ][ ]

2. How long ago was your last hospitalization for a physical problem? [ ][ ] YRS. [ ][ ] MOS.

3. Do you have any chronic medical problems which continue to interfere with your life? [ ]
   0 – No 1 – Yes

4. Are you taking any prescribed medication on a regular basis for a physical problem? [ ]
   0 – No 1– Yes

MEDICAL STATUS

5. *Do you receive a pension for a physical disability?* (Exclude psychiatric disability.) [ ]
   0 – No
   1 – Yes
   Specify _____

6. How many days have you experienced medical problems in the past 30? [ ][ ]

***FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE.***

7. How troubled or bothered have you been by these medical problems in the past 30 days? [ ]

8. *How important to you* now *is treatment for these medical problems?* [ ]

INTERVIEWER SEVERITY RATING

9. How would you rate the patient's need for medical treatment? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? [ ]
    0 – No 1 – Yes

11. Patient's inability to understand? [ ]
    0 – No 1 – Yes 20

**COMMENTS**

---

*1. Education completed *(GED = 12 years)* 21 [ ][ ] YRS. [ ][ ] MOS.

*2. Training or technical education completed [ ][ ] MOS.

3. Do you have a profession, trade or skill? [ ]
   0 – No
   1 – Yes _____
   Specify

4. Do you have a valid driver's license? [ ]
   0 – No 1 – Yes

5. Do you have an automobile available for your use? *(Answer No if no valid driver's license.)* [ ]
   0 – No 1 – Yes

6. How long was your longest full-time job? [ ][ ] YRS. [ ][ ] MOS.

*7. Usual (or last) occupation. [ ]
   _____
   *(Specify in detail)*

8. Does someone contribute to your support in any way? [ ]
   0 –No 1 –Yes

9. (ONLY IF ITEM 8 IS YES)
   Does this constitute the majority of your support? [ ]
   0 – No 1 – Yes

EMPLOYMENT/SUPPORT STATUS

10. Usual employment pattern, past 3 years. [ ]
    1 – full time (40 hrs/wk)
    2 – part time (reg. hrs)
    3 – part time (irreg., daywork)
    4 – student
    5 – service
    6 – retired/disability
    7 – unemployed
    8 – in controlled environment

11. How many days were you paid for working in the past 30? *(Include "under the table" work.)* [ ][ ]

How much money did *you* receive from the following sources in the past 30 days?

12. Employment *(net income)* [ ][ ][ ][ ]
13. Unemployment compensation [ ][ ][ ][ ]
14. DPA [ ][ ][ ][ ]
15. Pension, benefits or social security [ ][ ][ ][ ]
16. Mate, family or friends *(Money for personal expenses).* [ ][ ][ ][ ]
17. Illegal [ ][ ][ ][ ]

18. How many people depend on you for the majority of their food, shelter, etc.? [ ]

19. How many days have you experienced employment problems in the past 30? [ ][ ]

***FOR QUESTIONS 19 & 20 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE***

20. How troubled or bothered have you been by these employment problems in the past 30 days? [ ]

21. How important to you *now* is counseling for these employment problems? [ ]

INTERVIEWER SEVERITY RATING

22. How would you rate the patient's need for employment counseling? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by: [ ]

23. patient's misrepresentation?
    0 – No 1 – Yes

24. Patient's in ability to understand?
    0 – No 1 – Yes 71 [ ]

I.D. 1 [ ][ ][ ][ ]

CODE #

| | PAST 30 DAYS | LIFETIME USE YRS. | LIFETIME USE MOS. |
|---|---|---|---|
| *01 - Alcohol - Any use at all | | | |
| *02 - Alcohol - To intoxication | | | |
| *03 - Heroin | | | |
| *04 - Methadone | | | |
| *05 - Other opiates/ analgesics | | | |
| *06 - Barbiturates | | | |
| *07 - Other sed/ hyp/tranq. | | | |
| *08 - Cocaine | | | |
| *09 - Amphetamines | | | |
| *10 - Cannabis | | | |
| *11 - Hallucinogens | | | |
| *12 - Inhalants | | | |

CARD 3 80

Note: See manual for representative examples for each drug class.

*13 - More than one substance per day *(Incl. alcohol)*. [ ][ ] DAYS [ ][ ][ ][ ] YRS. MOS.

## DRUG/ALCOHOL USE

14. Which substance is the major problem? *(Please code as above or 00 - No problem;* 15 - Alcohol & Drug (Dual addiction) ; 16-Polydrug; *when not clear, ask patient).* [ ][ ]

15. How long was your last period of voluntary abstinence from this major substance? *(00 - never abstinent).* [ ][ ] MOS.

16. How many months ago did this abstinence end? *(00 - still abstinent).* [ ][ ]

*17. How many times have you:
- Had alcohol d.t.'s [ ][ ]
- Overdosed on drugs [ ][ ]

*18. How many times in your life have you been treated for:
- Alcohol abuse [ ][ ]
- Drug abuse [ ][ ]

*19. How many of these were detox only?
- Alcohol [ ][ ]
- Drug [ ][ ]

20. How much would you say you spent during the past 30 days on:
- Alcohol [ ][ ]
- Drugs [ ][ ]

21. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? *(Include NA, AA).* [ ][ ]

22. How many days in the past 30 have you experienced:
- Alcohol Problems [ ][ ]
- Drug Problems [ ][ ]

*FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE*

23. How troubled or bothered have you been in the past 30 days by these:
- Alcohol Problems [ ]
- Drug Problems [ ]

24. How important to you *now* is treatment for these:
- Alcohol Problems [ ]
- Drug Problems [ ]

INTERVIEWER SEVERITY RATING

25. How would you rate the patient's need for treatment for:
- Alcohol Abuse [ ]
- Drug Abuse [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation?
0 – No 1 – Yes [ ]

27. Patient's inability to understand?
0 – No 1 – Yes 50 [ ]

**COMMENTS**

I.D. [ ][ ][ ][ ]

1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.)? [ ]

0 – No 1 – Yes

2. Are you on probation or parole? [ ]

0 – No 1 – Yes

How many times in your life have you been arrested and charged with the following criminal offenses:

CODE #

| | | |
|---|---|---|
| *03 | shoplifting/vandalism | [ ][ ] |
| *04 | parole/probation violations | [ ][ ] |
| *05 | drug charges | [ ][ ] |
| *06 | forgery | [ ][ ] |
| *07 | weapons offense | [ ][ ] |
| *08 | burglary, larceny, B & E | [ ][ ] |
| *09 | robbery | [ ][ ] |
| *10 | assault | [ ][ ] |
| *11 | arson | [ ][ ] |
| *12 | rape | [ ][ ] |
| *13 | homicide, manslaughter | [ ][ ] |
| *14 | other | [ ][ ] |

## LEGAL STATUS

*15 How many of these charges resulted in convictions? [ ][ ]

How many times in your life have you been charged with the following:

*16 Disorderly conduct, vagrancy, public intoxication [ ][ ]

*17 Driving while intoxicated [ ][ ]

*18. Major driving violations (reckless driving, speeding, no license, etc.). [ ][ ]

*19 How many months were you incarcerated in your life? [ ][ ]

20. How long was your last incarceration? [ ][ ] MOS.

21. What was it for? *(Use code 3-14, 16-18. If multiple charges, code most severe)* [ ][ ]

22 Are you presently awaiting charges, trial or sentence? [ ]

0 – No 1 – Yes

23 What for? *if multiple choice, use most severe).* [ ][ ]

24 How many days in the past 30 were you detained or incarcerated? [ ][ ]

25 How many days in the past 30 have you engaged in illegal activities for profit? [ ]

*FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE*

26 How serious do you feel your present legal problems are? *(Exclude civil problems)* [ ]

27 How important to you *now* is counseling or referral for these legal problems? [ ]

INTERVIEWER SEVERITY RATING

28 How would you rate the patient's need for legal services or counseling? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29 Patient's misrepresentation? [ ]

0 – No 1 – Yes

30 Patient's inability to understand? [ ]

0 – No 1 – Yes 56

CARD 5 80

I.D. ☐☐☐☐

1. Marital Status ☐
   1 – Married 4 – Separated
   2 – Remarried 5 – Divorced
   3 – Widowed 6 – Never Married
2. How long have you been in this marital status? ☐☐ YRS. ☐☐ MOS.
   *(If never married, since age 18).*
3. Are you satisfied with this situation? ☐
   0 – No
   1 – Indifferent
   2 – Yes
4. Usual living arrangements (past 3 yr.) ☐
   1 – With sexual partner and children
   2 – With sexual partner alone
   3 – With parents
   4 – With family
   5 – With friends
   6 – Alone
   7 – Controlled environment
   8 – No stable arrangements
5. How long have you lived in these arrangements. ☐☐ YRS. ☐☐ MOS.
   *(If with parents or family, since age 18).*
6. Are you satisfied with these living arrangements? ☐
   0 – No
   1 – Indifferent
   2 – Yes

FAMILY/SOCIAL RELATIONSHIPS

7. With whom do you spend most of your free time: ☐
   1 – Family 3 – Alone
   2 – Friends
8. Are you satisfied with spending your free time this way? ☐
   0 – No 2 – yes
   1 – Indifferent
9. How many *close* friends do you have? ☐☐
10. How many days in the past 30 have you had serious conflicts:
    A. with your family? ☐☐
    B. with other people? (excluding family). ☐☐

Have you had significant periods in which you have experienced serious problems with:

0 – No 1 – Yes

| | PAST 30 DAYS | IN YOUR LIFE |
|---|---|---|
| *11. Mother | ☐ | ☐ |
| *12. Father | ☐ | ☐ |
| *13. Brothers/Sisters | ☐ | ☐ |
| *14. Sexual partner/spouse | ☐ | ☐ |
| *15. Children | ☐ | ☐ |
| *16. Other significant family | ☐ | ☐ |
| *17. Close friends | ☐ | ☐ |
| *18. Neighbors | ☐ | ☐ |
| *19. Co-workers | ☐ | ☐ |

*FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE*

How troubled or bothered have you been in the past 30 days by these:

20. Family problems? ☐
21. Social problems? ☐

How important to you *now* is treatment or counseling for these:

22. Family problems? ☐
23. Social problems? ☐

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

25. Patient's misrepresentation ☐
26. Patient's inability to understand ☐
    0 – No
    1 – Yes

CARD 6 80

**COMMENTS**

---

1. How many times have you been treated for any psychological or emotional problems?
   In a hospital ☐☐
   As an Opt. or Priv. patient ☐☐
2. Do you receive a pension for a psychiatric disability? ☐
   0 – No 1 – Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 – No 1 – Yes

| | PAST 30 DAYS | IN YOUR LIFE |
|---|---|---|
| 3. Experienced serious depression | ☐ | ☐ |
| 4. Experienced serious anxiety or tension | ☐ | ☐ |
| 5. Experienced hallucinations | ☐ | ☐ |
| 6. Experienced trouble understanding, concentrating or remembering | ☐ | ☐ |
| 7. Experienced trouble controlling violent behavior | ☐ | ☐ |
| 8. Experienced serious thoughts of suicide | ☐ | ☐ |
| 9. Attempted suicide | ☐ | ☐ |
| 10. Have you taken prescribed medicine for any psychological /emotional problem | ☐ | ☐ |

PSYCHOLOGICAL STATUS

11. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐
13. How important to you *now* is treatment for these psychological problems? ☐

*THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER*

At the time of this interview, is patient:

0 – No 1 – Yes

14. Obviously depressed/withdrawn ☐
15. Obviously hostile ☐
16. Obviously anxious/nervous ☐
17. Having trouble with reality testing, thought disorders, paranoid thinking ☐
18. Having trouble comprehending, concentrating, remembering ☐
19. Have suicidal thoughts ☐

INTERVIEWER SEVERITY RATING

20. How would you are the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

21. Patient's misrepresentation? ☐
    0 – No 1 – Yes
22. Patient's inability to understand? ☐
    0 – No 1 – Yes 38

CARD 7 80

COMMENTS

Developed by : Robert E. Drake, M.D., et al.

Client Name: _____
Date of Rating: _____

## CLINICIAN ALCOHOL USE SCALE

Please rate your client's use of alcohol over the past six months according to the following scale. If the person is in an institution, the reporting interval is the time period prior to institutionalization. You should weight evidence from self-report, interviews, behavioral observations, and collateral reports (family, day center, community, etc.) in making this rating.

_____ 1 = **ABSTINENT** Client has not used alcohol during this time interval.

_____ 2 = **USE WITHOUT IMPAIRMENT** Client has used alcohol during this time interval, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use and no evidence of recurrent dangerous use.

_____ 3 = **ABUSE** Client has used alcohol during this time interval and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use. For example, recurrent alcohol use leads to disruptive behavior and housing problems. Problems have persisted for at least one month**.**

_____ 4 = **DEPENDENCE** Meets criteria for moderate plus at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of alcohol use, continued use despite knowledge of substance-related problems, marked tolerance, characteristic withdrawal symptoms, alcohol taken to relieve or avoid withdrawal symptoms. For example, drinking binges and preoccupation with drinking have caused client to drop out of job training and non-drinking social activities.

_____ 5 = **DEPENDENCE WITH INSTITUTIONALIZATION** Meets criteria for severe plus related problems are so severe that they make noninstitutional living difficult. For example, constant drinking leads to disruptive behavior and inability to pay rent so that client is frequently reported to police and seeking hospitalization.

Developed by : Robert E. Drake, M.D., et al.

Client Name: _____
Date of Rating: _____

## CLINICIAN DRUG USE SCALE

Please rate your client's use of drugs over the past six months according to the following scale. If the person is in an institution, the reporting interval is the time prior to institutionalization. You should weight evidence from self-report, interviews, behavior observations, and collateral reports (family, day center, community, etc) in making this rating.

_____ 1 = **ABSTINENT** Client has not used drugs during this time interval.

_____ 2 = **USE WITHOUT IMPAIRMENT** Client has used drugs during this time interval, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use and no evidence of recurrent dangerous use.

_____ 3 = **ABUSE** Client has used drugs during this time interval and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use. For example, recurrent drug use leads to disruptive behavior and housing problems. Problems have persisted for at least one month.

_____ 4 = **DEPENDENCE** Meets criteria for moderate plus at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of drug use, continued use despite knowledge of substance-related problems, marked tolerance, characteristic withdrawal symptoms, drugs taken to relieve or avoid withdrawal symptoms. For example, binges and preoccupation with drugs have caused client to drop out of job training and non-drug social activities.

_____ 5 = **DEPENDENCE WITH INSTITUTIONALIZATION** Meets criteria for severe plus related problems are so severe that they make noninstitutional living difficult. For example, constant drug use leads to disruptive behavior and inability to pay rent so that client is frequently reported to police and seeking hospitalization.

*Circle drugs used:* cannabis cocaine hallucinogens opiates PCP sedatives/hypnotics/anxiolytics stimulants over-the-counter
Other _____

Developed by : Robert E. Drake, M.D., et al.

## Substance Abuse Treatment Scale

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last six months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.

1. Pre-engagement. The person (not client) does not have contact with a case manager, mental health counselor or substance abuse counselor.

2. Engagement. The client has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contact implies lack of a working alliance.

3. Early Persuasion. The client has regular contacts with a case manager or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

4. Late Persuasion. The client in engaged in a relationship with case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g. Antabuse) may be involved in reduction.

5. Early Active Treatment. The client is engaged in treatment, is discussing substance use or attending a group, has reduced use of at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.

6. Late Active Treatment. The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.

7. Relapse Prevention. The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least six months. Occasional lapses, not days of problematic use, are allowed.

8. In Remission or Recovery. The client has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment.

Developed by : Robert E. Drake, M.D., et al.

Table 7

Vignettes for
Substance Abuse Treatment Scale

***1 = Pre engagement  The person does not have contact with a case manager, mental health counselor, or substance abuse counselor.***

John was seen by Emergency Services after being picked up by the police for disturbing the peace. He had been drinking heavily and was yelling loudly at passerby's to "stop looking at him". He had no particular residence and no visible means of support. From old hospital records it was found that he had been in a state psychiatric hospital for 20 years and had been discharged 5 years ago. After a brief period of hospitalization for stabilization on meds and detox he was referred to the community support program at the local mental health center (MHC). He did not keep any appointments at the center but is often seen in the company of other clients of case management.

Jeanne, a woman of indeterminate age, lives in a SRO building and has high visibility in the local community because of her "weird" behaviors which become worse when she is using substances. Police and local merchants have called the MHC about her and several attempts have been made by MHC outreach staff to get her into the center. She continues to refuse these offers.

***2 = Engagement  The client has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contact implies lack of working alliance.***

A young single man who has been diagnosed in the past as suffering from schizophrenia, occasionally shows up at the mental health center and demands to see someone. He knows he has a case manager but cannot remember his name. He last saw his case manager 3 months ago when he wanted to get fuel assistance. His contacts are infrequent, and usually involve wanting money, food, or cigarettes. He smokes marijuana on a daily basis but does not speak to his case manager about it.

After a brief hospitalization at the local psychiatric unit following a psychotic episode, a young college student was assigned a case manager. She saw her case manager on 2 occasions following discharge but has not been seen for several months at the MHC and has not responded to phone calls or letters. The client's mother has called the case manager and says that she is worried about her daughter's increasing paranoia and indiscriminate use of substances.

***3 = Early Persuasion The client has regular contacts with a case manger or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.***

Julie sometimes initiates contact with her case manager and usually keeps her appointments. Most of her contacts are in regards to basic needs. She is able to listen when her case manager brings up her binges and other substance use but does not contribute to the conversation or acknowledge a problem. The case manager approach is to increase Julie's awareness of substance use without any demands for abstinence.

Fred has been a client of the MHC for many years. He was a long time resident of the state hospital prior to his involvement with the MHC. Fred continues to drink at least a quart of wine daily and is not compliant with taking his Haldol. He does meet weekly with his case manager and sometimes calls when in crisis. The meetings usually deal with concrete needs and activities of daily living.

***4 = Late Persuasion The client in engaged in a relationship with a case manager or counselor, is discussing substance use or attending group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.***

Ezekial, a young man with a history of Schizoaffective disorder and heavy marijuana use, was placed in a group home. His mother became representative payee to control his funds. Since his placement, his relationship with the case manager has improved. He attends weekly sessions and is about to start a substance abuse group. It appears that his substance use has decreased so as not to be a daily occurrence. Ezekial is able to discuss in his sessions what the effects of substances are and on rare occasions verbalizes a goal of abstinence.

Star lives in a supported apartment with two other clients of the mental health center. She attends a day treatment program at the MHC 3 days a week and sees her case manager twice a month. Star attends a "Double Trouble" AA group once or twice a month in the community. Her case manger reports the number of "parties" at the apartment have decreased considerably and Star has not been bingeing as much.

***5 = Early Active Treatment The client is engaged in treatment, is discussing substance use or attending a group, has reduced use, for at least one month, and is working towards abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.***

Joe is a 44 year old twice divorce father of two who has a 20 year history of bipolar disorder and poly drug abuse. In the past year, he has taken more responsibility for his substance abuse. He is beginning to discuss it with his case manager and in weekly group meetings at the MHC. He has started to chart his weekly use and though not abstinent he says that eventually he wants to be clean and sober. He complies with his psychiatric meds and is attempting to make social contacts with non abusers.

Crystal is a grandmother with years of polysubstance abuse. Her psychiatric symptoms are controlled with medication which she receives every other week from the MHC nurse. She sees her case manager at least monthly. Six months ago she went on a binge of drinking and also smoking crack. She was out of control, was brought to the ER and scared her daughter and her 2 grandchildren. Since that incident she has contracted with her case manager and her daughter not to use crack and is trying to cut down on her drinking. She wants to be able to still drink in a controlled manner but if this does not work then she states that she would have abstinence as a goal. She has begun to attend AA again and is calling her case manager weekly to report her progress and discuss her concerns.

***6 = Late Active Treatment The person is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems), but for less than six months.***

Gina is a young single woman with bipolar disorder who is active in NA and AA for her cocaine addiction. She has been abstinent for 2 months and prior to that has had a 5-month and a 4-month period of abstinence. After her last lapse she asked to be in a more structured living situation associated with a treatment program. She knows that cocaine is her drug problem and uses this as a focus of her weekly meetings with her case manager. Her goals include abstinence and getting to work.

Jonathan has been actively engaged in the case management program at the MHC for over one year. During this time he has made much progress on his daily abuse of alcohol and has now been abstinent for 3 months. With the help of his case manager and the weekly substance abuse groups, he realizes that his delusions and his behavior are affected by his substance abuse. He now takes his psychiatric medications regularly.

***7 = Relapse Prevention The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least six months. Occasional lapses, not days of problematic use, are allowed.***

Vanessa, a middle-aged woman with a bipolar disorder sees her case manager weekly. She has been sober for 2 years with one lapse of 2 days several months ago. She became depressed over a love relationship, loss of a job and financial problems and slipped. Following this she went into an 8-week day treatment program and has continued to work with her case manager in treatment to deal with these issues.

Sky is active in AA, where he has a sponsor, and also attends the weekly substance abuse group at the MHC. He actively engages other clients and confronts them about their abuse. He has been clean and sober for 2 and _ years. He still has cravings but has utilized his case manager and community support system to get through these periods. Sky has completed a year of college and is active in the mental health consumer group.

***8 = Recovered The client has had no problems related to substance use for over one year and is no longer in any type of substance abuse treatment.***

Jefferson is a long-term client of the mental health system. He has an excellent relationship with his case manager where the focus is on social skills and maintaining himself in the community. For many years he had a heavy alcohol dependency but has not used any substances in over 22 months and has no craving to do so. He is maintained on his injection of Prolixin and his social needs are met by the consumer drop-in center.

Arianne began abusing cocaine following her first psychotic break in college. Her polydrug abuse spanned 10 years but with the help of the appointment of a guardian, enforced medication compliance and payeeship, she gradually became engaged with her case manager. Since she was not comfortable attending groups she and her case manager confronted the substance abuse problem along with stabilizing her psychiatric symptoms. She has not had any substances in over 3 years, works 10 hours a week at the newspaper and sees her case manager monthly.

## Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

**Code** **(Note:** Use intermediate codes when appropriate. e.g. 45.68.72.)

100 | 91 **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**

90 | 81 **Absent or minimal symptoms** (e.g., mild anxiety before an exam)**, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family members).

80 | 71 **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument): **no more than slight impairment in social, occupational, or school functioning** (e.g., temporarily falling behind in schoolwork)

70 | 61 **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**

60 | 51 **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g., few friends, conflicts with peers or co-workers).

50 | 41 **Serious symptoms** (e.g., suicidal ideation, sever obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).

40 | 31 **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work: child frequently beats up younger children, is defiant at home, and is failing at school).

30 | 21 **Behavior is considerably influenced by delusions of hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

20 | 11 **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death: frequently violent; manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in communication** (e.g., largely incoherent or mute).

10 | 1 **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.**

0 Inadequate information.

---

The rating of overall psychological functioning on a scale of 0-100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians Judgments of Mental Health." *Archives of General Psychiatry* 7:407-417. 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J. Spitzer RL. Fleiss JL. Cohen J: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766-771. 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

## Social and Occupational Functioning Assessment Scale (SOFAS)

The SOFAS is a new scale that differs from the Global Assessment of Functioning (GAF) Scale in that it focuses exclusively on the individual's level of social and occupational functioning and is not directly influenced by the overall severity of the individual's psychological symptoms. Also in contrast to the GAF Scale, any impairment in social and occupational functioning that is due to general medical conditions is considered in making the SOFAS rating. The SOFAS is usually used to rate functioning for the current period (i.e., the level of functioning at the time of the evaluation). The SOFAS may also be used to rate functioning for other time periods. For example, for some purposes it may be useful to evaluate functioning for the past year (i.e., the highest level of functioning for at least a few months during the past year).

## Social and Occupational Functioning Assessment Scale (SOFAS)

Consider social and occupational functioning on a continuum from excellent functioning to grossly impaired functioning. Included impairments in functioning due to physical limitations, as well as those due to mental impairments. To be counted, impairment must be a direct consequence of mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not to be considered.

| Code | **(Note:** Use intermediate codes when appropriate. e.g., 45, 68, 72.) |
|---|---|
| 100<br>91 | Superior functioning in a wide range of activities. |
| 90<br>81 | Good functioning in all areas, occupationally and socially effective. |
| 80<br>71 | No more than a slight impairment in social, occupational, or school functioning (e.g., infrequent interpersonal conflict, temporarily falling behind in schoolwork). |
| 70<br>61 | Some difficulty in social, occupational, or school functioning, but generally functioning well, has some meaningful interpersonal relationships. |
| 60<br>51 | Moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). |
| 50<br>41 | Serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). |
| 40<br>31 | Major impairment in several areas, such as work or school, family relations (e.g., depressed man avoids friends, neglects family, and is unable to work: child frequently beats up younger children, is defiant at home, and is failing at school). |
| 30<br>21 | Inability to function in almost all areas (e.g., stays I bed all day; no job, home or friends). |
| 20<br>11 | Occasionally fails to maintain minimal personal hygiene: unable to function independently. |
| 10<br>1 | Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g., nursing care and supervision). |
| 0 | Inadequate information |

The rating of overall psychological functioning on a scale of 0-100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: "Clinicians Judgments of Mental Health." *Archives of General Psychiatry* 7:407-417. 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J. Spitzer RL. Fleiss JL. et al.: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766-771. 1976). The SOFAS is derived form the GAS and its development is described in Goldman HH. Skodol AE. Lave TR: "Revising Axis V for DSM-IV: A review of Measures of Social Functioning." *American Journal of Psychiatry* 149:1148-1156. 1992.

**UMDNJ-CMHC OUTCOME PILOT STUDY**

**THE SPECIFIC LEVEL OF FUNCTIONING (SLOF) SCALE**

**INSTUCTIONS: Your assessment should reflect the client's typical functioning during the last WEEK. Circle the number that best describes this person's typical functioning on each item listed below. MARK ONLY ONE NUMBER FOR EACH ITEM. BE SURE TO MARK ALL ITEMS.**



| **A. PHYSICAL FUNCTIONING** | **No Problem** | **Problem, but no effect on general functioning** | **Slight effect on general functioning** | **Restricts general functioning substantially** | **Prevents general functioning** |
|---|---|---|---|---|---|
| 1. VISION | 5 | 4 | 3 | 2 | 1 |
| 2. HEARING | 5 | 4 | 3 | 2 | 1 |
| 3. SPEECH IMPAIRMENT | 5 | 4 | 3 | 2 | 1 |
| 4. WALKING, USE OF LEGS | 5 | 4 | 3 | 2 | 1 |
| 5. USE OF HANDS AND ARMS | 5 | 4 | 3 | 2 | 1 |
| **B. PERSONAL CARE SKILLS** | **Totally self-sufficient** | **Needs verbal advice or guidance** | **Needs some physical help or assistance** | **Needs substantial help** | **Totally dependent** |
| 6. TOILETING (uses toilet properly; keeps self and area clean) | 5 | 4 | 3 | 2 | 1 |
| 7. EATING (uses utensils properly; eating habits) | 5 | 4 | 3 | 2 | 1 |
| 8. PERSONAL HYGIENE (body and teeth; general cleanliness) | 5 | 4 | 3 | 2 | 1 |
| 9. DRESSING SELF (selects appropriate garments; dresses self) | 5 | 4 | 3 | 2 | 1 |
| 10. GROOMING (hair, make-up, general appearance) | 5 | 4 | 3 | 2 | 1 |
| 11. CARE OF OWN POSSESSIONS | 5 | 4 | 3 | 2 | 1 |
| 12. CARE OF OWN LIVING SPACE | 5 | 4 | 3 | 2 | 1 |
| **C. INTERPERSONAL RELATIONSHIPS** | **Highly typical of this person** | **Generally typical of this person** | **Somewhat typical of this person** | **Generally untypical of this person** | **Highly untypical of this person** |
| 13. ACCEPTS CONTACT WITH OTHERS (does not withdraw or turn away) | 5 | 4 | 3 | 2 | 1 |
| 14. INITIATES CONTACT WITH OTHERS | 5 | 4 | 3 | 2 | 1 |
| 15. COMMUNICATES EFFECTIVELY (speech and gestures are understandable and to the point) | 5 | 4 | 3 | 2 | 1 |
| 16. ENGAGES IN ACTIVITIES WITHOUT PROMTING | 5 | 4 | 3 | 2 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| 17. PARTICIPATES IN GROUPS | 5 | 4 | 3 | 2 | 1 |
| 18. FORMS AND MAINTAINS FRIENDSHIPS | 5 | 4 | 3 | 2 | 1 |
| 19. ASKS FOR HELP WHEN NEEDED | 5 | 4 | 3 | 2 | 1 |
| **D. SOCIAL ACCEPTABILITY** | **Never** | **Rarely** | **Sometimes** | **Frequently** | **Always** |
| 20. VERBALLY ABUSES OTHERS | 5 | 4 | 3 | 2 | 1 |
| 21. PHYSICALLY ABUSES OTHERS | 5 | 4 | 3 | 2 | 1 |
| 22. DESTROYS PROPERTY | 5 | 4 | 3 | 2 | 1 |
| 23. PHYSICALLY ABUSES SELF | 5 | 4 | 3 | 2 | 1 |
| 24. IS FEARFUL, CRYING, CLINGING | 5 | 4 | 3 | 2 | 1 |
| 25. TAKES PROPERTY FROM OTHERS WITHOUT PERMISSION | 5 | 4 | 3 | 2 | 1 |
| 26. PERFORMS REPETITIVE BEHAVIORS (pacing, rocking, making noises etc.) | 5 | 4 | 3 | 2 | 1 |
| **E. ACTIVITIES** | **Totally self-sufficient** | **Needs verbal advice or guidance** | **Needs some physical help or assistance** | **Needs substantial help** | **Totally dependent** |
| 27. HOUSEHOLD RESPONSIBILITIES (cleaning, cooking, laundry, etc.) | 5 | 4 | 3 | 2 | 1 |
| 28. SHOPPING (selection, choice of store, payment at register) | 5 | 4 | 3 | 2 | 1 |
| 29. HANDLING PERSONAL FINANCES (budgeting, paying bills) | 5 | 4 | 3 | 2 | 1 |
| 30. USE OF TELEPHONE (getting number, dialing, speaking, listening) | 5 | 4 | 3 | 2 | 1 |
| 31. TRAVELING FROM RESIDENCE WITHOUT GETTING LOST | 5 | 4 | 3 | 2 | 1 |
| 32. USE OF PUBLIC TRANSPORTATION (selecting route, using timetable, paying fares, making transfers) | 5 | 4 | 3 | 2 | 1 |
| 33. USE OF LEISURE TIME (reading, visiting friends, listening to music) | 5 | 4 | 3 | 2 | 1 |
| 34. RECOGNIZING AND AVOIDING COMMON DANGERS (traffic safety, fire safety) | 5 | 4 | 3 | 2 | 1 |
| 35. SELF-MEDICATION (understanding purpose, taking as prescribed, recognizing side effects) | 5 | 4 | 3 | 2 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| 36. USE OF MEDICAL AND OTHER COMMUNITY SERVICES (knowing when to contact, how and when to use) | 5 | 4 | 3 | 2 | 1 |
| 37. BASIC READING, WRITING AND ARITHMETIC (enough for daily use) | 5 | 4 | 3 | 2 | 1 |
| **F. WORK SKILLS** | **Highly typical of this person** | **Generally typical of this person** | **Somewhat typical of this person** | **Generally untypical of this person** | **Highly untypical of this person** |
| 38. HAS EMPLOYABLE SKILLS | 5 | 4 | 3 | 2 | 1 |
| 39. WORKS WITH MINIMAL SUPERVISION | 5 | 4 | 3 | 2 | 1 |
| 40. IS ABLE TO SUSTAIN WORK EFFORT (not easily distracted; can work under stress) | 5 | 4 | 3 | 2 | 1 |
| 41. APPEARS AT APPOINTMENTS ON TIME | 5 | 4 | 3 | 2 | 1 |
| 42. FOLLOWS VERBAL INSTRUCTIONS ACCURATELY | 5 | 4 | 3 | 2 | 1 |
| 43. COMPLETES ASSIGNED TASKS | 5 | 4 | 3 | 2 | 1 |

CLIENT NAME: _____ CLIENTID: | | | | | | |

DATE: _____ /_____ /_____

COMMENTS:

rev 5/28/94

# APPENDIX A

# GHAA'S

# CONSUMER

# SATISFACTION

# SURVEY

## SECOND EDITION

Prepared for
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For further details regarding the development and use of this survey, please consult: *GHAA's Consumer Satisfaction Survey and User's Manual*, available from GHAA's Department of Research and Analysis at the above address. Please contact the Dept. of Research and Analysis for copyright permission.



## MAY 1991

# Design of a Survey to Monitor Consumers' Access to Care, Use of Health Services, Health Outcomes, and Patient Satisfaction

## Questionnaire and Survey Materials (Draft #2)

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