

The MHSIP Quality Report

Mental Health Statistics Improvement
Program



**The Next Generation
of Mental Health
Performance Measures**

THE MHSIP QUALITY REPORT

The Next Generation of Mental Health Performance Measures

FINAL REPORT

Mental Health Statistics Improvement Program

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Suggested Reference:

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PREFACE

This report is the culmination of a two-year, multi-stakeholder effort involving extensive review, comment and input from over a thousand people across the country. But, even with this considerable input, the Mental Health Statistics Improvement Program (MHSIP) Quality Report remains a work in progress. We think the performance indicators and measures proposed in this report reflect both the consensus on values and the science at the current time. Nevertheless, we are very conscious that there are gaps that still exist and concerns that may need more emphasis. Also, while many measures are proposed in this report, many remain untested. Before proceeding with the implementation of the indicators and measures that are proposed, we recommend that the next phase in promulgating the MHSIP Quality Report be a testing phase. This caution cannot be overstated. The performance measures in the first generation MHSIP Consumer-Oriented Report Card were promoted without testing and refinement, resulting in idiosyncratic applications and modifications. We do not want to repeat that experience.

To address this next phase, we are seeking sites and organizations that may want to test these measures either individually or as a set. If you are interested in participating in this next phase, please go to the MHSIP website at www.mhsip.org and complete the MHSIP Quality Report Testing Form, or contact Vijay Ganju at (703) 739-9337, or Mary Smith at (312) 814-4948. At the website, you can also provide comments and suggestions regarding this report or its companion toolkit. Updates on the MHSIP Quality Report and its development will also be available at this website.

We look forward to both hearing from and working with you in the future.

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ACKNOWLEDGEMENTS

The work involved in the development of the MHSIP Quality Report was informed and supported by numerous organizations and individuals. Without exaggeration, more than a thousand persons – consumers, family members, advocates, providers, managed care organization representatives, accreditation organization staff members, and state mental health agency staff – were involved in this process. We acknowledge the unique contribution that each person has made to the development of the performance indicators and measures in this report. More specifically, we acknowledge the following organizations and individuals:

First, we thank the various organizations that worked with MHSIP on the Quality Report Workgroup: The National Association of Consumer/Survivor Mental Health Administrators, the Recovery Measurement Workgroup, the Federation of Families for Children’s Mental Health, the National Alliance for the Mentally Ill, the American Managed Behavioral Healthcare Association, the National Mental Health Association, the National Association of Mental Health Planning and Advisory Councils, the National Council of Community Behavioral Healthcare, the National Association of State Mental Health Program Directors, the NASMHPD Research Institute, the American College of Mental Health Administration, the Human Services Research Institute, the Outcomes Roundtable for Children and Families, and SAMHSA’s Center for Mental Health Services. Each individual was a representative of, and a conduit to, one of the organizations involved. We thank each Workgroup member (whose names are listed on page ix) for their special and unique contributions to this report.

Several organizations provided significant expertise, resources and support for various activities that resulted in this report and the companion toolkit. We appreciate the contributions of the following organizations:

- ◆ The Human Services Research Institute, for providing resources for the development of the companion toolkit (specifically Dow Wieman and Neera Jain of the Institute).
- ◆ A Consumer Expert Panel (whose names are listed on page xii), for providing guidance, insight and feedback to the activities of the Workgroup;
- ◆ The Recovery Measurement Development Group (whose names are listed on page xiii), for providing input and direction related to the measurement of recovery orientation;
- ◆ The Oklahoma Department of Mental Health and Substance Abuse Services, for supporting the web-based survey and analysis of data provided by 982

persons from across the country through the work of Steve Davis, Director, Decision Support Services, Mark Reynolds, Data Projects Manager and Ray Bottger, Data Analyst;

- ◆ The National Alliance for Multi-ethnic Behavioral Healthcare Associations, under the leadership of Mareasa Isaacs, for providing valuable expertise and input for the development of the measure related to cultural competence;
- ◆ Representatives of accreditation organizations National Committee on Quality Assurance (NCQA); The Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA) and The Council on Quality and Leadership) who provided insights about their approaches to performance measures development, reactions and feedback to the initial set of proposed MHSIP indicators, and information regarding possibilities for joint testing efforts;
- ◆ Representatives of the Outcomes Roundtable for Children and Families and the Performance Measurement Forum, who participated in some of the workgroup meetings;
- ◆ The 982 respondents to the web-based survey, who helped identify issues and priorities related to the initial set of proposed indicators;
- ◆ Last, but perhaps foremost, special thanks go to Ron Manderscheid and his staff at the Survey and Analysis Branch at SAMHSA's Center for Mental Health Services for providing resources, support and guidance throughout this effort.

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THE MHSIP QUALITY REPORT

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INTRODUCTION

The MHSIP Quality Report (MQR) is a set of proposed performance measures that lays the groundwork for the next generation of activities in mental health performance measurement. These proposed measures represent a consensus from diverse stakeholder organizations, including the American Managed Behavioral Healthcare Association (AMBHA), the American College of Mental Health Administration (ACMHA), the National Alliance for the Mentally Ill (NAMI), the National Mental Health Association (NMHA), the Federation of Families, the National Association of State Mental Health Program Directors (NASMHPD), the NASMHPD Research Institute, Inc. (NRI), the National Council of Community Behavioral Healthcare (NCCBH), the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA), the National Association of Mental Health Planning and Advisory Councils (NAMHPAC), state mental health planners, Center for Mental Health Services (CMHS), and representatives of the Recovery Measurement Group and the Outcomes Roundtable for Children and Families. These organizations were represented on the Workgroup responsible for developing the MHSIP Quality Report. Workgroup members served both as representatives of and liaisons with their respective organizations.

Besides organizational representatives, other groups provided considerable expertise, insight and input into this initiative as well. A consumer expert panel identified key concerns and provided feedback as different products were developed; representatives from various accreditation organizations, including the National Committee on Quality Assurance (NCQA); the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA) and The Council on Quality and Leadership, provided feedback and explored the potential for joint initiatives; representatives from the federally-sponsored Forum on Performance Measures and the developers of the Experience of Care and Health Outcomes survey (ECHO) provided suggestions, insight and lessons learned in their initiatives to inform Workgroup activities; the Human Services Research Institute provided resources and support for the companion toolkit; the Oklahoma Department of Mental Health and Substance Abuse Services supported a broad based web-survey to solicit the perspectives of consumers, family members, advocates, managed care organizations, accreditation organizations, state mental health agencies and community providers.

This document reflects the cumulative effort of all these activities. The result of these activities is three proposed sets of measures: a universal set that applies to all populations and settings; a population-specific set that applies to specific sub-groups, e.g., children and adults with serious mental illness; and a setting-specific set that applies to populations in settings specific to hospitals and managed care organizations. The last two sets are additional measures that could be applied in addition to the universal measures, if specific populations or settings were of concern. Besides these proposed indicators and measures, a companion toolkit has been developed to address issues of methodology, implementation and potential uses.

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At this stage, the indicators and measures in the MQR are proposed for testing and refinement. While the proposed indicators and measures reflect the best judgment and consensus based on the input received and lessons from past experiences, the Workgroup strongly recommends that the next generation of mental health performance measures be based on empirical findings.

This document describes the MQR and summarizes its strengths, the process of development and the proposed testing plan. The appendices contain detailed operational definitions of the measures, key reports such as those of the Recovery Orientation Measurement Group, the results of the web-based survey, and proposed survey instruments for obtaining some of the measures. The document also includes an invitation to organizations that may be interested in testing individual measures or specific components of the MHSIP Quality Report.

What Is The MHSIP Quality Report?

The MHSIP Quality Report (MQR) is a set of mental health performance measures that was developed through a consensus of representatives of mental health stakeholder organizations with broad public input from consumers, family members, advocates, providers and administrators. Building upon lessons learned from the development and implementation of mental health performance measures in both the public and private sectors, the MHSIP Quality Report reflects the ‘cutting edge’ in the development of the next generation of mental health performance measures.

The MQR consists of a universal set of performance indicators that apply across different populations and settings with additional population-specific and setting-specific indicators. The MQR is specially designed to reflect current concerns and priorities for behavioral health. The MQR is:

- **Consumer-focused** – The MHSIP Quality Report (MQR) is a second-generation development of the *MHSIP Consumer-Oriented Mental Health Report Card* published in 1996. The MQR reflects consumer goals and priorities. The report included consumers in the development group, involved feedback from a consumer expert panel, and incorporated feedback from 270 consumers across the country. Some of the measures are based on the work of consumer researchers in the area of recovery measurement.

While the MQR reflects consumer priorities, it also reflects the priorities of other stakeholder groups, including parents of children and adolescents receiving services and other family members, advocates, providers, managed care organizations and state mental health authorities. One of the strengths of the MQR is that it not only addresses consumer concerns, but also includes the priorities of these other stakeholder groups as well.

- **Outcome-focused** – The MQR is based upon the assumption that mental health systems exist to produce specific outcomes, and to achieve these outcomes, certain attitudes, processes and services need to be in place. This is a continuation of the focus put forth in the *MHSIP Consumer-Oriented Mental Health Report Card*. Although the MQR Workgroup members recognized that there are many definitional and methodological issues that remain in this area; the proposed measures are based on the best knowledge currently available. Also, the MQR has been designed to incorporate all of SAMHSA’s National Outcomes Measures (NOMs).
- **Recovery-oriented** – Recovery as a concept has received recognition both in the *Surgeon General’s Report on Mental Health* and in the more recent *President’s New Freedom Commission on Mental Health Report*. Designed in collaboration with a group of consumer researchers, the MQR includes measures of a system’s recovery orientation. While recovery is often considered a concept related primarily to adults with serious mental illnesses, this document considers recovery orientation as a universal concept and applies it both to adults and children. In fact, many of the

indicators that were highly prioritized for children relate to recovery. (For example, some of the universal aspects of recovery orientation include choice, social relationships and staff's strength-based attitudes.)

- **Inclusive of Children's Issues** – The MHSIP Quality Report has very consciously included children's concerns in the performance measurement sets. The MHSIP Quality Report Workgroup coordinated activities with the Outcomes Roundtable for Children and Families and specifically identified performance indicators for all children with mental health problems, as well as indicators for children with serious emotional disturbances.
- **Responsive to Concerns for Cultural Competence** – Proposed for testing in the MHSIP Quality Report are items related to cultural competence. These items were based on domains of cultural competence identified as priorities by representatives of the National Alliance of Multi-ethnic Behavioral Healthcare Associations.
- **Value-based** – Implicit in the MQR measures are key values and expectations of the mental health system. These include:
 - Consumers and their families should have quick and easy access to clinically and culturally appropriate services.
 - Consumers and their families should receive state-of-the-art services appropriate to individual needs and preferences.
 - The treatment and support that consumers and family members receive should address the problems and concerns for which services were sought.
 - Consumers and family members should receive services that do no harm, either directly through the services received or in the environment within which services are provided.
- **Responsive to Current National Priorities and Initiatives** – The MHSIP Quality Report is the only mental health performance measurement set that addresses the key issues in *The President's New Freedom Commission on Mental Health Report* and those related to recovery, cultural competence, and children's mental health services. Also, the MHSIP Quality Report has performance measures that address many concerns in the Institute of Medicine's *Crossing the Quality Chasm Report*, such as safety, effectiveness, patient-centered services, access and equity.
- **Responsive to SAMHSA priorities** – Building on and working with the SAMHSA/CMHS the MHSIP Quality Report is responsive to the reporting requirements proposed for the Performance Partnership Grant program. Also, all of SAMHSA's National Outcomes Measures (NOMs) have been incorporated in the MQR.

Why Was The MHSIP Quality Report Developed?

The purpose of the MHSIP Quality Report is to consolidate the lessons and experiences of performance measures development and implementation in the mental health field, and to propose a set of performance measures that reflect key concerns in mental health systems or organizations performance. The MHSIP Quality Report recognizes that different sets of measures may be needed for different populations in different settings, but a major emphasis will be to develop consistency and commonality across these sets.

As such, the MQR:

- Addresses performance measurement requirements for both adults and children and is intended to apply to the entire mental health or behavioral health field, both public and private.
- Builds on the work of the Recovery Advisory Group and the Recovery Measurement Group.
- Incorporates the common measures developed by the Performance Measurement Forum.
- Emphasizes the implementation, reporting and use of performance measures.
- Gives special attention to developing a second generation of consumer survey instruments building on the current MHSIP Consumer Surveys (i.e., Youth Services Survey, Adult Consumer Survey and Inpatient Survey and the Experience of Care and Health Outcomes (ECHO) Survey).

How Is The MQR Different From The Original MHSIP Consumer-Oriented Mental Health Report Card?

This second-generation effort is different from the original MHSIP Report Card in two important ways. First, this new effort recognizes that different sets of measures may be needed for different populations in different settings. However, a major aim of this effort has been to develop consistency and commonality across all sets.

Second, MQR builds on lessons learned from performance measurement initiatives that have been implemented over the last eight years. In preparation for Version 2, information from the following organizations' initiatives was reviewed: the American Managed Behavioral Healthcare Association (AMBHA), the American College of Mental Health Administration (ACHMA), the National Alliance for the Mentally Ill (NAMI), the National Association of State Mental Health Program Directors (NASMHPD) President's Taskforce on Performance Measures, the Center for Mental Health Services (CMHS) 16-State Study, the Outcomes Roundtable for Children and Families, the Recovery Advisory Group and the Recovery Measurement Workgroup, the Performance Measurement Forum (Adult and Child

Workgroups), the MHSIP Consumer-Oriented Report Card (Version 1) and the work of various accreditation agencies.

Additional input was sought and incorporated from representatives of the National Mental Health Association (NMHA), the National Council for Community Behavioral Healthcare (NCCBH), the Human Services Research Institute (HSRI), the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA), and the National Association of Mental Health Planning and Advisory Councils (NAMHPAC).

Third, the performance indicators and measures proposed reflect current consumer and national concerns and priorities. Indicators related to recovery orientation, cultural competence, dual diagnosis (mental health and substance abuse) and SAMHSA's National Outcomes Measures (NOMs) are included.

How Were The Indicators Selected For Inclusion In The MQR Performance Measurement Set?

Development of mental health performance indicators for review and prioritization.

In its initial phase of activities, the Workgroup reviewed the indicators and measures in various mental health performance measurement initiatives. These included: 1) the PERMS system implemented by the American Managed Behavioral Healthcare Association (AMBHA); 2) the NAMI Report Card; 3) the performance indicator set proposed by the American College of Mental Health Administration (ACMHA); 4) the implementation of the MHSIP Consumer-Oriented Report Card in state mental health systems supported by SAMHSA's Center for Mental Health Services; 5) the National Association of State Mental Health Program Directors (NASMHPD) Framework of Performance and Outcomes Measures, and the implementation of this NASMHPD framework in the 5-state feasibility and 16-state performance indicators studies sponsored by SAMHSA's Center for Mental Health Services; 6) performance measurement initiatives of accreditation organizations, including those of the National Committee on Quality Assurance (NCQA), The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA) and The Council on Quality and Leadership; 7) the development of the Consumer Assessment of Behavioral Health Services (CABHS) and Experience of Care and Health Outcomes (ECHO) Survey instruments; and 8) the survey work conducted by the Outcomes Roundtable for Children and Families. At the same time, through MHSIP's work with the federally-sponsored Forum on Performance Measures, additional standardized measures were also included.

This extensive review process resulted in a large, inclusive set of performance indicators. However, since these systems had evolved through a 'cross-pollination' process, there was also considerable overlap and duplication across these systems. Use and implementation of each indicator were reviewed. Even if the indicator was not successfully implemented, it was not necessarily excluded if feasible measurement options were available.

The Workgroup also included representation from researchers developing a measure of mental health system's recovery orientation. Inclusion of a measure of recovery was a major goal of the development of the MHSIP Quality Report. The Recovery Orientation Measurement Group was committed to developing a small set of items that could be used in the MQR (see Appendix F).

Based on the review process, the workgroup developed three sets of performance indicators: 1) those with a relatively clear operational definition of an associated performance measure; 2) those with multiple operational definitions, and 3) those that were developmental and needed an operational definition or measure specified. For each indicator the domain, the concern being addressed, the numerator and denominator for each measure, and the populations being measured by the indicator were stated.

Although, the resulting pool of indicators was considerable, there was concern that key issues of Mental Health consumers may still have been excluded. To address this possible gap, a consumer expert panel was established to review the set of indicators, and measures developed by the Workgroup. This process resulted in inclusion of additional indicators such as those related to safety, provider competence, availability of services and peer support services.

The workgroup then winnowed down the larger pool of indicators into unique sets. Fifty-two indicators ultimately comprised the final set that was then further reviewed and prioritized.

Prioritization and Selection of Performance Indicators.

These 52 performance indicators became part of a web-based survey developed and analyzed by the Oklahoma Department of Mental Health and Substance Abuse Services for the MHSIP Quality Report Workgroup. Invitations to participate in the survey were distributed widely to mental health stakeholder groups by letter and by e-mail. Liaisons from the Workgroup to these key organizations also helped facilitate the process.

Respondents were asked to answer four demographic questions to identify their primary perspective. First they were asked which stakeholder group they represented, (e.g., advocate, consumer, state mental health authority), then the organizational affiliation they might represent, then the primary population they were interested in, and finally any particular treatment setting in which they had an interest. Respondents were then asked to rate each of the 52 indicators as high, medium or low priority based on their specific perspective. The average rating for each indicator was calculated for each perspective and overall. Using the average ratings for each perspective, the 52 indicators were then ranked by perspective. To further summarize the data, the number of times an indicator was selected in the 'Top 5' rankings of any perspective was tallied.

A total of 982 persons completed the survey. Of those who identified their perspective, 1 was from an accreditation organization, 117 were mental health advocates, 270 were consumers of mental health services, 283 were family members, 33 were from local mental health authorities, 8 were from managed care organizations, 132 were providers, 74 were from state

mental health authorities, and 64 represented miscellaneous or unnamed groups (Appendix G). There were also 6,953 comments from respondents which were reviewed, indicator by indicator, and were incorporated in the final prioritization process.

To ensure that perspectives of people who had interests in particular populations or specific treatment settings were represented in the findings, the rating and ranking analysis described above was repeated for each reported population interest category and each setting category. These were the basis for prioritization for the population-specific and setting-specific indicators.

The resulting tables, included in Appendix G were the basis for the Workgroup's process of selecting indicators. The top five indicators selected by any stakeholder group are included in the final set. The Workgroup also added indicators that reflected other indicators that had national importance or priority. Also, two indicators related to SAMHSA's National Outcomes Measures (NOMs) — symptom reduction and social support/connectedness — were included.

What Performance Indicators Are Proposed?

The indicators and measures proposed in the MQR consist of a universal set (which applies to all population subgroups and settings) and additional indicators that apply to specific populations or specific settings.

For example, quality of treatment or services is a concern that applies across populations and settings. Cultural competence is another universal concern. On the other hand, an indicator such as improvement in school functioning applies specifically to children. Similarly, a system's recovery orientation applies primarily to adults with serious mental illnesses. There are also measures which apply more to the setting in which services are delivered than to the population being served. For example, seclusion and restraint measures apply more to inpatient and residential settings than to community outpatient programs.

Listed below are the indicators and definitions for each of the different sets proposed. The measures that are associated with these indicators are provided in the Appendices.

A. THE MQR UNIVERSAL SET OF PERFORMANCE INDICATORS

- **Consumer Outcomes** – An indicator related to improvement in functioning, i.e., how consumers handle social roles and problems, family and social situations and cope with crises and psychological distress.
- **Active Participation in Treatment Planning** – An indicator of the degree to which consumers (or, for children, family members) participate in treatment decision-making.

- **Recovery Orientation** – An indicator focused on the degree to which an agency or organization is recovery-oriented.
- **Quality of Interaction Between Clinicians and Consumers** – An indicator of the degree to which consumers feel they are treated with respect and dignity and feel safe and involved in their treatment.
- **Quality of Treatment** – An indicator of what consumers think about the overall quality of the treatment they receive.
- **Safety** – An indicator related to patient safety focused on medication errors.
- **Availability of Services** – An indicator of the range of service options and treatments available.
- **Availability of Information/Education** – An indicator of the degree to which consumers and family members receive information and education that helps them make informed choices about mental health services.
- **Initiation of Treatment** – An indicator of whether persons with mental illness have access to appropriate care.
- **Cultural Competence** – An indicator of the degree to which a consumer’s needs related to language, culture, ethnicity, gender, sexual orientation, age, and disability are taken into account.
- **Co-occurring Problems / Screening** – An indicator of how often screenings are performed to detect substance abuse problems.
- **Reduction of Symptoms** – An indicator of whether mental health treatment results in a reduction of a consumer’s symptoms and an improved ability to function.
- **Social Support/Connectedness** – An indicator of whether social support/connectedness is facilitated, and supports recovery.

B. ADDITIONAL POPULATION-SPECIFIC INDICATORS

1. All Adults

- **Peer Support** - This indicator reflects the availability of consumer-operated or peer-support services, including drop-in centers, peer case management, peer professional services, and social clubs.

- **Improvement in Work Functioning** – An indicator of how much consumers recently entering the work force think their ability to do paid work has improved.

2. Adults with Serious Mental Illness

- **Adults with Schizophrenia — New Generation Medications** – An indicator of how available “new generation” medications are in the Mental Health System.
- **Illness Self-Management** – An indicator of how available illness self-management training is in the Mental Health System.
- **Involvement in the Criminal Justice System** – An indicator of a consumer’s contact with the criminal justice system.

3. All Children (Including Children with Serious Emotional Disturbances)

- **Improvement in School Functioning** - An indicator of improvement in children's attendance and school performance.
- **Social Relationships** – An indicator related to how social and personal relationships play important roles in facilitating recovery.
- **Involvement with Juvenile Justice System** - An indicator of a consumer's contact with the juvenile justice system.
- **Illness Self-Management** - An indicator of how available illness self-management training is in the Mental Health System.

C. **ADDITIONAL SETTING-SPECIFIC INDICATORS** -- (Note: The only settings identified as having specific measures were hospitals and comprehensive community systems. The proposed universal measures applied to all other settings.)

1. Hospitals / Inpatient

- **Seclusion** - An indicator of how often restrictive therapies are used or that treatment providers lack training or respect for client autonomy and dignity.
- **Restraint** - An indicator of how often restrictive therapies are used or that treatment providers lack training or respect for client autonomy and dignity

2. Comprehensive Community Systems

- **Perception of Access** – An indicator of how consumers feel about access to services – are they available at times that are convenient, is location convenient, etc.

How Were The Measures Associated With The Performance Indicators Developed?

In proposing measures, the MQR Workgroup reviewed definitions from many mental health performance measurement sets. For some indicators with slight variations, there was a single approach or measure. For others, there was a consensus that the indicator reflected a high priority concern, but there were multiple definitions in use. For those indicators that were relatively new or had been refined for the MQR, there were measures proposed which remain untested.

The approach to the presentation of the measures, presented in the Appendices follow this pattern. Where the MQR Workgroup felt that one measure had worked well, one measure is proposed. For indicators with multiple definitions, the Workgroup considered whether to propose one measure that, in its judgment, worked best, but decided that an empirical approach was superior. So, in some cases, indicators are proposed with multiple measures, first, so that they can be tested to see if one is operationally superior or otherwise preferable; and second, to provide options depending on a system's capacities for data gathering.

The Workgroup approach also proposes testing to derive MQR measures for indicators for which current instruments are too long and onerous for ongoing use. The MQR workgroup proposed to derive abbreviated versions of these measures through a testing process for MQR application.

In summary, while measures are proposed in this document, it is critical to note that **these measures are proposed as a testing set**, not as a final, implementation-ready version for ongoing application.

What Do The New MHSIP Surveys Look Like?

There are currently three forms of the MHSIP Consumer Survey: the MHSIP Adult Consumer Survey, the Youth Services Survey with a separate form for parents—the Youth Services Survey for Families—and the MHSIP Inpatient Survey. The MHSIP Adult Survey is the original survey that was developed as a component of the MHSIP Consumer-Oriented Report Card. The 40-item survey was revised in February 2000, to the 28-item version which is in use today. This survey has been implemented by more than 45 states, and the items are used as the basis for calculating various performance measures that are reported as part of the SAMHSA CMHS State Data Infrastructure Grant. The Adult survey has also been the basis for the development of other surveys that are used in the mental and behavioral health fields. The Youth Surveys, like the Adult survey, have been implemented by a number of states (28 at last count) and they serve as the basis for performance measures that are part of the SAMHSA CMHS State Data Infrastructure Grants. The Inpatient Survey is currently used by many SMHAs as the basis for performance measures that are collected and reported as part of the NRI performance measurement system. Additionally, the survey is the basis for several NRI/JCAHO-approved performance measures. The fact that each of these surveys is in

widespread use makes it necessary that there be some continuity between current surveys and planned revisions.

The revision of the MHSIP surveys will reflect the general approach undertaken in the development of the MHSIP Quality Report. That is, there are universal items, as well as items for specific populations and specific settings.

Changes to the MHSIP Adult Consumer survey will be based on three strands of work: (1) recommendations from the February 2000 consumer survey workgroup; (2) recommendations from the consumer survey workgroup that has been convened under the umbrella of the MHSIP Quality Report; and (3) feedback obtained from the web-based survey which was used to gather recommendations from a wide variety of stakeholders regarding the proposed measures for the MHSIP Quality Report. The proposed testing set of items is included in Appendix H.

The work on Youth Surveys has begun with the formation of a task force that will be reviewing the current survey forms to ensure “fit” with the Quality Report framework. Similar work will also be conducted on the Inpatient Survey.

Self-Report Items — In addition to items related to perception of care, a separate section relating to other performance indicators, such as involvement in the criminal/juvenile justice system, school attendance, access to primary health care, social connectedness and functioning/symptom reduction. It has been recommended that the use of self-report items be explored as a source of gathering information on these performance measures that may be more difficult to obtain from administrative databases.

How Should These Performance Measures Be Implemented And Used?

The intent of the MHSIP Quality Report performance measures is that they be used as a set of measures to reflect critical domains of an organization’s performance. When the original MHSIP Consumer-Oriented Report Card was proposed, many organizations selected a few of the measures. Nothing precludes this happening again, but it is important to note that the goal of any performance measurement system is to obtain a systemic view of the organization’s operation. Use of individual indicators prevents a systemic picture of an organization. At a minimum, performance measures from all the domains must be obtained to reflect the intent of the performance measures in the MQR.

The MHSIP Quality Report can be used for various purposes: management, planning, quality improvement and providing information to consumers and family members regarding an organization’s performance. To reflect such performance accurately, attention must be given to data completeness and quality, the methodologies for sampling, analysis and benchmarking, and the types of reports produced for different audiences and different uses.

To address these issues, this report has a companion toolkit developed by the Human Services Research Institute, Cambridge, Massachusetts, for the MHSIP Quality Report Workgroup. It

THE MHSIP QUALITY REPORT

is provided as a companion document with this report. This document is a critical component for implementing the MQR; it identifies critical issues related to implementation and provides suggestions and options for various uses.

The Testing Plan

One of the major differences between the release of the original MHSIP Consumer-Oriented Report Card and the plan for MHSIP Quality Report is the explicit proposal to test measures prior to dissemination. Testing would aid in the standardization of the measures and produce methodologies to insure appropriate application and dissemination of the performance measures.

The testing plan for the MQR is comprehensive, but there is no expectation that all phases be complete before the MQR is implemented. There are several phases proposed for the testing plan. The first phase is to develop a smaller set of items for some indicators and to do some initial work to empirically test indicators with multiple definitions prior to large scale implementation.

The two proposed phases of the testing plan are:

- C. **Test individual indicators** – The objective here is to test operational definitions for new measures (i.e., measures not previously implemented) and to test differences in multiple definitions for existing measures.
- D. **Test the set of performance measures in the MHSIP Quality Report** – This is a subsequent phase of testing where the focus is on testing the entire set of measures in different settings. As described earlier, the objective is to test whether the set of measures can be implemented to reflect the performance of the system and be used effectively for quality improvement. An integral value of the MQR is that multiple domains must be monitored simultaneously to be useful for management, quality improvement and planning purposes. To measure some performance indicators and not others undermines the systemic nature of these indicator sets. The objective of this phase of testing is to understand the relationships and potential redundancy across the proposed measures. This phase will also test the measures for use with various populations and settings.

While these are proposed as two distinct phases, both these testing components could occur at the same time. The plan is to test both measures derived from administrative databases and from surveys under development. The intent is to test these performance measures in different settings and, if possible, for different uses.

A significant aspect of the testing plan is coordination with other measurement testing initiatives. MQR Workgroup members met with Data Infrastructure Grant outcomes group representatives on September 23, 2004, to review and discuss testing for the two new SAMHSA National Outcomes Measures. This meeting resulted in initial conceptualization of the two measures and guidance from SAMHSA and CMHS staff regarding rationale and approach to these two measures.

Similarly, to coordinate testing efforts of measures proposed in the MQR with other testing efforts, SAMHSA sponsored a meeting on October 8, 2004, to convene representatives from various national testing initiatives including: the Performance Measurement Forum, the Data Infrastructure Grant initiative, the Recovery Measurement Group, SAMHSA's Co-Occurring Disorder Infrastructure Grant (COSIG) initiative, the National Committee on Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The product of this meeting was a set of recommendations about how best to coordinate and develop a testing plan that could address the needs of the individual groups. The report from this meeting and the proposed testing plan is available on the MHSIP website at www.mhsip.org.

How Can You Be Involved?

You can participate in the testing plan for the MHSIP Quality Report in several ways. These include:

- (1) Volunteering to work with the MHSIP Quality Report Testing Committee to pilot-test some of the performance measures. If you are interested in participating in this next phase, please go to the MHSIP website at www.mhsip.org and complete the MHSIP Quality Report Testing Form, or contact Vijay Ganju at (703) 739-9333 or Mary Smith at (312) 814-4948. At the website, you can also provide comments and suggestions regarding this report or its companion toolkit.
- (2) Incorporating proposed MQR measures into their grant initiatives to help test these measures by those states that have the capacity to produce basic and developmental tables.
- (3) Sharing information about the MQR with your key stakeholders as a means of marketing the concepts of standardized measurement and system performance improvement embodied by the MQR.

APPENDICES

TABLE OF APPENDICES

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APPENDIX A:

Proposed Measures — Universal Set

APPENDIX A: PROPOSED MEASURES -- UNIVERSAL SET

<p>1. PERFORMANCE INDICATOR: CONSUMER PERCEPTION OF OUTCOMES/ CONSUMER PERCEPTION OF IMPROVEMENT</p>
<p>Concern: This indicator is the most direct measure of the consumer’s perception of the outcomes of services received. (The outcomes are those identified as important outcomes for consumers.)</p>
<p>Performance Measure: Seven items from the MHSIP Consumer Survey. 1. I deal more effectively with daily problems. 2. I am better able to control my life. 3. I am better able to deal with crisis. 4. I am getting along better with my family. 5. I do better in social situations. 6. I do better in school and/or work. 7. My symptoms are not bothering me as much. Numerator: Total number of respondents with an average scale score of greater than or equal to 2.5. Denominator: Total number of respondents.</p>
<p>2. PERFORMANCE INDICATOR: ACTIVE PARTICIPATION IN TREATMENT PLANNING AND DECISIONS</p>
<p>Concern: Participation by consumers (and family members for children) in decisions regarding treatment fosters a collaborative, trusting relationship and supports the consumer’s (or family member’s) ability to make decisions and act responsibly. Both for health and mental health services, research indicates that such involvement is correlated with positive outcomes.</p>
<p>Performance Measure: Two items from the MHSIP Consumer Survey are recommended: · I, not staff, decided my treatment goals · I felt comfortable asking questions about my treatment and medication Numerator: Total number of respondents with an average scale score of greater than or equal to 2.5. Denominator: Total number of respondents.</p>
<p>3. PERFORMANCE INDICATOR: RECOVERY ORIENTATION OF SYSTEM</p>
<p>Concern: Recovery is an important concept that is a goal of persons receiving mental health services. A systems- or organization-level recovery orientation is critical to achieving this goal.</p>
<p>Performance Measure: Self-report items related to the following domains (see Recovery-Oriented System Report). ▪ Meaningful Activities (work, education, voluntary and/or group advocacy activities that are meaningful to the individual facilitate recovery).</p>

<ul style="list-style-type: none"> ▪ Social Relationships (Social and personal relationships play important roles in facilitating recovery.) ▪ Choice (Having choices, as well as support in the process of making choices, regarding housing, work, social service, and treatment as well as other areas of life, facilitates recovery.) <p>Note: Additional measures may be included.</p>
<p>4. PERFORMANCE INDICATOR: QUALITY OF INTERACTION BETWEEN CLINICIANS AND CONSUMERS</p>
<p>Concern: Persons receiving treatment services should feel that those who provide the services treat them with respect, communicate effectively, and spend sufficient time with them, and that they themselves feel safe and are sufficiently involved in their treatment.</p>
<p>Performance Measure: The people I went to for services explained things in a way I understood. The people I went to for services spent enough time with me. Numerator: Total number of respondents with an average scale score of greater than or equal to 2.5. Denominator: Total number of respondents.</p>
<p>5. PERFORMANCE INDICATOR: PERCEPTION OF OVERALL QUALITY OF TREATMENT</p>
<p>Concern: Persons receiving treatment services should experience high quality treatment.</p>
<p>Performance Measure: Overall Quality of Treatment (single item excerpted from ECHO) Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate the counseling or treatment you received in the last [] months? Also for consideration, items from the MHSIP Adult Consumer Survey: Staff believed I could grow, change and recover. I felt free to complain. Staff told me what side effects to watch for. Staff respected my wishes about who is and is not to be given information about my treatment. Staff were sensitive to my cultural/ethnic background. Staff helped me obtain the information I needed so I could take charge of managing my illness.</p>
<p>6. PERFORMANCE INDICATOR: SAFETY (with a focus on medication errors)</p>
<p>Concern: A critical component of the treatment of persons with mental illnesses, particularly those clients with severe and persistent illnesses is pharmacotherapy. If appropriately prescribed, distributed, administered and monitored, pharmacotherapy can produce significant improvement in symptoms. However, if inappropriately prescribed, distributed, administered or monitored, medications can be associated with significant harm or death to the consumer. Given the relatively high incidence of medication use among consumers of psychiatric services and the high potential for adverse outcomes of medication-related errors, tracking of such errors and subsequent identification of causal factors is an essential component of the performance improvement process in organizations providing psychiatric health care.</p>

<p>Performance Measure: Numerator: Total number of medication errors. Denominator: The sum of the total number of consumers on the inpatient census at the end of the reporting period, the total number of discharges other than by death during the reporting period and the total number of deaths occurring during the reporting period (duplicated count).</p>
<p>7. PERFORMANCE INDICATOR: AVAILABILITY OF SERVICES (Under Development)</p>
<p>Concern: A full range of mental health service options should be available. Another aspect of this concern is that the mental health system should facilitate access to other community and physical health services</p>
<p>Performance Measure: While this indicator is considered to reflect a critical concern, performance measures for this indicator are under development. The approach adopted in the original MHSIP Report Card was for the performance indicator to identify “marker” services to monitor, such as consumer peer support services and services delivery in home settings, the assumption being that, if such services were present, then a full range was likely to be available. Measures for different populations and different settings still remain to be developed.</p>
<p>8. PERFORMANCE INDICATOR: AVAILABILITY OF INFORMATION/EDUCATION</p>
<p>Concern: Service recipients should receive information that enables them to make informed choices about services. The premise of this concern is that consumers and family members must be informed about treatment options, expectations and consequences. To enhance consumer’s inclusion in the therapeutic process, they must have the information necessary to make informed choices about their care.</p>
<p>Performance Measure: Could potentially be measured by questions included on the MHSIP Consumer Survey or through administrative data. Some questions that were used in the original MHSIP Survey included the following:</p> <ul style="list-style-type: none"> • I felt comfortable asking questions about my treatment and medication. • I was given information about my rights. • Staff told me what side effects to watch for. <p>Numerator: Total number of respondents with an average scale score of greater than or equal to 2.5. Denominator: Total number of respondents.</p>
<p>9. PERFORMANCE INDICATOR: INITIATION OF TREATMENT</p>
<p>Concern: Systems of care have a responsibility to provide access to appropriate care to persons identified as having mental health problems.</p>
<p>Performance Measure: The percent of persons with a new episode of services for any of a specified set of mental</p>

<p>disorders* who meet one of the following criteria during the course of a year. (A new episode is defined by the absence of a claim or encounter with an ICD-9 or DSM-IV diagnosis code for any of the selected conditions during a period of 120 days prior to the index visit.)</p> <p>a) At least one outpatient mental health visit with a primary or secondary diagnosis code for any of the selected conditions within 14 days after the index encounter (i.e. the encounter at which the diagnosis was made);</p> <p>b) An encounter in a residential mental health treatment facility or an intensive structured mental health outpatient program within 14 days after the index encounter;</p>
<p>c) An index encounter in an inpatient mental health facility with a primary or secondary diagnosis code for any of the selected conditions (initiation is complete at discharge);</p> <p>d) An index encounter in a general medical inpatient setting with a primary diagnosis code for any of the selected conditions (initiation is complete at discharge);</p> <p>e) An index encounter in a general medical inpatient setting with a secondary diagnosis code for any of the selected conditions and a mental health procedure code (initiation is complete at discharge).</p> <p>Numerator: Number of persons enrolled for a full year who meet any of criteria (a) through (e). Denominator: Number of persons enrolled for a full year that have a new episode of services for one of the specified mental disorders.</p> <p>*Schizophrenia and Psychosis; Disorders of Mood; Anxiety; Eating; Somatoform; Dissociative; Impulse (not elsewhere classified); Personality.</p>
<p>10. PERFORMANCE INDICATOR: CULTURAL COMPETENCE</p>
<p>Concern: Consumers must have access to a primary mental health provider who meets their needs in terms of ethnicity, language, culture, age, and disability. This concern identifies the degree to which cultural and linguistic barriers might affect access to services. Consumer survey items are a direct measure of this concern. A comparison of utilization rates across population groups is an indirect measure of a potential problem in this area. If compatibility is an obstacle, the problem group would be expected to have a higher rate of one and only one visit (which suggests dropouts), and a lower rate of one or more visits, compared to other groups. Of course, there are other possible interpretations for this type of outcome, and effort should be made to assess other differences among clients that might account for variations in service use.</p>
<p>Performance Measure: The following consumer survey items are proposed for testing:</p>
<ul style="list-style-type: none"> -My individual needs and goals were met. -Staff were sensitive to my cultural background (race, ethnicity, religion, language, age, sexual orientation, etc.). (current Adult MHSIP item) -My culture and race/ethnicity was included in planning the services I received. -Staff understood the customs and traditions of my race/ethnic group. -I was able to get services from staff of my race/ethnicity group when I wanted. -Staff was able to speak my language (or use interpreters) whenever I needed. <p>Numerator: Total number of respondents with an average scale score of greater than or equal to 2.5.</p> <p>Denominator: Total number of respondents.</p>

<p>11. PERFORMANCE INDICATOR: CO-OCCURRING PROBLEMS/SCREENING – Note: This indicator is currently being redefined in collaboration with the following SAMHSA initiatives: CMHS Data Infrastructure Grants, CSAT Data Infrastructure Grants, Co-Occurring State Infrastructure Grants</p>
<p>Performance Measures: The following two measures are recommended.</p>
<p>Measure 1: Percentage of persons screened for a co-occurring mental illness/substance abuse diagnosis.</p>
<p>Numerator: Number of persons screened for a co-occurring mental illness/substance disorder. Denominator: Number of persons seen for an intake/screened during the fiscal year. Measure 2: Percentage of persons with a co-occurring mental illness/substance abuse diagnosis on Axis I or Axis II of DSM-IV. Numerator: Number of persons with a co-occurring mental illness/substance abuse diagnosis on Axis I or Axis II of DSM-IV. Denominator: Number of intakes (screenings) performed during the fiscal year.</p>
<p>12. PERFORMANCE INDICATOR: REDUCTION OF SYMPTOMS – Note: This indicator is in the process of being operationalized across multiple performance measurement initiatives, including CMHS Data Infrastructure Grants, CSAT Data Infrastructure Grants, and SAMHSA CO-SIG Grants. Discussion has included “reduction of symptoms” in the context of its relationship to functioning.</p>
<p>Concern: Mental health treatment should result in a reduction of a consumer’s symptoms and an improvement in ability to function. Symptom level is distinct from symptom distress. Currently, <i>symptom level</i> is assessed by the mental health service provider, while <i>symptom distress</i> is usually reported by the consumer. For this reason, level of distress was selected to represent most closely whether an individual's symptoms are relieved following treatment. There may be individuals for whom self-reported psychological distress may not be an appropriate measure (e.g., children, people receiving involuntary treatment).</p>
<p>Performance Measure: The following survey items have been proposed by a Data Infrastructure Workgroup for testing: <u>Adults (Use response scale for MHSIP Adult Survey)</u> <i>As a result of the services I received ...</i> I do things that are more meaningful to me. I am better able to take care of my needs. I am better able to handle things when they go wrong. I am better able to do things that I want to do. <u>Caregiver: Children/Adolescents (Use response scale for the MHSIP YSS/YSF Survey)</u> <i>As a result of the services my child received ...</i> My child is better able to do things he or she wants to do.</p>

<p>13. PERFORMANCE INDICATOR: SOCIAL SUPPORT/CONNECTEDNESS - Note: This indicator is in the process of being operationalized across multiple SAMHSA performance measurement initiatives, including CMHS Data Infrastructure Grants,</p> <p>13. PERFORMANCE INDICATOR: SOCIAL SUPPORT/CONNECTEDNESS - Note: This indicator is in the process of being operationalized across multiple SAMHSA performance measurement initiatives, including CMHS Data Infrastructure Grants, CSAT Data Infrastructure Grants, and CO-SIG Grants.</p>
<p>Concern: Social support/connectedness supports consumers' movement toward recovery</p>
<p>Performance Measure: The following survey items have been proposed by a Data Infrastructure Workgroup for testing:</p> <p><u>Adults (Use response scale for MHSIP Adult Survey)</u></p> <p><i>Other than my service providers ...</i></p> <ol style="list-style-type: none">1. I know people who will listen and understand me when I need to talk.2. In a crisis, I would have the support I need from family or friends.3. When I need help right away, I know people I can call on.4. I have more than one friend.5. I am happy with the friendships I have.6. I have people with whom I can do enjoyable things.7. I feel I belong in my community. <p><u>Caregiver: Children/Adolescents (Use response scale for the MHSIP YSS/YSF Survey)</u></p> <p><i>Other than my child's service providers ...</i></p> <ol style="list-style-type: none">1. I know people who will listen and understand me when I need to talk.2. In a crisis, I would have the support I need from family or friends.3. I have people that I am comfortable talking with about my child's problems.4. I have people that I am comfortable talking to about private things.5. I have more than one friend.6. I am happy with the friendships I have.7. I have people with whom I can do enjoyable things.

APPENDIX B:

**Proposed Measures – Population
Specific**

APPENDIX B: PROPOSED MEASURES

ALL ADULTS

<p>1. PERFORMANCE INDICATOR: ADULTS RECEIVING PEER SUPPORT SERVICES.</p>
<p>Concern: Peer support services use the principles, philosophy and many of the methods of self-help groups and are critical for the provision of role models and mentors to spur recovery. Consumers have identified a lack of peer-run and peer-support services as a deterrent to recovery</p>
<p>Performance Measure: Peer-run and peer-support services are independent of, or adjunct to, formal mental health services and include: drop-in centers, peer case management, peer professional services, and social clubs. Numerator: Unduplicated number of consumers with severe mental illness receiving peer support services during the reporting period. Denominator: Unduplicated number of adults with serious mental illness served during the reporting period.</p>
<p>2. PERFORMANCE INDICATOR: PERCENT OF RESPONDENTS RECENTLY IN THE WORK FORCE REPORTING A TARGET LEVEL OF IMPROVEMENT IN ABILITY TO PERFORM PAID WORK.</p>
<p>Concern: Persons receiving treatment services should maintain or improve their ability to function at work.</p>
<p>Performance Measure: Perceived work functioning improvement item (with screeners/case mix adjuster). Screener: (In work force at some time during specified period, and measure of full-time/part-time): <u>In the last [] months</u>, have you worked at any time in a job where you were paid at least minimum wage? Include self-employment. Do not count work you did as part of treatment for an illness. (Response options: Yes, full-time (35 hours/wk or more; Yes, part-time (less than 35hrs/wk; No.) Measure of current employment and current work impairment: <u>In the past two weeks</u>, how many days, if any, have you had to <u>miss or cut back on time at work</u> as a result of mental, emotional, physical, or family problems? <u>If “yes” to screener: Compared to [] months ago</u>, how would you rate your ability to perform paid work now?</p>

ADULTS WITH SERIOUS MENTAL ILLNESS

<p>1. PERFORMANCE INDICATOR: ADULTS WITH SCHIZOPHRENIA RECEIVING NEW GENERATION MEDICATIONS*</p>
<p>Concern: New generation anti-psychotic medications have been found to be preferable to many older agents in the treatment of schizophrenia, in particular, and psychoses more generally. Therefore, the extent to which such agents are available in the mental health system may be one indication of the degree to which consumers with such mental illnesses are receiving optimal treatment.</p>

<p>Performance Measure: Numerator: The number of adults with a primary 295 diagnosis receiving a scheduled or standing order of one or more new generation antipsychotic medications (see list of new generation antipsychotic medications below) at any time during their treatment in the fiscal year.</p>
<p>Denominator: Count of all adults with a primary 295 diagnosis receiving treatment during the same fiscal year. *New generation medications: Clozapine, Quetiapine, Olanzapine, Risperidone, Ziprasidone, (Note: Other agents may be approved in the future).</p>
<p>2. PERFORMANCE INDICATOR: AVAILABILITY OF ILLNESS SELF-MANAGEMENT TRAINING.</p>
<p>Concern: Evidence-based services that promote long-term recovery should be important components of any system that serves people with serious mental illness.</p>
<p>Performance Measure: Includes a broad range of health, lifestyle, and self-assessment and treatment behaviors by the individual with mental illness, often with the assistance and support of others, so they are able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. Self-management includes psychoeducation, behavioral tailoring, early warning sign recognition, coping strategies, social skills training, and cognitive behavioral treatment. Numerator: Number of adults receiving illness self-management training Denominator: Number of adults receiving mental health services</p>
<p>3. PERFORMANCE INDICATOR: INVOLVEMENT IN THE CRIMINAL JUSTICE SYSTEM</p>
<p>Concern: The interface of the mental health and criminal justice systems is an area of concern for mental health program administrators who must deal with multiple consumer sub-populations with diverse needs. Knowing the size of specific sub-populations is important for planning targeted activities and allocating resources. A measure that assesses changes in the proportion of the caseload that has involvement with the criminal justice system is an indicator of treatment outcomes as well as a tool for planning interventions.</p>
<p>Performance Measure: Various performance measures have been associated with this indicator, some based on matched administrative data and some based on consumer survey or self-report. The following items are recommended for testing: <u>Measure 1:</u> Percentage of consumers with arrests during the treatment year. Numerator: Number of consumers with at least one arrest during the fiscal year. Denominator: Total number of consumers receiving service during the fiscal year. <u>Measure 2:</u> Newly Proposed Self-Report Measures (including versions for adults and youth, with a reworded version for caregivers): How many times were you arrested in the last 6 months? How many times were you arrested in the same 6 months last year?</p>

APPENDIX B: PROPOSED MEASURES (continued)

ALL CHILDREN (Note: The indicators identified for children with serious emotional disturbance were the same as those identified for all children.)

<p>1. PERFORMANCE INDICATOR: IMPROVEMENT IN SCHOOL FUNCTIONING</p> <p>Concern: From a societal perspective, the impact of mental illness and mental health treatment on school attendance and performance are major issues. It is recognized that school attendance and school performance are not determined solely by the mental health services received and that mental health service providers cannot be held solely responsible for school performance. However, this is a critical objective for such services and mental health services should have some impact.</p> <p>Performance Measure: Various performance measures have been associated with this indicator, some based on administrative data collection and data matching, and some based on consumer survey or self-report. The work group is considering the use of these options for this indicator.</p> <p>As an outcome measure, a longitudinal approach to monitoring change for an individual is recommended, but cross-sectional approaches can be used. Measures of school attendance, while not necessarily ideal, were considered less burdensome.</p> <p>As a result of the 16-State Pilot Indicator Project, the Children’s Workgroup developed two items that are included in the Youth Services Survey (YSS) and Youth Services Survey for Families (YSS-F) that gather information related to school improvement:</p> <p><u>Measure 1:</u> “As a direct result of services I received, I am doing better in school or work”.</p> <p><u>Measure 2:</u> Number of Days Absent from School in Last 30 days, as a percentage of available school days</p> <p>Numerator: Sum number days absent across all consumers 6 – 17 years old enrolled in school (Absence rate at admission minus Absence rate from school during last 30 days)</p> <p>Denominator: Total number of consumers 6 - 17 years old enrolled in school</p> <p><u>Measure 3:</u> Change in functioning as measured by scores on standardized functioning assessment scales in the school domain.</p> <p>Numerator: Number of consumers age 6 – 17 years old enrolled in school with a change (improvement or regression, not both) reported during a defined time period.</p> <p>Denominator: Total number of consumers 6 - 17 years old enrolled in school.</p> <p><u>Measure 4:</u> Self-report of parents using the Youth Service Survey for Families (YSS-F).</p> <p>Numerator: Number of parents reporting improvement or regression (not both) in consumers age 6 – 17 years) school functioning during a defined time period)</p> <p>Denominator: Total number of consumers 6 - 17 years old enrolled in school for whom YSS-F was completed.</p> <p><u>Measure 5.</u> Self-report of youth using the Youth Services Survey (YSS).</p> <p>Numerator: Number of youth (age 6 – 17 years) reporting improvement or regression in school functioning during a defined time period using the YSS.</p> <p>Denominator: Total number of consumers 6 - 17 years old enrolled in school for whom YSS was completed.</p> <p>Newly Proposed Self-Report Measures for Testing (Data Infrastructure Grant)</p> <p>-During the last month you were in school in this past year, how many days were you absent?</p> <p>-How many days were you absent in the same time period in the previous year?</p>

<p>2. PERFORMANCE INDICATOR: AVAILABILITY OF ILLNESS SELF-MANAGEMENT TRAINING FOR ADOLESCENTS</p>
<p>Concern: Evidence-based services that promote long-term recovery should be important components of any system that serves people with serious mental illness.</p>
<p>Performance Measure: Includes a broad range of health, lifestyle, self-assessment and treatment behaviors by the individual with mental illness, often with the assistance and support of others, so they are able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. Self-management includes Psychoeducation, behavioral tailoring, early warning sign recognition, coping strategies, social skills training, and cognitive behavioral treatment. Numerator: Number of adolescents receiving illness self-management training. Denominator: Number of adolescents receiving mental health services.</p>
<p>3. PERFORMANCE INDICATOR: INVOLVEMENT IN THE JUVENILE JUSTICE SYSTEM</p>
<p>Concern: The interface of the mental health and criminal justice systems is an area of concern for mental health program administrators who must deal with multiple consumer sub-populations with diverse needs. Knowing the size of specific sub-populations is important for planning targeted activities and allocating resources. A measure that assesses changes in the proportion of the caseload that has involvement with the juvenile justice system is an indicator of treatment outcomes as well as a tool for planning interventions.</p>
<p>Performance Measure: Various performance measures have been associated with this indicator, some administrative and some based on consumer survey or self-report. The following newly proposed items are recommended for testing: -How many times were you arrested in the last 6 months? -Was that more, less or about the same, when compared to the same 6 months last year?</p>

APPENDIX C:

Proposed Measures – Setting-Specific

APPENDIX C: PROPOSED MEASURES – SETTING SPECIFIC

Proposed Measures for Specific Settings

(Note: The only settings identified as having specific measures were hospitals and comprehensive community systems. The proposed universal measures and specific population measures applied to all other settings.)

HOSPITAL SETTINGS

<p>1. PERFORMANCE INDICATOR: RESTRAINT</p>
<p>Concern: Mental health service providers that are consumer-focused value an individual’s autonomy and independence. Therefore, these providers seek to maximize the use of service modalities that are minimally, if at all, restrictive. While restrictive treatments are sometimes necessary, utilization of such treatments must be minimized and closely monitored. Over-utilization of highly restrictive treatments may represent the unavailability of more appropriate, less restrictive therapies or the presence of treatment providers who lack respect for client autonomy and dignity.</p>
<p>Performance Measure: Measure 1: Hours of restraint as a percent of client hours Numerator: The total number of hours that all clients spent in restraint during a reporting period Denominator: Sum of the daily census (excluding clients on leave status) for each day in a reporting period (client days) multiplied by 24 hours Measure 2: Percent of clients restrained at least once during the reporting period Numerator: The total number of clients (unduplicated) who were restrained at least once during a reporting period Denominator: The total number of unduplicated clients who were inpatients at the facility during the reporting period</p>
<p>2. PERFORMANCE INDICATOR: SECLUSION</p>
<p>Concern: Mental health service providers that are consumer-focused value an individual’s autonomy and independence. Therefore, these providers seek to maximize the use of service modalities that are minimally, if at all, restrictive. While restrictive treatments are sometimes necessary, utilization of such treatments must be minimized and closely monitored. Over-utilization of highly restrictive treatments may represent the unavailability of more appropriate, less restrictive therapies or the presence of treatment providers who lack respect for client autonomy and dignity.</p>
<p>Performance Measure: Measure 1: Hours of seclusion as a percent of client hours Numerator: The total number of hours that all clients spent in seclusion. Denominator: Sum of the daily census (excluding clients on leave status) for each day (client days) multiplied by 24 hours Measure 2: Percent of clients secluded at least once during a reporting period Numerator: The total number of clients (unduplicated) who were secluded at least once during a reporting period Denominator: The total number of unduplicated clients who were inpatients at the facility during a reporting period</p>

APPENDIX C: Proposed Measures – Setting Specific

COMPREHENSIVE COMMUNITY SYSTEM

<p>1. PERFORMANCE INDICATOR: CONSUMER/FAMILY MEMBER PERCEPTION OF ACCESS / Percent of responses from recipients of service reporting that access to treatment is at or above a specific target level</p>
<p>Concern: Quick, convenient entry into the healthcare system is a critical aspect of the accessibility of services. Delays can result in inappropriate care or an exacerbation of distress. If a person's problem is related to behavioral health, the time it takes to have contact with a mental health professional, rather than a professional with some other expertise, is a critical component of appropriate treatment.</p> <p>Performance Measure: Various performance measures have been associated with this indicator, some administrative and some based on consumer survey or self-report. The work group is considering the use of these options for this indicator.</p>
<p>Performance Measure:</p> <ol style="list-style-type: none">1. The location of services was convenient (parking, public transportation, distance, etc.)2. Staff was willing to help as often as I felt it was necessary.3. My calls were returned within 24 hours.4. Services were available at times that were good for me. <p>Numerator: Total number of respondents with an average scale score of greater than or equal to 2.5.</p> <p>Denominator: Total number of respondents.</p>

APPENDIX D: MHSIP SURVEYS

MHSIP ADULT SURVEY

MHSIP Consumer Survey (Version 1.1, Feb, 2000)						
In order to provide the best possible mental health services, we need to know what you think about the services you received during the last (specify timer period), the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers. Please indicate your agreement/ disagreement with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle the number 9 to indicate that this item is "not applicable" to you.						
	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.	1	2	3	4	5	9
2. If I had other choices, I would still get services from this agency.	1	2	3	4	5	9
3. I would recommend this agency to a friend or family member.	1	2	3	4	5	9
4. The location of services was convenient (parking, public transportation, distance, etc.).	1	2	3	4	5	9
5. Staff were willing to see me as often as I felt it was necessary.	1	2	3	4	5	9
6. Staff returned my call in 24 hours.	1	2	3	4	5	9
7. Services were available at times that were good for me.	1	2	3	4	5	9
8. I was able to get all the services I thought I needed.	1	2	3	4	5	9
9. I was able to see a psychia- trist when I wanted to.	1	2	3	4	5	9
10. Staff here believe that I can grow, change and recover.	1	2	3	4	5	9
11. I felt comfortable asking questions about my treatment and medication.	1	2	3	4	5	9
12. I felt free to complain.	1	2	3	4	5	9
13. I was given information about my rights.	1	2	3	4	5	9
14. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	9
15. Staff told me what side effects to watch out for.	1	2	3	4	5	9
16. Staff respected my wishes about who is and who is not to be given information about my treatment.	1	2	3	4	5	9
17. I, not staff, decided my treatment goals.	1	2	3	4	5	9

THE MHSIP QUALITY REPORT

18. Staff were sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	9
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.	1	2	3	4	5	9
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1	2	3	4	5	9
MHSIP CONSUMER SURVEY (VERSION 1.1, FEB, 2000)						
In order to provide the best possible mental health services, we need to know what you think about the services you received during the last (specify timer period), the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers.						
	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
As a Direct Result of Services I received:						
21. I deal more effectively with daily problems.	1	2	3	4	5	9
22. I am better able to control my life.	1	2	3	4	5	9
23. I am better able to deal with crisis.	1	2	3	4	5	9
24. I am getting along better with my family.	1	2	3	4	5	9
25. I do better in social situations.	1	2	3	4	5	9
26. I do better in school and/or work.	1	2	3	4	5	9
27. My housing situation has improved.	1	2	3	4	5	9
28. My symptoms are not bothering me as much.	1	2	3	4	5	9

Please feel free to use this space (and on the back of this form) to comment on any of your answers. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

Please provide the following information for statistical compilation purposes.

Male _____ Female _____ Age: _____
 Ethnicity: (check one) _____ Caucasian _____ Asian _____ African-American _____ Native-American
 _____ Latino _____ Other (please specify) _____

YOUTH SERVICES SURVEY (YSS)

PLEASE HELP OUR AGENCY MAKE SERVICES BETTER BY ANSWERING SOME QUESTIONS ABOUT THE SERVICES YOU RECEIVED OVER THE LAST 6 MONTHS. Your answers are confidential and will not influence the services you receive. Please indicate if you Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree with each of the statements below. Put a cross (x) in the box that best describes your answer. Thank you!!!

	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services I received.					
2. I helped to choose my services.					
3. I helped to choose my treatment goals.					
4. The people helping me stuck with me no matter what.					
5. I felt I had someone to talk to when I was troubled.					
6. I participated in my own treatment.					
7. I received services that were right for me.					
8. The location of services was convenient.					
9. Services were available at times that were convenient for me.					
10. I got the help I wanted.					
11. I got as much help as I needed.					
12. Staff treated me with respect.					
13. Staff respected my family's religious/spiritual beliefs.					
14. Staff spoke with me in a way that I understood.					
15. Staff were sensitive to my cultural/ethnic background.					
<u>As a result of the services I received:</u>					
16. I am better at handling daily life.					
17. I get along better with family members					
18. I get along better with friends and other people.					
19. I am doing better in school and/or work.					
20. I am better able to cope when things go wrong.					
21. I am satisfied with my family life right now.					

22. What has been the most helpful thing about the services you received over the last 6 months?

23. What would improve the services here?

Molly Brunk, Ph.D, 1999. This instrument was developed as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS).

It was adapted from the Family Satisfaction Questionnaire used with the CMHS Comprehensive Community Mental Services for Children and their Families Program and the MHSIP Consumer Survey. 6/5/01

Please answer the following questions to let us know how you are doing.

24. How long did you receive services from this Center?

<input type="checkbox"/>	a. Less than 1 month
<input type="checkbox"/>	b. 1-2 months
<input type="checkbox"/>	c. 3-5 months
<input type="checkbox"/>	d. 6 months to 1 year
<input type="checkbox"/>	e. More than 1 year

25. Are you still getting services from this Center? ___ Yes ___ No

26. Are you currently living with one or both parents? ___ Yes ___ No

27. Have you lived in any of the following places in the last 6 months?
(CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> a. With one or both parents | <input type="checkbox"/> g. Group home |
| <input type="checkbox"/> b. With another family member? | <input type="checkbox"/> h. Residential treatment center |
| <input type="checkbox"/> c. Foster home | <input type="checkbox"/> i. Hospital |
| <input type="checkbox"/> d. Therapeutic foster home | <input type="checkbox"/> j. Local jail or detention facility |
| <input type="checkbox"/> e. Crisis shelter | <input type="checkbox"/> k. State correctional facility |
| <input type="checkbox"/> f. Homeless shelter | <input type="checkbox"/> l. Runaway/homeless/on the streets |
| | <input type="checkbox"/> m. Other describe): _____ |

28. **In the last year**, did you see a medical doctor (nurse) for a health check up or because you were sick? (Check one)

- Yes, in a clinic or office Yes, but only in a hospital emergency room
 No Do not remember

29. Are you on medication for emotional/behavioral problems? Yes ___ No ___

29a. If yes, did the doctor or nurse tell you what side effects to watch for? Yes ___ No ___

30. In the last month, did you get arrested by the police? Yes ___ No ___

31. In the last month, did you go to court for something you did? Yes ___ No ___

32. How often were you absent from school during the last month?

<input type="checkbox"/>	a. 1 day or less
<input type="checkbox"/>	b. 2 days
<input type="checkbox"/>	c. 3 to 5 days
<input type="checkbox"/>	d. 6 to 10 days
<input type="checkbox"/>	e. More than 10 days
<input type="checkbox"/>	f. Not applicable / not in school
<input type="checkbox"/>	g. Do not remember

Please answer the following questions to let us know a little about you.

Race: (Check two if needed)

___American Indian/Alaskan Native ___White (Caucasian) ___Black (African American)

___Asian/Pacific Islander ___Other (describe): _____

Are either of your parents Spanish/Hispanic/Latino? ___Yes ___No

Gender: ___Male ___Female

Birth Date: _____

Today's Date: _____

Do you have Medicaid insurance? ___ Yes ___No ___Don't know

Thank you for taking the time to answer these questions!

YOUTH SERVICES SURVEY (YSS-F) PARENT/FAMILY FORMAT

Please help our agency make services better by answering some questions about the services your child received **OVER THE LAST 6 MONTHS**. Your answers are confidential and will not influence the services you or your child receive. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree** or **Strongly Agree** with each of the statements below. Put a cross (X) in the box that best describes your answer. Thank you!!!

	Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
1. Overall, I am satisfied with the services my child received.					
2. I helped to choose my child's services.					
3. I helped to choose my child's treatment goals.					
4. The people helping my child stuck with us no matter what.					
5. I felt my child had someone to talk to when he/she was troubled.					
6. I participated in my child's treatment.					
7. The services my child and/or family received were right for us.					
8. The location of services was convenient for us.					
9. Services were available at times that were convenient for us.					
10. My family got the help we wanted for my child.					
11. My family got as much help as we needed for my child.					
12. Staff treated me with respect.					
13. Staff respected my family's religious/spiritual beliefs.					
14. Staff spoke with me in a way that I understood.					
15. Staff were sensitive to my cultural/ethnic background.					
As a result of the services my child and/or family received:					
16. My child is better at handling daily life.					
17. My child gets along better with family members					
18. My child gets along better with friends and other people.					
19. My child is doing better in school and/or work.					
20. My child is better able to cope when things go wrong.					
21. I am satisfied with our family life right now.					

22. What has been the most helpful thing about the services you and your child received over the last 6 months?

23. What would improve the services here?

Molly Brunk, Ph.D, 1999. This instrument was developed as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS).

It was adapted from the Family Satisfaction Questionnaire used with the CMHS Comprehensive Community Mental Services for Children and their Families Program and the MHSIP Consumer Survey. 6/5/01

Please answer the following questions to let us know how your child is doing.

24. How long did your child receive services from this Center?

<input type="checkbox"/>	a. Less than 1 month
<input type="checkbox"/>	b. 1-2 months
<input type="checkbox"/>	c. 3-5 months
<input type="checkbox"/>	d. 6 months to 1 year
<input type="checkbox"/>	e. More than 1 year

25. Is your child still getting services from this Center? ___ Yes ___ No

26. Is your child currently living with you? ___ Yes ___ No

27. Has your child lived in any of the following places in the last 6 months?
(CHECK ALL THAT APPLY)

- | | |
|--|---|
| <input type="checkbox"/> a. With one or both parents | <input type="checkbox"/> g. Group home |
| <input type="checkbox"/> b. With another family member | <input type="checkbox"/> h. Residential treatment center |
| <input type="checkbox"/> c. Foster home | <input type="checkbox"/> i. Hospital |
| <input type="checkbox"/> d. Therapeutic foster home facility | <input type="checkbox"/> j. Local jail or detention |
| <input type="checkbox"/> e. Crisis shelter | <input type="checkbox"/> k. State correctional facility |
| <input type="checkbox"/> f. Homeless shelter | <input type="checkbox"/> l. Runaway/homeless/on the streets |
| | <input type="checkbox"/> m. Other (describe): _____ |

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28. In the last year, did your child see a medical doctor (or nurse) for a health check up or because you were sick? (Check one)

- Yes, in a clinic or office Yes, but only in a hospital emergency room
 No Do not remember

29. Is your child on medication for emotional/behavioral problems? ___ Yes ___ No

29a. If yes, did the doctor or nurse tell you and/or your child what side effects to watch for?
 ___ Yes ___ No

30. In the last month, did your child get arrested by the police? ___ Yes ___ No

31. In the last month, did your child go to court for something he/she did? ___ Yes ___ No

32. How often was your child absent from school during the last month?

<input type="checkbox"/>	a. 1 day or less
<input type="checkbox"/>	b. 2 days
<input type="checkbox"/>	c. 3 to 5 days
<input type="checkbox"/>	d. 6 to 10 days
<input type="checkbox"/>	e. More than 10 days
<input type="checkbox"/>	f. Not applicable / not in school
<input type="checkbox"/>	g. Do not remember

Please answer the following questions to let us know a little about your child.

Child's Race: (Check two if needed)

___ American Indian/Alaskan Native ___ White (Caucasian) ___ Black (African American)

___ Asian/Pacific Islander ___ Other (describe): _____

Are either of the child's parents Spanish/Hispanic/Latino? ___ Yes ___ No

Child's Birth Date: _____ **Today's Date:** _____

Child's Gender: ___ Male ___ Female

Does your child have Medicaid insurance? ___ Yes ___ No ___ Don't know

Thank you for taking the time to answer these questions!

NRI / MHSIP Inpatient Consumer Survey

Unit ID _____

Survey No. _____

Date _____
(MM/YY)

In order to provide the best possible mental health services, we need to know what you think about the services you received during this hospital stay, the people who provided it, and the results. Please indicate your level of disagreement or agreement with each of the statements below. Your answers are confidential and will not influence the services you receive. CIRCLE THE NUMBER in the box that best describes your answer. There is space at the end of the survey to comment on any your answers.

	Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Does Not Apply
As a direct result of the services I received	1	2	3	4	5	N/A
1. I am better able to deal with crisis.	1	2	3	4	5	N/A
2. My symptoms are not bothering me as much.	1	2	3	4	5	N/A
3. The medications I am taking help me control symptoms that used to bother me.	1	2	3	4	5	N/A
4. I do better in social situations.	1	2	3	4	5	N/A
5. I deal more effectively with daily problems.	1	2	3	4	5	N/A
During my hospital stay:	1	2	3	4	5	N/A
6. I was treated with dignity and respect.	1	2	3	4	5	N/A
7. Staff here believed that I could grow, change and recover.	1	2	3	4	5	N/A
8. I felt comfortable asking questions about my treatment and medications.	1	2	3	4	5	N/A
9. I was encouraged to use self-help/support groups.	1	2	3	4	5	N/A
10. I was given information about how to manage my medication side effects.	1	2	3	4	5	N/A
11. My other medical conditions were treated.	1	2	3	4	5	N/A
12. I felt this hospital stay was necessary.	1	2	3	4	5	N/A
13. I felt free to complain without fear of retaliation.	1	2	3	4	5	N/A
14. I felt safe to refuse medications or treatment during my hospital stay.	1	2	3	4	5	N/A
15. My complaints and grievances were addressed.	1	2	3	4	5	N/A
16. I participated in planning my discharge.	1	2	3	4	5	N/A
17. Both I and my doctor or therapist from the community were actively involved in my hospital treatment plan.	1	2	3	4	5	N/A
18. I had an opportunity to talk with my doctor or therapist from the community prior to discharge.	1	2	3	4	5	N/A
19. The surroundings and atmosphere at the hospital helped me get better.	1	2	3	4	5	N/A
20. I felt I had enough privacy in the hospital.	1	2	3	4	5	N/A
21. I felt safe while I was in the hospital	1	2	3	4	5	N/A
22. The hospital environment was clean and comfortable.	1	2	3	4	5	N/A
23. Staff were sensitive to my cultural background	1	2	3	4	5	N/A
24. My family and/or friends were able to visit me.	1	2	3	4	5	N/A
25. I had a choice of treatment options.	1	2	3	4	5	N/A
26. My contact with my Doctor was helpful.	1	2	3	4	5	N/A
27. My contact with nurses and therapists was helpful.	1	2	3	4	5	N/A
28. If I had a choice of hospitals, I would still choose this one.	1	2	3	4	5	N/A

NASMHPD Research Institute, Inc. 2001.

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 phone 703.739.9333 fax 703.548.9517



THE MHSIP QUALITY REPORT

Please answer the following questions to let us know a little about you.

29. Age
 13-17
 18-24
 25-34
 35-54
 55-64
 65 and older

**32. Length of Stay
(This episode)**
 1 week or less
 1 month or less
 3 months or less
 More than 3 months

34. Marital Status
 Never Married
 Married
 Separated
 Divorced
 Widowed

30. Gender
 Male
 Female

**33. Race/Ethnicity
(check one)**
 Native American/Alaskan
Native
 Asian/Pacific Islander
 African American
 Hispanic/Latino
 White/Caucasian
 Other

35. Legal Status
 Voluntary Patient
 Voluntary by parent, guardian, etc.
 Involuntary: Civil
 Involuntary: Criminal
 Involuntary: Juvenile Judge
 Other

**31. I am completing this
survey at discharge?**
 Yes
 No

Comments:

Please return the completed survey to the facility. Thank you for your response.

NASMHPD Research Institute, Inc. 2001
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 phone 703.739.9333 fax 703.548.9517

APPENDIX E:

Charge to the MQR Workgroup

APPENDIX E: CHARGE TO THE WORKGROUP

Introduction

In April 1996, the report of the MHSIP Consumer-Oriented Mental Health Report Card was published and released at a public news conference. Shortly afterwards, the Center for Mental Health Services developed a grant program for states to implement mental health performance measurement systems using the indicators and measures in the report card as a model. At the same time, other performance initiatives -- the NASMHPD performance measures initiative, the ACMHA initiative, AMBHA, NCQA -- have used the MHSIP Report Card as a basis for their work, some more than others. The report card was also endorsed by several advocacy organizations including NAMI, NASMHPAC, and the Association of Ambulatory Behavioral Healthcare. Standardization of measures across states has been and is being tested through the five-state feasibility study and the 16-state indicator project sponsored by the Center of Mental Health Services. Standardization efforts are also being tested by the combining of the MHSIP survey and the Consumer Assessment of Behavioral Health Systems (CABHS) into the ECHOS instrument.

Also, through various development efforts, new instruments and measures have emerged which refine and enhance the original MHSIP Report Card. Instruments related to children's measures, the measurement of recovery, and inpatient settings are currently under development or being tested.

Various lessons have been learned through these initiatives and so it is time to incorporate these into a new formulation of a performance measurement system for the field of behavioral health. This is essentially what the workgroup is charged to do.

Rationale for the MHSIP Quality Report

The purpose of the MHSIP Quality Report effort is to maintain the momentum to build a consumer-driven, consumer-focused system that helps consumers move in the direction of recovery. Based on the factors described in the previous section, the time is opportune for the development of the next generation of recommendations for behavioral health performance measurement systems and it is fitting that the MHSIP community provide leadership to the field as it has in the past.

The rationale for the development of the MHSIP Quality Report is:

1. To incorporate the lessons learned from the development and implementation experiences of the MHSIP Report Card 1.0.
2. To incorporate refinements to existing measures, add new measures and delete measures that did not work.
3. To propose analytical and data presentation reports that could be adapted for various uses including systems accountability, quality improvement, contract management and consumer choice.

Charge

The charge to the Workgroup is to:

1. Build on the lessons learned and current refinements and developments related to performance measures proposed in MHSIP Report Card 1.0 and other behavioral health performance measurement initiatives to propose a set of behavioral health performance measures for the next generation of activity;
2. Develop a toolkit related to methodological and implementation issues related to the proposed measures;
3. Propose data presentation reports for different uses and audiences, and;
4. Incorporate new technologies for the implementation of performance measures and for the dissemination and distribution of reports.

APPENDIX F:

Report on Development of Recovery Orientation Measure

MENTAL HEALTH RECOVERY: WHAT HELPS AND WHAT HINDERS?
 A NATIONAL RESEARCH PROJECT FOR THE DEVELOPMENT OF RECOVERY
 FACILITATING SYSTEM PERFORMANCE INDICATORS

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**The MHSIP Quality Report:
 Report on the Development the Recovery
 Oriented System Indicators (ROSI) Measure**

Background

This national research project evolved from collaborative efforts among a team of consumer and non-consumer researchers, state mental health authorities, and a consortium of sponsors working to operationalize a set of mental health system performance indicators for facilitating an orientation in mental health recovery. The project was conceptualized as a three phase process that involved grounded theory inquiry concerning the phenomenon of recovery, creation of prototype systems-level performance indicators, and large scale pilot testing.

Phase One has been completed. Structured focus groups and grounded theory qualitative research methods were used in nine states with a diverse cross-section of 115 consumer/survivors to gain knowledge on what helps and what hinders mental health recovery. The research team then used a process of qualitative coding and member checks to develop a single set of emergent themes and findings. These findings inform and articulate a conceptual paradigm for organizing and interpreting the phenomenon of recovery. While recovery is a deeply personal journey, there are many commonalities in people’s experiences. Recovery is a product of complex, dynamic, synergistic and linked interaction among characteristics of the individual (the self, holism, hope, sense of meaning and purpose), characteristics of the environment (basic material resources, social relationships, meaningful activities, peer support, formal services, formal service staff), and the characteristics of the exchange (hope, choice, empowerment, independence, interdependence and referent power).

During Phase Two, the research team used the Phase One findings to develop two sets of performance indicators. The Phase One themes, codebook and findings provided the content and emphasis for the prototype indicators. The team reviewed each domain/ theme and corresponding branching (i.e., groupings, subgroupings, etc.) in the codebook, referring back to the unique concepts or natural meaning units as reflected in the codebook and Phase One findings for clarification of intent. They then brainstormed multiple performance indicator statements for each domain/theme.

The team then refined and edited the indicator items brainstormed, a process of reaching consensus on wording of the indicators items, eliminating redundancies, and checking the items against the codebook, Phase One findings and the Phase One member check priorities to ensure comprehensiveness (sometimes resulting in additional construction of indicator items). The team then reviewed other current mental health system performance measurement efforts as a further means of editing and refining a full range of recovery orientation system level performance indicators. Two sets of performance indicators emerged; 73 items were based on consumer self-report data (survey format) and 27 items based on administrative data (administrative profile format). Both sets of indicators attempt to capture how the orientation and practices within mental health systems help or hinder recovery.

Self-Report Item Set Refinement

The self-report item set has undergone extensive refinement. After consultation with Columbia University statisticians and survey methodologists and the statistician that evaluated the Mental Health Statistics Improvement Program (MHSIP) consumer survey, the research team developed two response scales, a six-point frequency scale and four point agreement scale, and matched each of the 73 self-report items to the more appropriate scale. Both scales had a “Does not Apply to Me” option.

In partnership with the South Carolina Mental Health Authority (MHA), the research team designed and conducted consumer review and feedback on the set of self-report indicators through the process of a Think Aloud. The goal of the Think Aloud was to solicit feedback on the clarity and specificity of the wording of each indicator. One facilitator, a research team member, conducted the Think Aloud session with 10 diverse volunteer consumers. Each participant received the 73 item set formatted into a survey. Each participant read the same item and replied using the response scale. The facilitator then provided the participants an opportunity to share their thinking about their understanding of the item. The facilitator and the recorder noted multiple understandings and disagreements as to the meaning of a given item. Participants also recorded some of their comments directly on the surveys, which were collected as part of the Think Aloud results.

The research team used the Think Aloud results, the results of a Flesch-Kincaid Grade Level readability check conducted by the Oklahoma MHA, and comments submitted by the Rhode Island and Arizona MHAs to further refine the self-report set of items. The goal was to make the meaning of the items clearer for consumers, thus increasing the likelihood that subsequent respondents arrive at similar understandings while retaining fidelity to what each item was intended to measure.

Working in partnership with the participating MHAs, the research team then designed a test and review of this self-report prototype indicator set. The test and review consisted of a background information set and a three part survey (respond to each item using the response scale, circle any wording that is not clear, and rate the importance of each item for evaluating mental health systems on a scale from 1-10). Eight MHAs volunteered to collect completed surveys from at least 25 consumers per state following a detailed sequential protocol (IRB

review, informed consent, definitions, incentives, and surveyor reports). Seven MHAs were successful in conducting the self-report prototype test and review (often exceeding the 25 participant goal), yielding 219 completed surveys. Working in conjunction with the state MHAs and HSRI, the research team participated in the development of codebooks for the background sheet and the survey. HSRI entered the data into one electronic data base and the research team and HSRI conducted data checks to ensure accuracy.

With the technical support of the New York MHA, a subgroup of the research team analyzed the prototype data results to further item refinement and overall parsimony. Each item was evaluated based on: (a) prototype importance rating, (b) factor loading values within a varimax rotated component matrix, (c) response scale distribution and direction, (d) Phase One originating theme, (e) items assessing similar content, (e) prototype clarity of wording, and (f) Phase One member check priorities. Selected demographic variables (e.g., housing status; parent status, etc.) were cross tabbed with selected item importance mean ratings to determine whether significant differences exist and therefore if an item should be retained or specified for a particular population. The resulting 41 items were then reviewed by the full research team, with opportunities to reconsider any of the dropped items. The end result is a 42 items, which have been crafted into the adult consumer self-report survey for the Recovery Oriented System Indicators (ROSI) measure.

Recognizing that a 42 self-report item set is lengthy, the research team also engaged in an effort to select a smaller subset of items. Eighteen items were selected based on a factor analysis of the 42 items set and research team review. The research team then used a queue sort process across a three point importance scale with “3” (highest), “2” (medium high), and “1” (low high). The research team retained nine items that averaged a rating of 2.0 or above and added a 10th item after preliminary review. The 10 item subset is not a stand alone measure or short version of the consumer survey. This 10 item subset is being advanced in conjunction with the full 42 item set to help inform the work on the MHSIP review of its consumer surveys as part of the MHSIP second generation performance indicator initiative, MHSIP Quality Report Version 2.0.

What follows is the original 73 self-report items organized under the Phase One themes (and sub-themes). Those items marked with an asterisk (*) are incorporated in the 42 item survey. Those items marked with a double asterisk (**) are included in the 10 item subset.

Recovery Theme: Meaningful Activities (involves the findings that work, education, voluntary and/or group advocacy activities that are meaningful to the individual facilitate recovery).

1. I have paid work opportunities that are meaningful to me.
 2. Mental health services helped me in get or keep employment.
 3. I have a chance to advance my education if I want to.
 4. Mental health services helped me in advancing my education if I wanted to.
- *21. Staff encourage me to do things that are meaningful to me.

Recovery Theme: Basic Material Resources (involves the findings that recovery from mental illness is incumbent on basic material resource needs being met).

- **5. I have housing that I can afford.
- 6. Mental health services helped me get housing that I can afford.
- *7. I have reliable transportation to get where I need to go.
- 8. Mental health services helped me get reliable transportation.
- *9. I have enough income to live on.
- 10. Mental health services helped me obtain enough income to live on.
- 11. I live in a safe location.
- *12. Mental health services helped me get housing in a place I feel safe.
- 13. My medical benefits do not meet my needs (for example, no dental care, no eye care, no choice in doctors, limited prescriptions, etc.).
- *14. Mental health services helped me get medical benefits that meet my needs.
- *22. Staff stood up for me to get the services and resources I needed.
- *51. I have a place to live that feels like a comfortable home to me.

Recovery Theme: Peer Support (involves the findings that peer support and consumer operated services in a myriad of forms facilitate recovery).

- *15. There was a consumer peer advocate to turn to when I needed one.
- *16. There are consumers working as paid employees in the mental health agency where I receive services.
- 17. I found helpful services in consumer run programs that were not available in other mental health services.
- 47. I have access to other consumers who act as role models.
- **48. I am encouraged to use consumer-run programs (for example, support groups, drop-in centers, etc.).

Recovery Theme: Choice (involves the findings that having choices, as well as support in the process of making choices, regarding housing, work, social, service, treatment as well as other areas of life facilitate recovery).

- 18. Staff support my right to try new things, take a risk or make a mistake.
- **19. I have a say in what happens to me when I am in crisis.
- *20. Staff give me complete information in words I understand before I consent to treatment or medication.
- *34. My right to refuse treatment is respected.
- *49. I do not have enough good service options to choose from.
- 50. Service programs restrict my freedom to associate with people of my choice.

Recovery Theme: Social Relationships (involves the findings concerning the roles social and personal relationships play in facilitating recovery).

- *30. Mental health staff interfere with my personal relationships.
- 55. I receive support to parent my children.

- **56. There is at least one person who believes in me.
- 57. I have supports to develop friendships with people outside the mental health system.

Social Relationships Sub-Theme: Community Integration/Involvement (involves the finding that community integration facilitates recovery).

- **58. I do not have the support I need to function in the roles I want in my community.

Recovery Theme: Formal Service Staff (involves the findings as to the critical roles formal service staff play in helping or hindering the recovery process).

Formal Service Staff Sub-Theme: Helpful Characteristics (involves the findings that there are certain formal service staff characteristics that are helpful to recovery).

- *23. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc.).
- **24. Staff believe that I can grow, change and recover.
- *25. Staff listen carefully to what I say.
- *26. Staff lack up-to-date knowledge on the most effective treatments.
- **52. Staff respect me as a whole person.

Formal Service Staff Sub-Theme: Partnering/Collaborative Relationships (involves the findings that formal service staff partnering or collaborating with consumers facilitates recovery).

- 27. I can have a say in how my service agency operates.
- **28. Staff see me as an equal partner in my treatment program.
- *29. My treatment plan goals are stated in my own words.

Formal Service Staff Sub-Theme: Hindering Characteristics (involves the findings that certain formal service staff characteristics hinder recovery).

- 53. Staff treat me as though I will never be able to function well.
- *54. Staff do not understand my experience as a person with mental health problems.

Recovery Theme: Formal Services (involves the findings that formal service systems' culture, organization, structure, funding, access, choice, quality, range, continuity and other characteristics can help or hinder the process of recovery).

Formal Services Sub-Theme: Helpful System Culture and Orientation (involves the findings that a formal service system's culture and orientation that is holistic and consumer oriented facilitates recovery).

- *31. Mental health staff help me build on my strengths.
- **32. Mental health staff support my self-care or wellness.

- 33. Staff help me stay out of psychiatric hospitals and avoid involuntary treatment.
- 59. I have help in exploring resources for my spiritual growth, when I want such help.

Formal Services Sub-Theme: Hindering System Culture and Orientation (involves the finding that a formal service system's culture and orientation which defines mental health need too narrowly in nature hinders recovery).

- *60. The mental health staff ignore my physical health.
- 61. I am afraid that if I do too well I will lose my supports and services.

Formal Services Sub-Theme: Coercion (involves the finding that coercion within formal service systems hinders recovery).

- 35. Treatment or medication was forced on me.
- **36. Staff use pressure, threats or force in my treatment.

Formal Services Sub-Theme: Confidentiality (involves the finding that respect for the confidentiality of consumers receiving formal services facilitates recovery).

- 37. Staff respect my wishes about who is and who is not given information about my treatment.

Formal Services Sub-Theme: General Hindering Characteristics (involves the findings that there are characteristics in formal services that hinder recovery).

- 38. The time I have with my psychiatrist is too brief to be helpful.
- 39. There are many changes in the staff that provide my services.
- 62. Complaints or grievances about mental health services were respectfully resolved.
- 63. Services are not flexible to meet my changing needs.
- *64. Mental health services have caused me emotional or physical harm.

Formal Services Sub-Theme: Access to Services (involves the findings as to getting the formal services that consumers feel they need and find helpful facilitates recovery).

- *40. The doctor worked with me to get on medications that were most helpful for me.
- *41. I have information and/or guidance to get the services and supports I need, both inside and outside my mental health agency.
- 42. I can get combined services and supports for both substance abuse and mental illness.
- *43. I can see a therapist when I need to.
- 65. I have access to specialized services for trauma or abuse as needed.
- *66. I cannot get the services I need when I need them.

Formal Services Sub-Theme: Education (involves the findings that there are education roles with respect to formal services that facilitate recovery).

- *44. My family gets the education or supports they need to be helpful to me.
- 45. I am given information about medication side effects in language I understand.

Formal Services Sub-Theme: External Stigma/Prejudice (involves the findings that stigma and prejudice hinder recovery).

- *46. I am treated as a psychiatric label rather than as a person.
- 73. I have support for challenging negative stereotypes, stigma and/or discrimination.

Recovery Theme: Self/Holism (involves the findings that characteristics that relate to one's sense of self, such as self-reliance, as well as having a holistic and human rights focus can facilitate recovery and other such characteristics, such as low self-esteem, can hinder recovery).

- 67. Staff encourage me to take responsibility for how I live my life.
- *68. Services help me develop the skills I need.
- 69. I have assistance in creating a plan for how I want to be treated in the event of a crisis, such as an advance directive.
- *70. Mental health services led me to be more dependent, not independent.
- 71. Mental health services fed into my negative feelings about myself.
- *72. I lack the information or resources I need to uphold my client and basic human rights.

A factor analysis of the 42 self-report items using the prototype data set resulted in components of Person-Center Decision-Making & Choice, Invalidated Personhood, Self-Care & Wellness, Basic Life Resources, Meaningful Activities & Roles, Peer Advocacy, Staff Treatment Knowledge, and Access. The items break out into these components as follows:

Person-Center Decision-Making & Choice

Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc.).

**Staff believe that I can grow, change and recover.

Staff give me complete information in words I understand before I consent to treatment or medication.

Staff listen carefully to what I say.

Staff stood up for me to get the services and resources I needed.

Staff encourage me to do things that are meaningful to me.

**Staff see me as an equal partner in my treatment program.

**I have a say in what happens to me when I am in crisis.

The doctor worked with me to get on medications that were most helpful for me.

I have information and/or guidance to get the services and supports I need, both inside and outside my mental health agency.

**Staff use pressure, threats or force in my treatment.

I lack the information I need to uphold my client and basic human rights.

Mental health services helped me get medical benefits that meet my needs.

*There is at least one person who believes in me.

There are consumers working as paid employees in the mental health agency where I receive services.

My treatment plan goals are stated in my own words.

Invalidated Personhood

I am treated as a psychiatric label rather than as a person.

**I do not have the support I need to function in the roles I want in my community.

Mental health staff interfere with my personal relationships.

Staff do not understand my experience as a person with mental health problems.

Mental health services have caused me emotional or physical harm.

The mental health staff ignore my physical health.

I do not have enough good service options to choose from.

**Staff respect me as a whole person.

Mental health services led me to be more dependent, not independent.

Self-Care & Wellness

My family gets the education or supports they need to be helpful to me.

**Mental health staff support my self-care or wellness.

Mental health staff help me build on my strengths.

My right to refuse treatment is respected.

I can see a therapist when I need to.

Basic Life Resources

I have reliable transportation to get to where I need to go.

**I have housing that I can afford.

I have enough income to live on.

I have a place to live that feels like a comfortable home to me.

Mental health services helped me get housing in a place I fell safe.

Meaningful Activities & Roles

Mental health services helped me in get or keep employment.

I have a chance to advance my education if I want to.

**I am encouraged to use consumer-run programs (for example, support groups, drop-in centers, etc.).

Services help me develop the skills I need.

Peer Advocacy

There was a consumer peer advocate to turn to when I needed one.

Staff Treatment Knowledge

Staff lack up-to-date knowledge on the most effective treatments.

Access

I cannot get the services I need when I need them.

Administrative-Data Item Set Refinement

The administrative-data recovery orientation item set has also undergone extensive refinement. The first step was a crosswalk of the 27 administrative-data items with the three current sets of MHSIP proposed indicators. Seven of the administrative-data items seemed to fit within MHSIP proposed indicators and 20 of administrative-data items did not. The research team condensed these 20 items into 12 indicators. The research team then generated specific measures and measure definitions (i.e., numerators and denominators) for the resulting 19 indicators (unless these measures were already specified by MHSIP).

The research team then designed a survey of the 19 indicators and 30 corresponding measures. The survey solicited feedback as to (a) the feasibility of implementing each measure (i.e., very feasible, fairly feasible, limited feasibility, not at all feasible), (b) the importance of each measure for improving system recovery orientation (very important, fairly important, limited importance, not at all important), (c) whether or not the data articulated in the measure was currently being collected (i.e., yes, no), and (d) specific comments on each measure. The 10 participating state MHAs were surveyed as well as the MHSIP Consumer Expert Panel and the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA). Two separate requests were made, nine state MHAs and three NAC/SMHA members responded. The research team then compiled these results within one document. Through a series of teleconferences the research team evaluated each measure as to importance rating, feasibility rating and comments. In addition, the research team considered the relation of the measure to the ROSI self-report item set and whether there were examples of states that collected this information.

What follows is the administrative-data profile for the Recovery Oriented System Indicators (ROSI) measure consisting of 16 indicators and 23 corresponding measures. All measures are at the authority level; most measures also have a provider level equivalent (modified for provider application). The administrative-data profile is organized under the themes which emerged from Phase One findings. This is in draft form and is intended for pilot testing.

Recovery Theme: Peer Support (involves the findings that peer support and consumer operated services in a myriad of forms facilitates recovery).

Performance Indicator: Free Standing Peer/Consumer Operated Programs (new)

Authority Measure 1: The percent of mental health catchment or service areas that have free standing peer/consumer operated programs.

Numerator: Total number of mental health catchment or service areas that have free standing peer/consumer operated programs.

Denominator: Total number of mental health catchment or service areas.

Provider Version of Measure 1: There is at least one free standing peer/consumer operated program within our community. (Yes/No)

Performance Indicator: Peer/Consumer Operated Services Funding

Authority Measure 2: The percent of state program funds allocated for peer/consumer operated services.

Numerator: The amount of program funds in the state mental health budget allocated for peer/consumer operated services during the reporting period.

Denominator: The total amount of program funds in state mental health budget during the reporting period.

Authority Measure 3: The percent of Medicaid funding reimbursed for peer/consumer delivered services.

Numerator: The amount of Medicaid reimbursement for services delivered in peer/consumer operated programs and by peer specialists during the reporting period.

Denominator: The total amount of Medicaid reimbursement for behavioral health care during the reporting period.

Performance Indicator: Consumer Employment within Mental Health Systems

Authority Measure 4: The number of annual slots specifically funded for training consumers in relevant educational and training programs and institutes to become mental health providers.

Authority Measure 5: The percent of local mental health provider agencies who have an affirmative action hiring policy regarding consumers.

Numerator: The number of local mental health provider agencies that have an affirmative action hiring policy regarding consumers.

Denominator: The total number of local mental health provider agencies.

Provider Version of Measure 5: Our agency has an affirmative action hiring policy regarding consumers. (Yes/No)

Recovery Theme: Choice (involves the findings that having choices, as well as support in the process of making choices, regarding housing, work, social, service, treatment as well as other areas of life facilitate recovery).

Performance Indicator: Advance Directives

Authority Measure 6: The percent of local mental health provider agencies that have an established mechanism to help clients develop advance directives.

Numerator: The number of local mental health provider agencies that have an established mechanism to help clients develop advance directives.

Denominator: The total number of local mental health provider agencies.

Provider Version of Measure 6: Our agency has an established mechanism to help clients develop advance directives. (Yes/No)

Performance Indicator: Involuntary Inpatient Commitments

Authority Measure 7: The percent of clients under involuntary commitments in public and private inpatient units.

Numerator: The number of clients who received involuntary inpatient commitments during the reporting period.

Denominator: The total number of clients who received inpatient services during the reporting period.

Provider Version of Measure 7: The percent of clients under involuntary commitments in inpatient units.

Numerator: The number of clients who received involuntary inpatient commitments during the reporting period.

Denominator: The total number of clients who received inpatient services during the reporting period.

Performance Indicator: Involuntary Outpatient Commitments

Authority and Provider Measure 8: The percent of clients under involuntary outpatient commitments.

Numerator: The number of clients who received involuntary outpatient commitments during the reporting period.

Denominator: The total number of clients who received outpatient services during the reporting period.

Recovery Theme: Formal Service Staff (involves the findings as to the critical roles formal service staff play in helping or hindering the recovery process).

Formal Service Staff Sub-Theme: Helpful Characteristics (involves the findings that there are certain formal service staff characteristics that are helpful to recovery).

Performance Indicator: Direct Care Staff to Client Ratio

Authority Measure 9: The ratio of direct care staff to clients within each local mental health provider agency.

Numerator: The total number of direct care staff (unduplicated) during the reporting period.

Denominator: The total number of clients (unduplicated) during the reporting period.

Provider Version of Measure 9: The ratio of direct care staff to clients within the provider agency.

Numerator: The total number of direct care staff (unduplicated) during the reporting period.

Denominator: The total number of clients (unduplicated) during the reporting period.

Recovery Theme: Formal Services (involves the findings that formal service systems' culture, organization, structure, funding, access, choice, quality, range, continuity and other characteristics can help or hinder the process of recovery).

Formal Services Sub-Theme: Helpful System Culture and Orientation (involves the finding that a formal service system's culture and orientation that is holistic and consumer oriented facilitates recovery).

Performance Indicator: Recovery Oriented Mission Statement

Authority Measure 10: The state mental health authority's mission statement explicitly includes a recovery orientation. (Yes/No).

Authority Measure 11: The percent of local mental health provider agencies whose mission statements explicitly include a recovery orientation.

Numerator: The number of local mental health provider agencies whose mission statement includes a recovery orientation.

Denominator: The total number of local mental health provider agencies.

Provider Version of Measure 11: Our agency's mission statement explicitly includes a recovery orientation. (Yes/No)

Performance Indicator: Consumer Involvement in Provider Contract Development

Authority Measure 12: The percent of provider agency performance contracts that have primary consumer involvement in their development/yearly review (specifying services, outcomes, target numbers, etc).

Numerator: The number of provider agency performance contracts documenting primary consumer involvement in their development/yearly review.

Denominator: The total number of provider agency performance contracts.

Performance Indicator: Office of Consumer Affairs

Authority Measure 13: The percent of staff in the State Office of Consumer Affairs who are former or current consumers.

Numerator: The number State Office of Consumer Affairs staff (unduplicated) who are disclosed consumers (former or current) during the reporting period.

Denominator: The total number of State Office of Consumer Affairs staff (unduplicated) during the reporting period.

Authority Measure 14: The percent of regional mental health offices/local mental health authorities (or equivalent) that have an Office of Consumer Affairs.

Numerator: The number of regional mental health offices/local mental health authorities (or equivalent) that have an Office of Consumer Affairs during the reporting period.

Denominator: The total number of regional mental health offices/local mental health authorities (or equivalent) during the reporting period.

Performance Indicator: Consumer Inclusion in Governance and Policy

Authority Measure 15: The percent of state mental health authority planning council members that are primary consumers.

Numerator: The number of primary consumers (unduplicated) who are state planning council members during the reporting period.

Denominator: The total number state planning council members (unduplicated) during the reporting period.

Authority Measure 16: The percent of local mental health provider agency board membership that are primary consumers.

Numerator: The number of primary consumers (unduplicated) who serve on local mental health provider agency boards during the reporting period.

Denominator: The total number local mental health provider agency board members (unduplicated) during the reporting period.

Provider Version of Measure 16: The percent of our agency's board membership that are primary consumers.

Numerator: The number of primary consumers (unduplicated) who serve on our board during the reporting period.

Denominator: The total number board members (unduplicated) during the reporting period.

Formal Services Sub-Theme: Coercion (involves the finding that coercion within formal service systems hinders recovery).

MHSIP's Proposed Indicator on Seclusion

Authority Measure 17: Hours of seclusion as a percent of client hours

Numerator: The total number of hours that all clients spent in seclusion.

Denominator: Sum of the daily census (excluding clients on leave status) for each day (client days) multiplied by 24 hours.

Authority Measure 18: Percent of clients secluded at least once during a reporting period

Numerator: The total number of clients (unduplicated) who were secluded at least once during a reporting period.

Denominator: The total number of unduplicated clients who were inpatients at the facility during a reporting period.

MHSIP's Proposed Indicator on Restraint

Authority Measure 19: Hours of restraint as a percent of client hours

Numerator: The total number of hours that all clients spent in restraint during a reporting period.

Denominator: Sum of the daily census (excluding clients on leave status) for each day in a reporting period (client days) multiplied by 24 hours.

Authority Measure 20: Percent of clients restrained at least once during the reporting period

Numerator: The total number of clients (unduplicated) who were restrained at least once during a reporting period.

Denominator: The total number of unduplicated clients who were inpatients at the facility during the reporting period.

Formal Services Sub-Theme: Access to Services (involves the findings as to getting the formal services that consumers feel they need and find helpful facilitates recovery).

MHSIP's Proposed Indicator on Involvement in the Criminal/Juvenile Justice System Add Authority Measure 21: The percent of mental health catchment or service areas that have jail diversion services.

Numerator: Total number of mental health catchment or service areas that have jail diversion services.

Denominator: Total number of mental health catchment or service areas.

Provider Version of Measure 21: There are jail diversion services available within our community for mental health consumers. (Yes/No)

MHSIP's Proposed Indicator on Reduced Substance Abuse Impairment

Add Authority Measure 22: The percent of mental health catchment or service areas that have integrated substance abuse and mental health services.

Numerator: Total number of mental health catchment or service areas that have integrated substance abuse and mental health services.

Denominator: Total number of mental health catchment or service areas.

Provider Version of Measure 22: There are integrated substance abuse and mental health services available within our community for mental health consumers. (Yes/No)

Performance Indicator: Trauma Service Provision

Authority Measure 23: The percent of mental health catchment or service areas that have trauma services.

Numerator: Total number of mental health catchment or service areas that have trauma services.

Denominator: Total number of mental health catchment or service areas.

Provider Version of Measure 21: There are trauma services available within our community for mental health consumers. (Yes/No)

Selection in Context

It is important to recognize that this selection is to some extent a subjective process. Kimmel¹(1983) reports that “gaming” (distorting data to appear favorably) contributes to the selection process of performance measurement. The research team has contended with this possibility. Wholey and Hatry² (1992) suggest that gaming could be minimized by the creation of realistic expectations, participatory development of performance indicators, implementation of a balanced system of performance indicators, and using performance indicators for comparisons only with comparable programs and consumers. These conditions have been present in the design of this project, as well as multiple efforts of grounding the work in the lived experiences of consumers/ survivors through consumer researcher involvement, member check, Think Aloud, prototype testing, and surveying.

Performance on the ROSI measure is expected to be objective given the multiple sources, reviews and refinements. It is important to keep in mind that the resulting performance

¹ Kimmel, W. (1983). Performance measurement and monitoring in mental health: Selected impressions in three states. Report to NIMH.

² Wholey, J.S. & Hatry, H.P. (1992). The Case for the Performance Monitoring. Public Administrative Review, 52(6), 604410.

indicators will be inter-related, that is, one aspect of performance (e.g., consumer's decisions are respected) will not be independent of others (e.g., there are choices in services). "The reading and interpretation of performance indicators should, therefore, be treated as a system of related measures and never in isolation" (Task Force on the Design of Performance Indicators Derived from the MHSIP Content³, 1993, p. 18).

In Phase Three, the research team proposes that the ROSI measure (survey and profile) undergo pilot testing. Consumers should be surveyed in adequate numbers to conduct psychometric testing on the self-report survey. The research team recommends the development and adoption of guidelines and standards, possibly in the form of a toolkit. The team also recommends that a plan be developed for dissemination of the ROSI, the results of Phase Three pilot testing, and the corresponding toolkit (if developed).

Please connect Steven Onken <so280@columbia.edu> if you are interested in helping with the pilot test or would like to incorporate some or all of the items in any of your current activities.

³ Task Force on the Design of Performance Indicators Derived from the MHSIP Content. (1993). Performance indicators for mental health services: Values, accountability, evaluation and decision support. <http://www.mhsip.org>: Final report to the MHSIP Advisory Group and CMHS.

Attachment A: Recovery Oriented System Indicators (ROSI) Self-Report Survey Measure

Purpose: To provide the best possible mental health services, we want to know what things helped or hindered your progress during the past six (6) months. Please follow the directions and complete all three sections.

Section One Directions: Please read the statement and then circle the response that best represents your situation during the last six months. These responses range from strongly disagree to strongly agree. If the statement was about something you did not experience, circle the last response “Does not apply to me.”

1. I am encouraged to use consumer-run programs (for example, support groups, drop-in centers, etc.).	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
2. Staff respect me as a whole person.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
3. There is at least one person who believes in me.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
4. I do not have the support I need to function in the roles I want in my community.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
5. I do not have enough good service options to choose from.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
6. Mental Health services helped me get housing in a place I feel safe.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
7. Staff do not understand my experience as a person with mental health problems.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
8. The mental health staff ignore my physical health.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
9. I have a place to live that feels like a comfortable home to me.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
10. Mental health services have caused me emotional or physical harm.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
11. I cannot get the services I need when I need them.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me

Please circle the response that best represents your situation during the last six months.

12. Mental Health services helped me to get medical benefits that meet my needs	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
13. Mental Health services led me to be more dependent, not independent.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
14. I lack the information or resources I need to uphold my client rights and basic human rights.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
15. I have enough income to live on.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me
16. Services help me develop the skills I need.	Strongly Disagree	Disagree	Agree	Strongly Agree	Does Not Apply To Me

Section Two Directions: Please read the statement and then circle the response that best represents your situation during the last six months. The responses range from never to always. If the statement was about something you did not experience, circle the last response “Does not apply to me.”

17. I have a say in what happens to me when I am in a crisis.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
18. Staff believe that I can grow, change and recover.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me

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19. I have housing that I can afford.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
20. Staff use pressure, threats, or force in my treatment.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
21. Staff see me as an equal partner in my treatment program.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
22. Mental health staff support my self-care or wellness.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
23. Mental health services help me get or keep employment.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
24. I have a chance to advance my education if I want to.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me

Please circle the response that best represents your situation during the last six months.

25. I have reliable transportation to get where I need to go.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
26. There was a consumer peer advocate to turn to when I need one.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
27. There are consumers working as paid employees in the mental health agency where I receive services.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
28. Staff give me complete information in words I understand before I consent to treatment or medication.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
29. Staff encourage me to do things that are meaningful to me.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
30. Staff stood up for me to get the services and resources I needed.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
31. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientations, etc).	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
32. Staff listen carefully to what to say.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
33. Staff lack up-to-date knowledge on the most effective treatments.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me

34. Mental health staff interfere with my personal relationships.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
35. Mental health staff help me build on my strengths.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
36. My right to refuse treatment is respected.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
37. My treatment plan goals are stated in my own words.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
38. The doctor worked with me to get on medications that were most helpful for me.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me

Please circle the response that best represents your situation during the last six months.

39. I am treated as a psychiatric label rather than as a person.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
40. I can see a therapist when I need to.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
41. My family gets the education or supports they need to be helpful to me.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me
42. I have information or guidance to get the services and supports I need, both inside and outside my mental health agency.	Never	Rarely	Sometimes	Often	Always	Does Not Apply To Me

APPENDIX G

Results of the Web-based Survey

APPENDIX G: Results of the Web-based Survey

MHSIP Web-based Survey
On Performance Measure Preferences
Among Mental Health Stakeholder Respondents

Report prepared for the
MHSIP Mental Health Quality Report Workgroup
By
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MHSIP Web-based Survey On Performance Measure Preferences

Background. At the July 2003 MHSIP Report Card Workgroup meeting, a discussion about conducting structured interviews to collect stakeholders' preferences among the performance indicators the workgroup had identified led to a suggestion to develop a web-based survey for the purpose. Advantages of a web survey included permitting responses from a broad array of settings, having easy links to definitions and other explanatory information, and having data immediately compiled in a database for rapid tabulation of results.

From July to September, a survey was drafted by workgroup members, based on indicators identified by the workgroup from the first version of the MHSIP Consumer-Oriented Mental Health Report Card and a number of other stakeholder sources. The survey was then implemented as a web-based application by the MHSIP website support staff at the Oklahoma Department of Mental Health and Substance Abuse Services. Several revisions followed before the final version of the survey was approved. The original organization of items by settings and populations was simplified, so items were listed by the domains of access (5 items), appropriateness (26 items), outcomes (11 items), recovery themes (8 items) and efficiency (2 items). Changes in the wording of several items were made, based on the review and recommendations of the workgroup's Consumer Expert Panel. The What Hinders and What Helps Recovery Research Group identified eight recovery themes in their research and those were added as survey items. Items recommended by the Adult Mental Health Workgroup of the Forum on Performance Measures in Behavioral Healthcare were also added (the final list of indicators included in the web survey is provided in Appendix 1 with a brief description of each item). An invitation to participate was posted on the MHSIP website and, as suggested in initial discussions of the project, Internet links to related projects, documents and operational definitions were included in the narrative. Letters to stakeholder groups were developed and distributed by postal service and electronic mail, including a deadline for completion.

A preliminary summary of results was reviewed at the October 2003 workgroup meeting. Counts of responses from some stakeholder groups were low, but provided a basis for discussing rules for interpreting respondents' preferences and selecting indicators. Workgroup members volunteered to contact their constituent groups to encourage their participation and the deadline for responses was extended to the end of November. At that time, paper surveys submitted by some respondents were entered and incomplete and duplicate web surveys were deleted before a final summary of the responses was compiled.

Analysis. Respondents were asked to answer four demographic questions to identify their primary perspective, any organizational affiliation they might represent, their primary population of interest, and any treatment setting in which they had an interest. They were then asked to rate each indicator as high, medium or low priority from their perspective. To summarize responses, high ratings were given a value of 3; medium ratings, a 2; and low ratings, a 1. Then the average rating for each indicator was calculated for each perspective and overall. Using the average ratings for each perspective, the 52 indicators were then

ranked by perspective. To further summarize the data, the number of times an indicator was selected in the 'Top 5' rankings of any perspective was tallied.

To ensure that perspectives of people who had interests in particular populations or specific treatment settings were represented in the findings, the rating and ranking analysis described above was repeated for each reported population interest category and each setting category. Finally, the counts of 'Top 5' rankings for each indicator were summarized in a single table for each setting, population and across all perspectives. Those survey items which three or more perspective groups ranked among their 'Top 5' preferences in any of the preceding tables were highlighted (the 'three Top 5 rankings' cut-off was selected to identify a 'minimum' list of indicators).

Results. There were 982 completed surveys submitted to the MHSIP Web-based Survey of Performance Measure Preferences. Of those who identified their perspective, one was from an accreditation organization, 117 were mental health advocates, 270 were consumers of mental health services, 283 were family members, 33 were from a local mental health authority, 8 were from managed care organizations, 132 were providers, 74 were from state mental health authorities, and 64 represented miscellaneous or unnamed groups (Table 1, Appendix 2). There

was also a large number of comments from respondents (6,953) with 5,766 addressing 44 indicators, 758 responding to the eight recovery themes, and 429 providing recommendations in the three additional fields offered at the end of the survey. The summary and analysis of the comments have not been completed at this time.

Survey respondents were also asked to identify an organization with which they have a primary affiliation (Table 2, Appendix 2). Those most often identified were....

Respondents were asked to identify a single population of people for which they had the most interest (Table 3, Appendix 2). There were 320 people who reported their population of interest was adults with serious mental illnesses. Eighty-one (81) people reported an interest in all adults with mental illnesses, 465 responded that all adults and youth were of interest to them. Thirty-nine (39) expressed an interest in all youth (children and adolescents) and 28 reported an interest in children with serious emotional disturbances. Forty (40) people replied their interest was with an unlisted population group and 21 left the item blank.

Respondents were asked to identify all treatment settings that were of interest to them (Table 4, Appendix 2). Their responses were ambulatory, 595; residential, 361; hospital/inpatient, 359; managed behavioral health care, 264; behavioral health system, 281; comprehensive community system, 350; all settings, 621; and no specific setting, 85.

The tables of rankings of indicators by perspectives, settings of interest, and populations of interest (Tables 1-17 in Appendix 3) showed considerable consistency among the indicators that were highly ranked. One perspective (accreditation organization) and some settings and populations were excluded from individual consideration of their rankings because their small number of respondents produced multiple tied high rankings that skewed results, but all responses were included in the overall summary.

In each column (2-10) in Table 1, the rankings of the 52 indicators are presented for each perspective reported by respondents. In column 11, the overall rankings across all perspectives are presented, and in the right-most column, counts of the number of perspective groups that ranked each indicator (row) in their ‘Top 5’ are displayed. It can be seen (as indicated by the gray bar highlights) that 17 items among the five domains of indicators were ranked in the ‘Top 5’ by least one of the perspective groups. Only the efficiency indicator domain did not have at least one item selected by this process.

In Tables 2-16, the same rankings by respondent perspective groups and overall are summarized for each of the eight settings and the seven populations of interest to respondents. As noted above, in some cases, a perspective was not included in the count of ‘Number of Top 5 Rankings’ because no one (n=0) from that perspective reported an interest in the setting or population summarized, or only one respondent (n=1) reported rankings. When n=1, there were many tied ranks of #1, which would have skewed the overall ranks had they been counted in the table summary column. For the same reason, the Missing and Other population tables were excluded from the final tally of responses.

Those tables with adequate numbers of responses are summarized in Table 17. In this table, the right-most columns (Number of Top 5 Rankings) from 14 of the preceding 16 tables are displayed (with the Rankings column from Table 1, Overall—i.e., across all settings and populations--on the right). The gray bars in Table 17 highlight the indicators (rows) for which at least three perspective groups (as displayed in Tables 2-16) ranked them in their ‘Top 5.’ Notably, there are only two indicators that were identified in the overall summary (APP14 and RTFORMAL) that were not ranked highly and frequently by those respondents who had interests in specific settings or populations.

Future Analysis. Compare the items on, and responses to, the MHSIP web survey with the items identified by the What Hinders and What Helps Recovery Research Group to determine what items may need to be added to ensure the MHSIP Mental Health Quality Report addresses all important concerns and domains.

Appendix G-1

MHSIP Web-based Survey of Performance Measure Preferences Indicator Set for which Ratings were Requested of Respondents

Appendix G-2

MHSIP Web-based Survey of Performance Measure Preferences Respondent Perspectives, Affiliations and Preferences

Question 1: Respondent perspective

Question 2: Respondent organizational affiliation

Question 3: Respondent Primary Population Interest

Question 4: Respondent Setting Interests

Appendix G-3

MHSIP Web-based Survey of Performance Measure Preferences Respondent Performance Measure Preference Rankings

Table 1. Rankings by Perspective Across Domains

Tables 2-9. Rankings by Perspective and Setting of Interest Across Domains

Tables 10-16. Rankings by Perspective and Population of Interest Across Domains

Table 17. Number of Top 5 Rankings Across Stakeholder Perspectives By Setting, Population and Overall

APPENDIX H:
Proposed Testing Set Items
MHSIP Surveys

APPENDIX H: Proposed Testing Set Items

MHSIP QUALITY REPORT ADULT CONSUMER SURVEY PROPOSED ITEM SET FOR TESTING WITH SPECIFIC POPULATIONS IN SPECIFIC SETTINGS**

Items for specific populations will be developed using the pool of items displayed below and items from existing surveys.

ACCESS DOMAIN

- * Staff were willing to see me as often as I felt was necessary.
- * Services were available at times that were good for me.
- * When I needed services right away, I was able to see someone as soon as I wanted.
- * My calls were returned within 24 hours.

APPROPRIATENESS DOMAIN

- * Staff respected my wishes about who is and who is not to be given information about my treatment.
- * Staff helped me obtain the information I needed so that I could take charge of managing my illness.
- * Staff were sensitive to my cultural background (race, religion, language, etc.).
- * I was treated with respect.
- * The people I went to explained things in a way I understood.
- * I helped to develop my treatment goals.
- * I was given information about my rights as a consumer.
- * The people I went to for services spent enough time with me.
- * Staff believe I can grow, change and recover.
- * I felt comfortable asking questions about my treatment and medication.
- * I was given information about different services that were available to me.
- * I was given enough information to effectively handle my condition.

OUTCOME DOMAIN

- * I deal more effectively with my problems.
- * I am better able to control my life.
- * I am better able to deal with crises.
- * I get along better with my family.
- * I do better in social situations.
- * My symptoms are not bothering me as much.
- * I am better able to accomplish the things I want to do.
- * I am better able to cope when things go wrong.
- * I am doing better in work/school.
- * I am not likely to use alcohol or other drugs

RECOVERY ORIENTATION SYSTEM ITEMS

- * Staff respect me as a whole person.
- * There is at least one person who believes in me.
- * I do not have the support I need to function in the roles I want in my community.
- * I have a say in what happens to me when I am in crisis.
- * I have housing that I can afford.
- * Staff use pressure, threats, or force in my treatment.
- * Staff see me as an equal partner in my treatment program.
- * Mental Health staff support my self-care or wellness.
- * I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).
- * Staff believe I can grow, change and recover.

**Note: Several additional items may be added related to such concerns as safety, cost as a barrier to access, and provider competence.

SURVEY MODULES FOR TESTING

The modules listed below will be tested, however they will comprise separate survey modules that can be used by systems who want an in-depth assessment of these areas.

CULTURAL COMPETENCE MODULE

- * My individual needs and goals were met;
- * Staff were sensitive to my cultural background (race, ethnicity, religion, language, age, sexual orientation, etc.);
- * My culture and race/ethnicity was included in planning the services I received;
- * Staff understood the customs and traditions of my race/ethnic group;
- * I was able to get services from staff of my race/ethnicity group when I wanted;
- * Staff were able to speak my language (or use interpreters) whenever I needed.

FULL SET - RECOVERY ORIENTATION SYSTEM MODULE ITEMS FOR TESTING

1. I am encouraged to use consumer-run programs (for example, support groups, drop-in centers, etc.).
2. Staff respect me as a whole person.
3. There is at least one person who believes in me.
4. I do not have the support I need to function in the roles I want in my community.
5. I do not have enough good service options to choose from.
6. Mental health services helped me get housing in a place I feel safe.
7. Staff do not understand my experience as a person with mental health problems.
8. The mental health staff ignore my physical health.
9. I have a place to live that feels like a comfortable home to me.
10. Mental health services have caused me emotional or physical harm.
11. I cannot get the services I need when I need them.

12. Mental health services helped me get medical benefits that meet my needs.
13. Mental health services led me to be more dependent, not independent.
14. I lack the information or resources I need to uphold my client rights and basic human rights.
15. I have enough income to live on.
16. Services help me develop the skills I need.
17. I have a say in what happens to me when I am in crisis.
18. Staff believe that I can grow, change and recover.
19. I have housing that I can afford.
20. Staff use pressure, threats, or force in my treatment.
21. Staff see me as an equal partner in my treatment program.
22. Mental health staff support my self-care or wellness.
23. Mental health services helped me get or keep employment.
24. I have a chance to advance my education if I want to.
25. I have reliable transportation to get where I need to go.
26. There was a consumer peer advocate to turn to when I needed one.
27. There are consumers working as paid employees in the mental health agency where I receive services.
28. Staff give me complete information in words I understand before I consent to treatment or medication.
29. Staff encourage me to do things that are meaningful to me.
30. Staff stood up for me to get the services and resources I needed.
31. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc).
32. Staff listen carefully to what I say.
33. Staff lack up-to-date knowledge on the most effective treatments.
34. Mental health staff interfere with my personal relationships.
35. Mental health staff help me build on my strengths.
36. My right to refuse treatment is respected.
37. My treatment plan goals are stated in my own words.
38. The doctor worked with me to get on medications that were most helpful for me.
39. I am treated as a psychiatric label rather than as a person.
40. I can see a therapist when I need to.
41. My family gets the education or supports they need to be helpful to me.
42. I have information or guidance to get the services and supports I need, both inside and outside my mental health agency.

SOCIAL CONNECTEDNESS MODULE

Adults

As a result of the services I received ...

1. I do things that are more meaningful to me.
2. I am better able to take care of my needs.
3. I am better able to handle things when they go wrong.
4. I am better able to do things that I want to do.

Parent/Caregiver

As a result of the services my child received ...

My child is better able to do things he or she wants to do.

REDUCTION OF SYMPTOMS/FUNCTIONING

Adult

Other than my service providers ...

1. I know people who will listen and understand me when I need to talk.
2. In a crisis, I would have the support I need from family or friends.
3. When I need help right away, I know people I can call on.
4. I have more than one friend.
5. I am happy with the friendships I have.
6. I have people with whom I can do enjoyable things.
7. I feel I belong in my community.

Caregiver/Children/Adolescents

Other than my child's service providers ...

1. I know people who will listen and understand me when I need to talk.
2. In a crisis, I would have the support I need from family or friends.
3. I have people that I am comfortable talking with about my child's problems.
4. I have people that I am comfortable talking to about private things.
5. I have more than one friend.
6. I am happy with the friendships I have.
7. I have people with whom I can do enjoyable things.

APPENDIX I

Report On Development Of Cultural Competence Measure

APPENDIX I: Report on Development of Cultural Competence Measure

Introduction

While cultural competence was identified as an important concern in the work of the MHSIP Consumer-Oriented Report Card, the approach to address the issue was addressed more by analysis than by the definition of a specific measure. In the performance measures proposed in the Report Card, recommendations were made to analyze access indicators by race/ethnicity breakouts. The specific item related to cultural competence that was incorporated in the Quality/Appropriateness domain of the MHSIP Consumer Survey was:

*Staff was sensitive to my cultural background (race/ethnicity, sex, age, sexual orientation, etc.);

This single item was considered inadequate to obtain a consumer perception of cultural competence. To address this issue in the MHSIP Quality Report, the objective was to develop a small set of items related to the consumer/family member perception of cultural competence so that they could be tested and refined.

Approach

The approach to developing a small set of items related to cultural competence was to review a range of cultural competence measures developed as self-report measures. Based on this review, key domains were identified. These key domains were then rated in terms of importance by members of the Board of the National Alliance of Multiethnic Behavioral Health Associations. Items were then developed for the domains that were rated as the most important.

Examples of these domains were:

- * Service providers understand the customs and traditions of race/ethnicity group of service recipient;
- * Understanding of service recipient's culture is included in service planning and provision;
- * Understanding (by service provider) of differences within service recipient's culture;
- * Inclusion of service recipient's spiritual and religious beliefs in service provision;
- * Availability of service providers who speak same language (or have interpreters);
- * Match of race/ethnicity group of service provider and service recipient;
- * Individual needs and goals were met;
- * Race/ethnicity differences in treatment were addressed.

Based on the ratings of such domains, those with higher priority were identified.

Then, using these high priority domains, items related to cultural competence were developed for testing.

These items were:

- * My individual needs and goals were met;
- * Staff was sensitive to my cultural background (race, ethnicity, religion, language, age, sexual orientation, etc.);
- * My culture and race/ethnicity were included in planning the services I received;
- * Staff understood the customs and traditions of my race/ethnicity group;

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- * I was able to get services from staff of my race/ethnicity group when wanted;
- * Staff was able to speak my language (or use interpreters) whenever I needed.

Kimmel, W. (1983). Performance measurement and monitoring in mental health: Selected impressions in three states. Report to NIMH.

Wholey, J.S. & Hatry, H.P. (1992). The Case for Performance Monitoring. Public Administration Review, 52(6), 604410.

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