

Technical Appendix

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Concerns, Indicators, and Measures

Note: The purpose of this section is to describe, in detail, the conceptual and operational recommendations within each domain. For each concern, there is a definition and a description of indicators, measures, and data sources. The rationale for the measurement strategy is also included. Further detail on data collection requirements and methods by data sources is provided in later sections of this technical appendix.

ACCESS

Quick and Convenient Entry Into Services

Concern: Entry into mental health services is quick, easy, and convenient.

Rationale: 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.

Access 1: *The average length of time from request for services to the first face-to-face meeting with a mental health professional.*

Measure : The total time between request for services and the first face-to-face contact with a mental health professional for new admissions during the year, divided by the total number of new admissions.

Notes: This will be reported separately for emergent and non-emergent situations, and will also be reported separately for the following groups: children and adolescents with serious emotional disturbances, children and adolescents with other emotional disturbances, adults with serious mental illnesses, adults with other mental illnesses, and adults with a dual diagnosis of a mental illness and substance use disorder¹.

An **emergent situation** is defined as one in which a person is in imminent danger to self or others or has a grave disability as a result of mental illness. A **mental health professional** is defined as a psychiatrist, psychologist, social worker, psychiatric nurse practitioner, marriage and family therapist, provider with specialty certification in mental health counseling from the National Board of Certified Counselors.

Source: Enrollment/encounter data.

¹This category may have to be broken down further into adults with *serious* mental illnesses and substance use disorders and adults with *other* mental illnesses and substance use disorders.

Access 2: *The percentage of consumers for whom the location of services is convenient.*

Measure : Consumer response to a survey question regarding location:
C The location of services was convenient (parking, public transportation, distance, etc.).

Note: The response format for all items on the consumer survey is a 5-point continuous scale from **Astrongly agree@** to **Astrongly disagree@**. The indicators based on this instrument are computed as the percentage of recipients who respond **Astrongly agree@** or **Aagree@** (or for those items that are reverse coded, those that respond **Astrong disagree@** or **Adisagree@**).

Source: Consumer survey.

Access 3: *The percentage of consumers for whom appointment times are convenient.*

Measure : Consumer response to a survey question regarding convenience:
C Services were available at times that were good for me.

Source: Consumer survey.

Access 4: *The percentage of consumers who report that physicians, mental health therapists, or case managers can be reached easily.*

Measure : Consumer response to a survey question regarding provider availability:
C Staff returned my call within 24 hours.

Source: Consumer survey.

A Full Range of Service Options

Concern: A full range of mental health service options is available.

Rationale: The indicators below clearly do not reflect the **Afull range@** of service options. They are indirect indicators of the extent to which a mental health system is (1) responsive to service needs articulated by enrollees,

and (2) able to deliver on its actual or implied promises. However, if resources expended on services important to consumers, including consumer-run services and services in natural settings, are increasing (or are relatively high), this would reflect that a full range of services is probably in place.

Access 5: *The average resources per enrollee expended on mental health services.*

Measure : The total amount of direct service expenditures on mental health services in one year, divided by the total number of full-time enrollees who received at least one mental health service.

Note: This will be computed separately for the following groups: children and adolescents with serious emotional disturbances, children and adolescents with other emotional disturbances, adults with serious mental illnesses, adults with other mental illnesses, and adults with a dual diagnosis of a mental illness and substance use disorder.

Source: Enrollment/encounter data; cost/expenditure data.

Access 6: *The proportion of resources expended on mental health services that are consumer-run.*

Measure : The total amount of expenditures on consumer-run mental health services in one year, divided by expenditures on mental health services.

Source: Enrollment/encounter data; cost/expenditure data.

Access 7: *The proportion of resources expended on mental health services provided in a natural setting (home, school, and work).*

Measure : For child and adolescent enrollees only: the total amount of direct service expenditures on mental health services that are provided *in the child's home* in one year, divided by the total amount of direct service expenditures for children and adolescents.

Source: Enrollment/encounter data; cost/expenditure data.

Access 8: *The percentage of consumers for whom services are readily available.*

Measure : Consumer response to survey questions regarding availability:
C I was unable to get the services I thought I needed.
C I was able to see a psychiatrist when I wanted to.
C Staff were willing to see me as often as I felt it was necessary.

Source: Consumer survey.

Cultural and Linguistic Access

Concern: Enrollees have access to a primary mental health provider who meets their needs in terms of ethnicity, language, culture, age, and disability.

Rationale: This concern identifies the degree to which cultural and linguistic barriers might affect access to services. The consumer survey item is 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 Aproblem 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 some effort should be made to assess potential differences among clients that might account for variations in service use.

Access 9: *The percentage of consumers who report that staff are sensitive to their ethnicity, language, culture, and age.*

Measure : Consumer response to a survey question regarding staff sensitivity:
C Staff were not sensitive to my cultural/ethnic background.

Source: Consumer survey.

Access 10: *The percentage of people served in a year who had only one mental health contact.*

Measures: (a) For each of the following age, sex, and ethnic groupings: the total number of enrollees receiving one

mental health services in the past year, divided by the total number of enrollees.

Age: 0-21, 22-64, 65+
Sex: Male, female
Ethnicity: (I) White, African-American, Asian, other
(ii) Hispanic, non-Hispanic

- (b) For the same age, sex, and ethnic groupings: the total number of enrollees receiving *one and only one* mental health service in the past year, divided by the total number of enrollees receiving *one or more* mental health services in the same year.

Source: Enrollment/encounter data.

Access 11: *The percentage of people receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits who received services.*

Measure : For enrollees who are also enrolled in SSI or SSDI: the total number of people receiving at least one mental health service in the past year, divided by the total count of this group.

Source: Enrollment/encounter data.

Financial Barriers

Concern: The out-of-pocket costs to enrollees do not discourage the use of necessary mental health services.

Rationale: Access barriers may be caused by system characteristics, including the cost of services. A consumer's inability to pay for care should not limit access to needed services.

Access 12: *The percentage of consumers for whom cost is an obstacle to service utilization.*

Measure : Consumer response to a survey question regarding financial barriers:
C I was unable to get some services I wanted because I could not pay for them.

Source: Consumer survey.

APPROPRIATENESS

Voluntary Participation in Services

Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized.

Rationale: Involuntary mental health interventions are usually counterproductive and often lead to lasting trauma. They erode the consumer's ability to make decisions and to act responsibly, and they are antithetical to fostering cooperative, trusting relationships between consumers and health professionals. Involuntary treatment may create or exacerbate problems or signs of illness (e.g., *Aparanoia*), and it may have the unintended effect of creating resistance to mental health interventions in general.

The proportion of recipients who report actively participating in their service plans is an indirect measure of the extent to which treatment and services are voluntary. The proportion of enrollees who report feeling coerced into treatment or services is an indirect measure of the extent to which treatment and services are involuntary. The proportion of involuntary admissions for psychiatric inpatient treatment is an explicit measure of the extent to which treatment and services are involuntary.

Appro. 1: *The percentage of consumers who actively participate in decisions concerning their treatment.*

Measure : Consumer response to survey questions regarding treatment:
C I, not staff, decided my treatment goals.
C I felt comfortable asking questions about my treatment and medication.

Source: Consumer survey.

Appro. 2: *The percentage of consumers who feel coerced into treatment options or services.*

Measure : Consumer response to survey question regarding treatment:
C Staff behaved as if I cannot choose what is best for me.
C I felt free to complain.

Source: Consumer survey.

Appro. 3: *The percentage of admissions for psychiatric inpatient treatment that are involuntary.*

Measure : The total number of inpatient admissions in which a recipient is admitted involuntarily, divided by the total number of inpatient admissions in a 12-month period.

Source: Enrollment/encounter data.

[Alternative: If not available on information systems, include the following on the consumer report items form:

During the past 12 months, were you admitted to a psychiatric hospital when you did not want to go? Yes__ No__]

Services that Promote Recovery

Concern: The mental health provider or system offers services that promote the process of recovery.

Rationale: There is an emerging distinction between services that address the acute symptoms of mental illnesses and those that promote long-term recovery. Services that promote recovery include psychiatric and psychosocial rehabilitation services that help people manage their illnesses and participate in their communities. Services that are focused on recovery should be an important component of any plan that serves people with serious mental illnesses.

Appro. 4: *The proportion of resources expended on services that promote recovery.*

Measure : The total amount of *unduplicated* expenditures in one year on psychiatric and/or psychosocial rehabilitation services (e.g., housing support, vocational services/supported employment, consumer-run services, family education, etc.) for adult enrollees with serious mental illnesses, divided by the total amount of expenditures for mental health services. (This *excludes* case management services.)

Source: Enrollment/encounter data.

Appro. 5: *The percentage of consumers who receive services that support recovery.*

Measure : The response of consumers with serious mental illnesses to survey questions regarding services that promote recovery:

- C Staff here believe that I can grow, change, and recover.
- C Staff encouraged me to take responsibility for how I live my life.
- C Staff helped me obtain the information I needed so that I could take charge of managing my illness.
- C I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone lines, etc.).

Source: Consumer survey.

Services that Maximize Continuity of Care

Concern: The mental health provider or system maximizes continuity of care.

Rationale: Disruptions in the provision of care are generally considered to be harmful. Three types of continuity are represented below. The first two, requiring prompt follow-up of inpatient or emergency care with outpatient services, are important to avoid the recurrence of acute symptoms and to move the process of recovery forward. The third assumes that any change in therapist, regardless of the cause, will impede recovery because of the need to start over with a new provider.

Appro. 6: *The percentage of people discharged from inpatient services who receive ambulatory services within 7 days.*

Measure : The total number of discharges from psychiatric inpatient care during the past year that were followed by at least one outpatient (non-emergency) care visit within 7 days, divided by the total number of all discharges from psychiatric inpatient care during the past year.

Source: Enrollment/encounter data.

Appro. 7: *The percentage of people discharged from emergency care who receive ambulatory services within 3 days.*

Measure : The total number of emergency psychiatric encounters during the past year that were followed by at least one outpatient (non-emergency) care visit within 3 days, divided by the total number of all emergency psychiatric encounters during the past year.

Source: Enrollment/encounter data.

Appro. 8: *The percentage of service recipients who had a change in principal mental healthcare provider during the year or term of treatment.*

Measure : The total number of service recipients who had a change in principal mental healthcare provider during the year or term of treatment, divided by all mental health service recipients during the year.

Source: Enrollment/encounter data.

Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities

Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.

Rationale: The indicator below provides a measure of consumer and family member involvement based on the structure and staffing patterns of the health plan. Meaningful involvement in the design, implementation, and delivery of behavioral health care services requires active participation by consumers and family members.

Appro. 9: *The percentage of enrollees who are adult consumers and family members who serve on planning and development groups or hold paid staff positions in the health plan.*

Measures: (a) The total number of full-time-equivalent (FTE) staff positions (either direct care or administrative) that are occupied by consumers of mental health services, divided by the total number of FTE direct care and/or administrative positions.

- (b) The amount of the mental health budget expended on peer advocates, divided by the total mental health budget.
- (c) The total number of mental health consumers on planning, evaluation, and Total Quality Management teams, divided by the total membership of these groups.
- (d) The total number of family members on planning, evaluation, and Total Quality Management teams, divided by the total membership of these groups.

Note: For purposes of these measures, consumers are defined as enrollees who have received or are currently receiving mental health services.

These measures assume that the provider's database includes measures of administrative structure, such as the number of planning committee members and paid staff who are identified consumers.

Source: Enrollment/encounter data.

[Alternative: If information is not available on information systems, include the following on the consumer report items form:

Does the agency providing you mental health services include consumers on its:

Advisory committees?	Yes__	No__	Don't know__
Planning groups?	Yes__	No__	Don't know__
Evaluation groups?	Yes__	No__	Don't know__
Quality improvement teams?	Yes__	No__	Don't know__]

Adequate Information to Make Informed Choices

Concern: Service recipients receive information that enables them to make informed choices about services.

Rationale: The participation of service recipients in treatment decisions contributes to positive outcomes. In order to enhance consumers' inclusion in the therapeutic process, they must have the information necessary to make informed choices about their care.

Appro. 10: *The percentage of consumers who receive adequate information to make informed choices.*

Measure : Consumer response to survey questions regarding adequate information:
C I felt comfortable asking questions about my treatment and medication.
C I was given information about my rights.
C Staff told me what side effects to watch for.

Source: Consumer survey.

Application of Best-Practice Guidelines

Concern: Services are delivered, where possible, in accordance with known and accepted best-practice guidelines.

Rationale: Given the large number of people who have major depression, and the fact that APA guidelines exist for the treatment of this illness, the percentage of consumers receiving treatment that does not follow these guidelines becomes very meaningful.

Appro. 11: *The percentage of service recipients whose treatment follows accepted, best-practice guidelines.*

Measure : The total number of adults with a diagnosis of depression who received medication within the range specified by American Psychiatric Association (APA) guidelines, divided by the total number of adults with the same diagnosis who were prescribed medication.

Source: Enrollment/encounter data; patient records.

Note: As additional practice guidelines are developed and receive broad support in the mental health professional and consumer communities, they should be incorporated into this indicator of appropriateness.

OUTCOMES

Physical Health²

Increased Access to General Healthcare

Concern: Mental health service recipients have equal access (relative to the general population) to effective, general healthcare.

Rationale: Studies indicate that people with mental illnesses have poor access to general healthcare. This often compounds their mental health problems and makes recovery difficult. Although having an annual physical is not equivalent to adequate medical care, it is a minimal indication that the physical health needs of these individuals are being addressed.

Differential mortality due to medical causes may serve as a red flag, indicating that people with serious mental illnesses are not getting the same degree of aggressive, effective medical care as the general population. Restriction of the age range to 35 to 50 years avoids confounding effects of aging. Suicides are excluded because rates are expected to differ, and differential rates would therefore not be an indication of differential medical care. Higher death rates due to suicide among people with psychiatric disabilities should be separated from higher death rates due to medical problems. Since accident-related deaths might mask some suicides, such deaths are also excluded.

Outcomes 1: *The percentage of people with mental illnesses who are connected to primary care.*

Measure: The total number of people with mental illnesses who received a physical exam during the past 12 months, divided by the total number of enrollees receiving mental health services during the past 12 months.

Note: This will be computed separately for the following groups: children and adolescents with serious emotional disturbances, children and adolescents with other emotional disturbances, adults with serious mental illnesses, adults with other mental illnesses, and adults with a dual diagnosis of a mental illness and substance use disorder.

Source: Enrollment/encounter data; patient records.

²*The outcomes listed follow the World Health Organization typology of physical health, psychological health, level of independence, and social relationships.*

[Alternative: If not available on information systems, include the following on the consumer report items form:

Have you had a physical exam in the last 12 months? Yes__ No__]

Outcomes 2: *The differential evidence of mortality due to medical causes for service recipients who have/do not have serious mental illnesses.*

Measure : The total number of mental health service recipients between the ages of 35 and 50 who died during the last 12 months by specific cause (excluding suicide and accidents), compared with the same measure for non-mental health service recipients.

Source: Enrollment encounter data; patient records (both should include the cause of death for all enrollees).

Minimal Negative Outcomes from Treatment

Concern: Service recipients experience minimal, adverse iatrogenic effects.

Rationale: Tardive dyskinesia is considered to be among the most serious negative side effects resulting from prolonged use of neuroleptic medications. This disorder can cause irreversible neurological symptoms and may complicate treatment of disorders like schizophrenia, which are usually accompanied by problems with social isolation. Clinical studies have found elderly patients to be at particularly high risk. Since this disorder is caused by medications commonly used to treat severe psychotic symptoms, it qualifies as an important iatrogenic effect.

Outcomes 3: *The average level of involuntary movements resulting from the use of psychotropic medications for specified service recipient groups.*

Measure : For consumers with a history of taking neuroleptic medication, the average change score from an initial evaluation, compared to subsequent evaluations taken at annual intervals, using the Abnormal Involuntary Movement Scale (AIMS).

Notes: The initial evaluation (baseline score) is obtained three months after beginning neuroleptic medications, or, for individuals who have been taking neuroleptic medications for at least three months, at the time of program enrollment.

For purposes of this measure, the baseline score will consist of the sum of each of the first seven scale items: Facial and Oral Movements (four items), Extremity Movements (two items), and Trunk Movements (one item).

Source: The AIMS.

Psychological Health

Reduced Psychological Distress

Concern: The level of psychological distress from symptoms is minimized.

Rationale: Symptom level is distinct from symptom distress. Currently, *symptom level* is assessed by the mental health service provider, while *symptom distress* 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).

Outcomes 4: *The percentage of consumers who experience a decreased level of psychological distress.*

Measures: The proportion of adults with mental illnesses who report a decreased level of psychological distress at selected intervals after admission for mental health treatment, according to the symptom distress scale:

- (a) During the past 7 days, about how much were you distressed or bothered by:
- C nervousness or shakiness inside
 - C being suddenly scared for no reason
 - C feeling fearful
 - C feeling tense or keyed up
 - C spells of terror or panic
 - C feeling so restless you couldn't sit still
 - C heavy feeling in arms or legs
 - C feeling afraid to go out of your home alone
 - C feeling of worthlessness

- C feeling lonely even when you are with people
- C feeling weak in parts of your body
- C feeling blue
- C feeling lonely
- C feeling no interest in things
- C feeling afraid in open spaces or on the streets

Notes: The response format is a 5-point continuous scale from **A**not at all to **A**extremely. Adults with serious mental illnesses, adults with other mental illnesses, and adults with a dual diagnosis of a mental illness and a substance use disorder will be asked to complete the symptom distress instrument at admission, following three months of mental health services, every 12 months thereafter, and at discharge.

For purposes of this measure, **A**admission is defined as the point at which an individual first enters a mental health program to receive services for a current mental health episode. This would not include admission to a facility due to organizational changes in the system.

- (b) The proportion of children and adolescents for whom there is a decreased level on the Child and Adolescent Functional Assessment Scale (CAFAS) Moods/Emotion subscale.

Note: This will be measured for children and adolescents with serious emotional disturbances and children and adolescents with other emotional disturbances.

- Source:**
- (a) Symptom distress scale (clinician administered), adapted from the SCL-90 and BSI.
 - (b) CAFAS for children and adolescents.

Increased Sense of Personhood

Concern: Service recipients experience an increased sense of personhood.

Rationale: Personhood is emerging as a critical concept and goal in the treatment of serious mental illnesses. It subsumes dignity, self-respect, self-mastery, self-esteem, and self-worth. The Rosenberg Self-Esteem

Scale is a surrogate measure of this concept. More work is needed to operationalize and measure this concept, but its fundamental nature should be reflected in any set of mental health outcomes being proposed.

Outcomes 5: *The percentage of consumers who experience an increased sense of self-respect and dignity.*

Measure : The proportion of service recipients with serious mental illnesses who report an increase in sense of self-esteem based on the Rosenberg Self-Esteem Scale (11 items):

- C I feel that I am a person of worth, at least on an equal basis with others.
- C I feel that I have a number of good qualities.
- C All in all, I am inclined to feel that I am a failure. *(reverse coded)*
- C I am able to do things as well as most other people.
- C I feel that I do not have much to be proud of. *(reverse coded)*
- C I take a positive attitude toward myself.
- C On the whole, I am satisfied with myself.
- C I wish I could have more respect for myself. *(reverse coded)*
- C I certainly feel useless at times. *(reverse coded)*
- C At times, I think that I am no good at all. *(reverse coded)*
- C There is really no way I can solve some of the problems I have. *(reverse coded)*

Source: Consumer response to the Rosenberg Self-Esteem Scale.

Level of Independence

Reduced Impairment from Substance Abuse

Concern: Enrollees experience minimal impairment from use of substances.

Rationale: Increased functioning is an important objective for people with mental disorders. This concern focuses on level of functioning related to alcohol or drug use.

Outcomes 6: *The average level of impairment in service recipients with substance abuse problems.*

- Measures:**
- (a) The rate of all adults receiving services in the mental health system who are identified with substance use A greater than or equal to 3@ on the Clinical Alcohol and Drug Use Scale.
 - (b) The proportion of children and adolescents for whom there is a decreased level on the CAFAS Substance Abuse subscale.
- Source:**
- (a) Clinical Alcohol and Drug Use Scale (clinician administered) for adults.
 - (b) CAFAS for children and adolescents.

Increase in Productive Activity

Concern: Enrollees experience minimal interference with productive activity, such as work, school, or volunteer activities, as a result of alcohol, drugs, and/or mental disorders.

Rationale: The economic loss resulting from alcohol, drug, and mental disorders is substantial. For the working population, as well as for their employers and other payers, a frequent and important goal of treatment is to maintain productivity. School attendance is an important aspect of role functioning for school-age children and adolescents. Attendance is a coarse but minimal measure of school functioning. Productive activity is an important component of role functioning and is typically assessed in health services outcomes research. The final indicator in this concern, taken from a widely used, consumer self-report measure of health status, taps a broader domain of productive activity than employment, and thus applies to a wider population of adults.

Outcomes 7: *The proportion of people with serious mental illnesses involved in competitive employment.*

Measure : Annual percentage figures based on positive consumer response to each of two questions:

- C During the past three months, have you worked at any time for at least minimum wage?
If so, did you do this work for any amount of time at least four weeks in a row?

Note: Because people with serious mental illnesses often begin work gradually and/or have an intermittent work history, a broad definition of employment is necessary. A narrow definition would exclude those who are just beginning their working life, or those who have been working recently but are currently unemployed. As more consumers become employed in competitive situations, the operational definition might be narrowed, or an indicator reflecting change in employment activity might be added.

Source: Consumer report items form.

Outcomes 8: *The average change in days of work lost.*

Measure : The response of employed adults with other mental illnesses to the following question:
C During the last four weeks, how many days did you miss work?

Note: The number of days lost as reported at follow-up is subtracted from days lost as reported at intake; this change score is averaged across respondents.

Source: Consumer report items form at entry into services and again at three months or at termination, whichever comes first.

Outcomes 9: *The increase in the level of school performance.*

Measure : The proportion of children and adolescents for whom there is an increase after three months on the CAFAS School Performance subscale.

Source: CAFAS for children and adolescents.

Outcomes 10: *The extent to which alcohol, drugs, or mental problems interfere with productive activity.*

Measure : The response of individuals without serious mental illnesses to the following question from the SF-36 scale:

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

- C Cut down on the amount of time you spent on work or other activities?
- C Accomplished less than you would like?
- C Didn't do work or other activities as carefully as usual?

Source: Consumer report items form.

Capacity for Independent Community Living

Concern: Enrollees function in community settings with optimal independence from formal service systems.

Rationale: Independent community living is a goal frequently endorsed by people with serious mental illnesses. Though housing status is affected by a wide variety of factors, systems that address and support independent community living are expected to show higher ratios on this measure than systems that do not. Improvement in a consumer's housing situation is an indirect measure of the degree to which a mental health provider or system promotes independent community living for people with serious mental illnesses. Maintaining children successfully and safely at home is a valued outcome for both children and their families. In addition, at-home treatment typically is less expensive than out-of-home placements.

Outcomes 11: *The percentage of children with serious emotional disturbances placed outside the home for at least one month during the year.*

Measure : The total number of children with serious emotional disturbances placed in any setting outside of the home for at least one month over the period of one year, divided by the total number of children with serious emotional disturbances served by the plan during the same year.

Source: Enrollment/encounter data.

Outcomes 12: *The percentage of adults with serious mental illnesses living in residences they own or lease.*

Measure : At the time of annual reporting, the total number of adults with serious mental illnesses currently living in residences they own or lease, divided

by the total number of adults with serious mental illnesses currently being served by the plan.

Source: Enrollment/encounter data.

Outcomes 13: *The percentage of consumers whose housing situations improve as a direct result of treatment.*

Measure : The response of consumers with serious mental illnesses to a survey question regarding housing:
C As a direct result of services I received, my housing situation has improved.

Source: Consumer survey.

Increase in Independent Functioning

Concern: Service recipients experience increased independent functioning.

Rationale: Mental health services are expected to improve a person's ability to respond to problems, crises, and everyday situations they encounter.

Outcomes 14: *The percentage of consumers who experience an increased level of functioning.*

Measures: (a) For children and adolescents, results of CAFAS.
(b) For adults, consumer response to survey questions regarding independent living:
As a direct result of services I received:
C I deal more effectively with daily problems.
C I am better able to control my life.
C I am better able to deal with crisis.
C I have become more effective in getting what I need.
C I can deal better with people and situations that used to be a problem for me.

Source: (a) CAFAS for children and adolescents.

(b) Consumer survey for adults.

Reduced Involvement in the Criminal Justice System

Concern: People with mental illnesses should experience reduced involvement in the criminal justice system.

Rationale: An increasing number of people with mental illnesses are involved, often inappropriately, with the criminal justice system. This is even more likely to happen when budget cuts make it difficult to access appropriate services. Although this item may not be reported accurately by consumers, the possibility of matching mental health and criminal justice system records was considered too onerous.

Outcomes 15: *The percentage of people who were in jail the past year.*

Measures:

- (a) The total number of adults with serious mental illnesses who report spending some time in jail during the past year, divided by the total number of adults with serious mental illnesses served during the past year.
- (b) The change in the proportion of children and adolescents involved with the legal system as reported on the CAFAS.

Source:

- (a) Consumer report items form.
- (b) CAFAS for children and adolescents.

Participation in Self-Help Activities

Concern: Recipients take an active role in managing their own illnesses.

Rationale: Participation in self-help activities helps consumers better manage illness or disability. Such activities include informal interaction with fellow consumers, regular participation in self-help or support groups, and individual reading and self-education. The Task Force recognizes the importance of self-help activities and the significant role a mental health provider or system can play in promoting and supporting such endeavors.

Outcomes 16: *The percentage of consumers who are involved in self-help activities.*

Measure : Consumer response to questions regarding their participation in self-help activities:

- C Do you participate in a self-help group or support group? (For example, AA, NA, depression support group, family support group, etc.) Yes__ No__
- C Does your plan provide you with written information about mental illness? Yes__ No__
- C Do you share information about mental illness with others? Yes__ No__

Source: Consumer report items form.

Minimal Recurrence of Problems

Concern: People experiencing an episode of acute psychiatric illness receive care that reduces the likelihood of a recurrence within a short period of time.

Rationale: Given the increasingly limited use of psychiatric inpatient care, hospitalization most likely indicates an acute episode of illness. An important goal of mental health treatment is to minimize such episodes. Avoiding the recurrence of acute illness within 30 days of discharge is an important benchmark of effective mental health treatment.

Outcomes 17: *The percentage of inpatient readmissions that occur within 30 days of discharge.*

Measure : The total number of admissions to psychiatric inpatient care that occurred within 30 days of a discharge from psychiatric inpatient care during the past year, divided by the total number of all discharges from psychiatric inpatient care during the past year.

Source: Enrollment/encounter data.

Positive Changes (in Areas for Which Treatment is Sought)

Concern: Services result in positive changes in problems as defined by consumers.

Rationale: People seek help with their illnesses to get relief from symptoms or to better handle certain aspects of their everyday lives. This indicator measures whether the desired outcome has been achieved.

Outcomes 18: *The percentage of consumers who report positive changes in the problems for which they sought help.*

Measure : Consumer response to the following question:
You came to our program with certain problems. How are these problems now?

Source: Consumer report items form.

Social Relationships

Increased Natural Supports and Social Integration

Concern: Service recipients experience increased natural supports and social integration.

Rationale: An individual's ability to have friends and a support network separate from the mental health system is critical to reducing dependence on case managers, therapists, and other care providers. In times of crisis, individuals may first seek assistance from friends, relatives, and other community members if these contacts have been developed.

Outcomes 19: *The percentage of consumers who experience increased activities with family, friends, neighbors, or social groups.*

Measures:

- (a) For adults, consumer response to the following questions from the SF-36 scale:
 - C During the past four weeks, to what extent has your physical health, emotional problem, and/or psychiatric disability interfered with your social activities with family, friends, neighbors, or groups?
 - C During the past four weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Note: The response format is a 5-item continuous scale from *Not at all* to *Extremely* for the first question, and from *None of the time* to *All of the time* for the second question.

(b) Also for adults, consumer response to the following survey questions regarding support and integration:

As a result of services I received:

C I am getting along better with my family.

C I do better in social situations.

C I do better with my leisure time.

(c) For children and adolescents, caregiver responses to the CAFAS and change in the CAFAS Behavior Toward Others subscale.

Source:

(a) SF-36 items for adults.

(b) Consumer survey for adults.

(c) CAFAS for children and adolescents.

PREVENTION

Recent research on preventing mental disorders has set aside an earlier framework based on primary, secondary, and tertiary prevention in favor of one defined in terms of universal, selective, and indicated preventive interventions.³ These are described in brief below.

Universal preventive measures are those that can apply to the general public. Examples include information about mental health risk factors, stress management, and moderation in use of alcohol and other drugs.

Selective preventive measures are directed toward apparently healthy individuals who are at elevated risk for developing mental disorders because of factors that include age, hazardous social setting, or an experience such as bereavement.

Indicated preventive measures are directed toward those individuals who show signs of increased risk for developing mental disorders; e.g., people engaged in high-risk use of alcohol, or children with school behavior problems who live in high-risk family settings.

Although the long-term goal of prevention is a reduction in the incidence of mental disorders (i.e., reduction in the occurrence of new cases), short-term strategies aim to reduce those risk factors that make certain individuals more likely than others to develop a mental disorder. Particular preventive interventions are typically focused on a single developmental stage, but prevention activities as a whole are relevant throughout the life cycle.

Research on the prevention of mental disorders is still in its infancy. It is too early to identify specific screening activities that will highlight risk factors for which effective interventions are known. Nonetheless, because early evidence indicates that many preventive efforts are useful, they should be incorporated in any comprehensive mental health treatment program. Currently, such activities can be monitored by determining how much a mental health provider or system spends on disseminating universal preventive information, and by the degree to which its members participate in selective and indicated interventions.

Apart from efforts to prevent illness, those activities that promote wellness (e.g., programs to enhance self-esteem) may be fundamental to preserving mental health. However, in the absence of empirical knowledge about their effectiveness, the Task Force has not incorporated health promotion activities in the formal evaluation of provider performance. To the extent that future research demonstrates their relevance, they should be included.

³Institute of Medicine (Patricia J. Mrazek and Robert J. Haggerty, Editors). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington, DC: National Academy Press, 1994.

Information Provided to Reduce the Risk of Developing Mental Disorders

Concern: Enrollees are provided information that helps lower their risk of developing mental and/or substance use disorders.

Rationale: The indicator below focuses on the degree to which health plans provide information designed to help enrollees make informed choices about their behavior. Such interventions are typically universal.

Prevent 1: *Expenditures per enrollee on dissemination of preventive information.*

Measure : Expenses incurred in developing and disseminating information about stress, depression, family communication, substance use, associated risk factors, and the availability of support or educational groups or other structured interventions for people at risk, divided by all enrollees in the plan.

Notes: To measure this effort, mental health providers must track costs for these activities. Where such information is not available, acceptable methods for providing valid estimates will have to be specified.

Source: Administrative information systems/reports.

Interventions Designed to Reduce the Risk of Developing Mental Disorders

Concern: Individuals at risk are provided specific programs that enable them to reduce their risk of developing mental disorders.

Rationale: The indicator below addresses the degree to which health plans take explicit steps to reduce the risk of developing mental disorders among people with known risk factors.

Prevent 2: *The percentage of enrollees participating in selected or indicated preventive programs.*

Measure : The total number of enrollees with identified risk factors who are enrolled during a one-year period in mutual help and other support programs; programs for people with job loss, bereavement, and subclinical depressive symptoms; and skill and other developmental programs for youth at risk of substance abuse or childhood behavior

problems, divided by the total number of enrollees during the same one-year period.

Note: To measure this activity, providers would have to track enrollment in these interventions. Typically, these activities are not covered healthcare services and are, therefore, not included in encounter data. Although including them in shadow claims systems might be ideal, alternative data sources would include an ad-hoc survey of providers within a plan or a survey of enrollees.

Source: Administrative information systems/reports

