Outcome Measures Manual

San Diego County Adult Outcome Measures

Health Services Research Center
University of California, San Diego

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Supplemental Materials

INTRODUCTION AND RESOURCES

The purpose of this document is to guide individuals through the use of assessments contained in the Mental Health Outcomes Management System (mHOMS). Within this document, you will find some information regarding each outcome measure, detailed instructions on assessment schedules, measure administration guidelines, and sample reports.

Selection of Outcome Measures

A Mental Health Services Evaluation Advisory Group (MHSEAG) comprised of subject matter experts and representatives of a range of stakeholder groups influenced the selection of outcome measures. The MHSEAG sought to minimize burden to staff, burden to people getting services, and costs of administration. In addition, they sought to maximize usefulness to staff and County/State administration, usefulness to people getting services, data quality and clarity of definitions, validity for measuring relevant goals/outcomes, and cultural competence/humility/sensitivity.

Training

The Health Services Research Center (HSRC) at the University of California, San Diego (UCSD) assists providers with implementing these measures. Each provider will receive in-person training, with follow-up trainings for new employees or as a refresher for current employees upon request. Additional training and support will be available based on individual program needs.

Technical Support

Technical support, including training videos and help documents, is available on the Help tab within mHOMS for technical support. Please contact HSRC for additional clarification and answers to specific questions.

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DESCRIPTION OF OUTCOME MEASURES

Clinician Assessment

Completed by Clinician

IMR: The Illness Management and Recovery Questionnaire (IMR) is completed by clinical staff members and is used to measure their perception of client recovery. The IMR has 15 items, each addressing a different aspect of illness management and recovery. Each item may function as a domain for improvement.

MORS: The Milestones of Recovery Scale (MORS) is a single-item instrument that is used to assess the clinician's perception of a client's current degree of recovery. Ratings are determined considering three factors: a client's level of risk (co-occurring disorders, likelihood of causing harm to self or others, and level of risky/unsafe behaviors), level of engagement within the mental health system, and level of skills and supports (which is a combination of one's abilities and support network and one's level of need from support staff). Clinical staff members will complete the MORS.

SATS-R: The Substance Abuse Treatment Scale – Revised (SATS-R) is a single-item assessment of a client's substance abuse stage of treatment/recovery, and is also completed by clinicians.

LOCUS: The Level of Care Utilization System (LOCUS) is a short assessment of a client's current level of care completed by clinicians. *This should be completed if required for your program by the county.*

Goals: Individual items measuring employment, housing, and education goal planning are included for clients for whom these goals are relevant or appropriate. This instrument includes three items completed by the clinician.

See pages 9-17 for more information about the instruments used in the Clinician Assessment.

Integrated Self-Assessment

Completed by Client

RMQ: To measure client perception of individual recovery, the Recovery Markers Questionnaire (RMQ) is included in the Integrated Self-Assessment, and is completed by all clients who are capable of doing so. The RMQ is a 26-item questionnaire that is comprehensive and recovery-oriented. The RMQ also includes items related to occupational activities and stage of recovery. In total, this assessment contains 35 items.

See pages 18-20 for more information about the instruments used in the Integrated Self-Assessment.

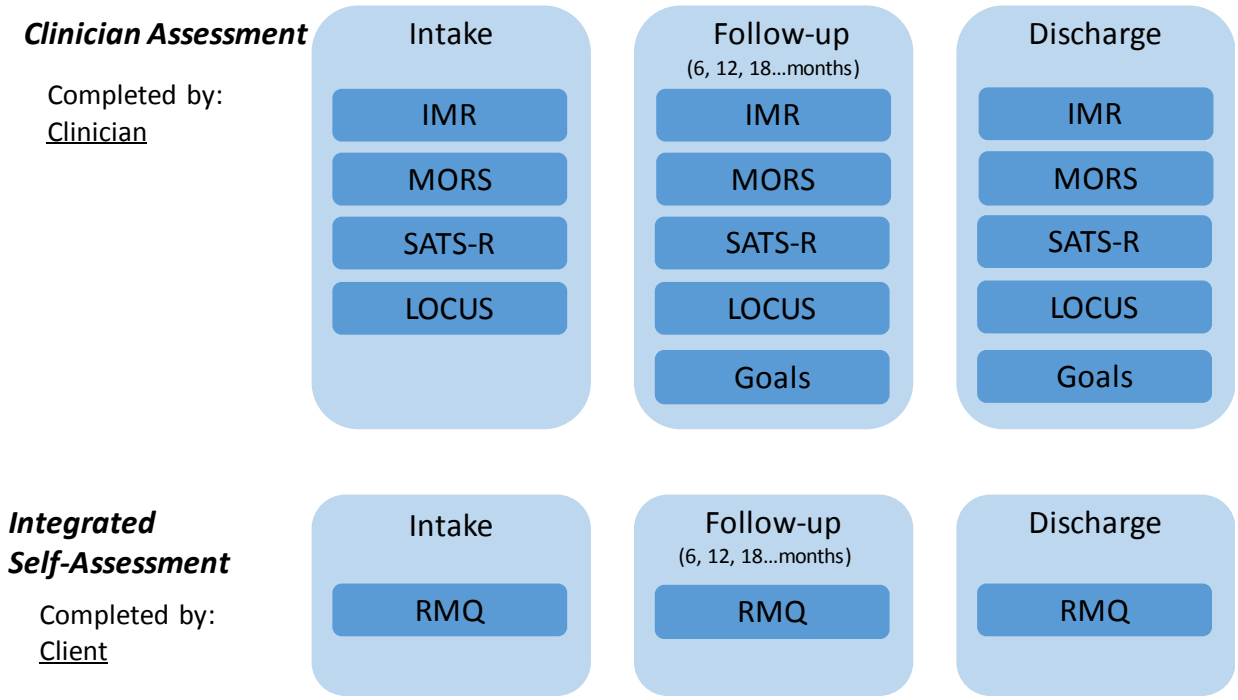
ASSESSMENT SCHEDULE

Clinicians and clients will complete assessments at intake (baseline), follow-up (usually every six months), and discharge. It is important to note that the system does not require assessments to fall within certain windows, but rather can accommodate real-world flexibility. For example, while the assumption is that all clients should be seen at least every six months, this is not always possible. Clients may miss appointments and miscommunications happen, leading to longer times between visits. For example, a client who was last seen eight months ago will require a treatment plan update when seen at that eight-month point, so the mHOMS follow-up assessment can be done at that same timepoint and the system will count it as a standard follow-up assessment.

Clinician: Clinicians should complete the IMR, MORS, and SATS-R at intake. Because client recovery and treatment plans should change throughout the program, clinicians will be asked to complete follow-up IMR, MORS, and SATS-R roughly every six months. The six-month assessment will also include the Goals items if recovery goals are part of the client's recovery plan. The discharge assessment includes the IMR, MORS, SATS-R, and Goals. *The LOCUS should be completed at intake, follow-up, and discharge if required for your program by the county.*

Client: All new clients should complete the RMQ at intake (baseline). Staff may ask clients to complete this measure while awaiting their first appointment, or immediately afterwards, as this time may be most convenient. Clients should also complete the RMQ at their six-month follow-up and at discharge.

Outcome Measures Timeline



FREQUENTLY ASKED QUESTIONS

Who should complete the Clinician Assessment (IMR, MORS, SATS-R, LOCUS, and Goals)?
Clinicians should complete the Clinician Assessment as a measure of client recovery. For cases in which clients see several different program staff at intake and throughout their involvement in the treatment program, the clinical staff member who works most closely with the client throughout the therapeutic process should complete the Clinician Assessment. This can be any staff member who has received training in the delivery of health services, such as a team leader, case manager, or clinician.

Who should complete the Integrated Self-Assessment?
All clients should complete the Integrated Self-Assessment.

What languages will the forms for clients be available in?
The Integrated Self-Assessment is available in English, Arabic, Spanish, Tagalog, and Vietnamese.

What if a person is monolingual or has difficulty reading in his or her preferred language?
Program staff can help clients complete the Integrated Self-Assessment through interviews. In addition, mHOMS hosts measures in English and Spanish and can support text-to-speech capabilities for participants who have difficulty reading in their preferred language.

How does my client complete the Integrated Self-Assessment?
Clients may complete the Integrated Self-Assessment directly in mHOMS (https://mhoms.ucsd.edu), or data may be collected using paper assessments and staff may enter that data into the system. See the mHOMS User Manual for instructions on completing the Integrated Self-Assessment via Participant Mode.

What if my client needs to complete his or her assessment on paper?
Clinicians may download and print out paper forms for each client due for an assessment from the mHOMS website via the Documents tab. Before having the client complete the Integrated Self-Assessment, please write his or her Client Username at the top of each page. Once the client has finished the assessment, please check each page to ensure all of the questions have been completed, and help the client with any questions as needed. Assessments completed on paper will need to be entered into the mHOMS electronic system through Back-Entry Mode on the Assessment tab to ensure that the assessment is associated with the correct assessment period. See the mHOMS User Manual for instructions on entering data using Back-Entry Mode.

What should I do if a client would like help completing his or her Integrated Self-Assessment?
Staff may help a client complete the Integrated Self-Assessment if he or she requires assistance. If a client is unable to complete the Integrated Self-Assessment, mHOMS will record the reason for non-completion.

How can we enter previous assessments and paper forms into mHOMS? How do we determine which data entry mode to use?

Via the Assessments tab, users may Review, Edit, or Back-Enter client data that has already been completed to promote data quality and completeness. This can be used to enter paper forms if clinicians prefer to complete the measures on paper.

- **Review Mode** allows users to view both client and clinician assessment information that has already been entered into the system.
- **Edit Mode** allows users to edit or add information to an existing, submitted assessment form in the system.
- **Back-Entry Mode** allows users to enter data from paper forms directly into the system.

Can we get reports of client data?

Reports summarizing client recovery are designed to be of clinical use for treatment planning, and are available to program staff in real time via mHOMS (https://mhoms.ucsd.edu). A sample client-level report is available on page 21, and a sample program-level report is available on page 26.

Supplemental Material

ILLNESS MANAGEMENT AND RECOVERY (IMR)

Aim: Researchers developed the Illness Management and Recovery (IMR) Scales (Mueser, Gingerich, Salyers, McGuire, Reyes, & Cunningham, 2004) to measure outcomes targeted by the Illness Management and Recovery Program. The IMR program is an evidence-based practice designed to assist individuals with psychiatric disabilities with developing personal strategies to manage their mental illness and advance toward their goals.

Conceptual Foundation: The IMR Scales were developed as a measure of illness management, based on the stress-vulnerability model of severe mental illness (SMI). According to this model, the severity of a mental illness and likelihood of relapses are determined by the interaction between biological vulnerability and socio-environmental stressors, both of which can be mitigated. Biological vulnerability can be reduced by adherence to prescribed medications and reduction or avoidance of alcohol or drug use. The effects of stress on vulnerability can be reduced by improved coping skills, social support, and involvement in meaningful activities.

Development: Consumers/survivors, families/friends of consumers/survivors, members of racial and ethnic minority groups, providers, researchers, and advocates contributed to the development of the instrument. Items were generated by IMR program practitioners and consumers in order to address the various content areas targeted by the IMR program with as few items as possible. Feedback was obtained from other clinicians and consumers about item selection and wording, and modifications were made accordingly.

Items and Domains: The IMR includes 15 Likert Scale items, with a five-point response scale wherein response anchors vary depending upon the item. The scales are not divided into domains. Rather, each item addresses a different aspect of illness, management, and recovery.

Populations: The IMR Scales are intended to be used to assess adults from diverse ethnic/racial backgrounds who have been diagnosed with SMI, including those who have a dual diagnosis. Testing of the instrument included an ethnically/racially diverse sample of respondents (Asian, Black or African American, White, Hispanic or Latino) who had a diagnosis of SMI, some of whom had a dual diagnosis.

Service Settings: The IMR Scales are intended for use in an array of service settings including the criminal justice system, inpatient service settings, outpatient service settings, peer-run programs, and residential service settings. Testing was conducted using a sample of respondents drawn from an outpatient service setting.

Frequency of Administration: The IMR should be completed by clinicians at intake, whenever there is a follow-up (which tends to be every six months), and at discharge.

Translations: The IMR has been translated into Spanish and 11 other languages.

ILLNESS MANAGEMENT AND RECOVERY SCALE (IMR)

1. Progress towards personal goals: In the past 3 months, s/he has come up with…

○	○	○	○	○
No personal goals	A personal goal, but has not done anything to finish the goal	A personal goal and made it a little way toward finishing it	A personal goal and has gotten pretty far in finishing the goal	A personal goal and has finished it

2. Knowledge: How much do you feel s/he knows about symptoms, treatment, coping strategies (coping methods), and medication?

○	○	○	○	○
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in mental health treatment: How much are people like family, friends, boyfriends/girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his/her mental health treatment?

○	○	○	○	○
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time and they really help with his/her mental health

4. Contact with people outside of family: In a normal week, how many times does s/he talk to someone outside of his/her family (like a friend, co-worker, classmate, roommate, etc.)?

○	○	○	○	○
0 times/week	1-2 times/week	3-4 times/week	5-7 times/week	8 or more times/week

5. Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

○	○	○	○	○
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/wk

6. Symptom distress: How much do symptoms bother him/her?

○	○	○	○	○
Symptoms really bother him/her a lot	Symptoms bother him/her quite a bit	Symptoms bother him/her somewhat	Symptoms bother him/her very little	Symptoms don't bother him/her at all

7. Impairment of functioning: How much do symptoms get in the way of his/her doing things that s/he would like to do or need to do?

○	○	○	○	○
Symptoms really get in his/her way a lot	Symptoms get in his/her way quite a bit	Symptoms get in his/her way somewhat	Symptoms get in his/her way very little	Symptoms don't get in his/her way at all

8. Relapse prevention planning: Which of the following would best describe what s/he knows and has done in order not to have a relapse?

○	○	○	○	○
Doesn't know how to prevent relapses	Knows a little, but hasn't made a relapse prevention plan	Knows 1 or 2 things to do, but doesn't have a written plan	Knows several things to do, but doesn't have a written plan	Has a written a plan and has shared it with others

9. Relapse of symptoms: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

○	○	○	○	○
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	Hasn't had a relapse in the past year

10. Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

○	○	○	○	○
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	No hospitalization in the past year

11. Coping: How well do you feel s/he is coping with his/her mental or emotional illness from day to day?

○	○	○	○	○
Not well at all	Not very well	Alright	Well	Very well

12. Involvement with self-help activities: How involved is s/he in consumer-run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

○	○	○	○	○
Doesn't know about any self-help activities	Knows about some self-help activities, but isn't interested	Is interested in self-help activities, but hasn't participated in the past year	Participates in self-help activities occasionally	Participates in self-help activities regularly

13. Using medication effectively: (Don't answer this question if his/her doctor has not prescribed medication). How often does s/he take his/her medication as prescribed?

○	○	○	○	○
Never	Occasionally	About half the time	Most of the time	Every day

☐ *Check here if the client is not prescribed psychiatric medications.*

14. <u>Impairment of functioning through alcohol use</u>: Drinking can interfere with functioning when it contributes to conflict in relationships or to financial, housing, and legal concerns; to difficulty showing up at appointments or focusing during them; or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

○	○	○	○	○
Alcohol use really gets in his/her way a lot	Alcohol use gets in his/her way quite a bit	Alcohol use gets in his/her way somewhat	Alcohol use gets in his/her way very little	Alcohol use is not a factor in his/her functioning

15. <u>Impairment of functioning through drug use</u>: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing, and legal concerns; to difficulty showing up at appointments or focusing during them; or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

○	○	○	○	○
Drug use really gets in his/her way a lot	Drug use gets in his/her way quite a bit	Drug use gets in his/her way somewhat	Drug use gets in his/her way very little	Drug use is not a factor in his/her functioning

MILESTONES OF RECOVERY SCALE (MORS)

Aim: The Milestones of Recovery Scale (MORS) was developed by Dave Pilon, PhD and Mark Ragins, MD, in collaboration with the California Association of Social Rehabilitation Agencies (CASRA) to provide mental health agencies with a tool to assess the objective and observable behavioral correlates (i.e., "milestones") of recovery.

Conceptual Foundation: Mental health recovery is a concept that is evolving through greater understanding of the lived experience of resilience and rebound among people with serious psychiatric disabilities. This focus on recovery has significant implications for the types of mental health services offered, the manner in which they are delivered, as well as the way in which the effectiveness of mental health programs are evaluated.

Development: The three underlying dimensions of the MORS were developed based upon feedback from a workgroup of 50 administrators, clinicians, and consumers in the mental health field. The MORS assesses a client's/consumer's (a) level of risk, which is comprised of the likelihood of physically harming oneself or others, one's level of participation in risky or unsafe behaviors, and one's level of co-occurring disorders; (b) level of engagement within the mental health system; and (c) level of skills and supports, which is a measure of the client's/consumer's abilities and support network, and his or her level of need from support staff. The MORS was psychometrically tested using staff at The Village, a multi-service organization serving the mentally ill homeless population in Long Beach, CA, and staff at the Vinfen Corporation, a large provider of housing service to mentally ill persons in Boston, MA (Fisher et al., 2009).

Items and Domains: Clients are given one of eight ratings: (1) extreme risk, (2) experiencing high risk/not engaged with mental health providers, (3) experiencing high risk/engaged with mental health providers, (4) not coping successfully/not engaged with mental health providers, (5) not coping successfully/engaged with mental health providers, (6) coping successfully/rehabilitating, (7) early recovery, or (8) advanced recovery. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the past month.

Populations: The MORS is intended for use with adults from diverse racial/ethnic backgrounds who have been diagnosed with a serious mental illness or who have a dual diagnosis. Individuals from several racial/ethnic groups were included in the sample during testing at The Village: Black or African American, White, and limited testing with Hispanic or Latino individuals, Asian individuals, and members from other minority groups. Individuals from several racial/ethnic groups were also included in the sample during testing at the Vinfen Corporation.

Service Settings: The MORS is intended for use with individuals who receive services in outpatient service settings, peer-run programs, residential service settings, and comprehensive community support programs. Testing of the instrument included data gathered from individuals receiving services in many of these settings.

Frequency of Administration: The MORS should completed by clinicians at intake, whenever there is a follow-up (which tends to be every six months), and at discharge.

Translations: There are no known translations.

MILESTONES OF RECOVERY SCALE (MORS)

Please circle the number that best describes the current (typical for the last **month**) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last **month**, please check here □ and do not attempt to rate the member. Instead, simply return the form along with your completed assessments.

1. **"Extreme risk"** – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails, or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. **"Experiencing high risk/not engaged with mental health providers" –** These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. **"Experiencing high risk/engaged with mental health providers"** – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

4. **"Not coping successfully/not engaged with mental health providers" –** These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. **"Not coping successfully/engaged with mental health providers" –** These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others, and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. **"Coping successfully/rehabilitating" –** These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.

7. **"Early recovery"** – These individuals are actively managing their mental health treatment to the extent that mental health staffs rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

8. **"Advanced recovery"** – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

SUBSTANCE ABUSE TREATMENT SCALE – REVISED (SATS-R)

Aim: The SATS-R should be used to assess a client's stage of substance abuse treatment. Please note that the instrument should not be used for determining diagnosis.

Frequency of Administration: The SATS-R should completed by a clinician at intake, whenever there is a follow-up (which tends to be every six months), and at discharge when the client has an active substance related treatment plan goal in his or her plan.

SATS-R

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. A clinician is required to complete a SATS-R when the client has an active substance related treatment plan goal in his/her client plan.

- O 1. **Pre-engagement**: The person (not yet a client) does not have contact with case manager, mental health counselor or substance abuse counselor, and meets criteria for substance abuse dependence.
- O 2. **Engagement**: The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.
- O 3. **Early Persuasion**: The client has regular contacts with a case manager or counselor; continues to use the same amount of substances, or has reduced substance use for less than 2 weeks; and meets criteria for substance abuse or dependence.
- O 4. **Late Persuasion**: The client has regular contacts with a case manager or counselor; shows evidence of reduction in use for the past 2-4 weeks (fewer drugs, smaller quantities, or both); but still meets criteria for substance abuse or dependence.
- O 5. **Early Active Treatment**: The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.
- O 6. **Late Active Treatment**: The person is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 1-5 months.
- O 7. **Relapse Prevention**: The client is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 6-12 months.
- O 8. **In Remission or Recovery**: The client has not met criteria for substance abuse or dependence for more than the past year.
- O Item not assessed

LEVEL OF CARE UTILIZATION SYSTEM (LOCUS)

Aim: The LOCUS should be used to assess a client's current level of care and should be completed by clinicians.

Frequency of Administration: The LOCUS should be completed by clinicians at intake, whenever there is a follow-up (which tends to be every six months), and at discharge.

Level of Care Utilization System (LOCUS)

- ○ 1. Recovery Maintenance and Health Maintenance
- ○ 2. Low Intensity Community Based Services
- ○ 3. High Intensity Community Based Services
- ○ 4. Medically Monitored Non-residential Services
- ○ 5. Medically Monitored Residential Services
- ○ 6. Medically Managed Residential Services
- ○ Item Not Assessed

GOALS

Aim: Three items measuring employment, housing, and education goal planning are included for clients for whom these goals are relevant or appropriate.

Frequency of Administration: Items measuring goals will be administered at follow-up (which tends to occur every six months), and at discharge.

GOALS

Since the last formal treatment plan update six months ago…	Yes	No	No goal on client's plan
1. Has the client demonstrated progress towards achieving his/her **employment goal**?	○	○	○
2. Has the client demonstrated progress towards achieving his/her **housing goal**?	○	○	○
3. Has the client demonstrated progress towards achieving his/her **education goal**?	○	○	○

RECOVERY MARKERS QUESTIONNAIRE (RMQ)

Aim: The Recovery Markers Questionnaire (RMQ) was developed to provide the mental health field with a multi-faceted measure that collects information on personal recovery.

Conceptual Foundation: Mental health recovery is a concept that is evolving through greater understanding of the lived experience of resilience and rebound among people with serious psychiatric disabilities. The instrument is a consumer-driven assessment of the service user's own state, and his or her preferences, needs and desires, and assessments concerning the assistance provided by the helping system that support and uphold recovery. Recovery is viewed as a complex multi-stage, multi-faceted journey experienced by people with prolonged psychiatric disorders, which can be facilitated and/or impeded by the formal helping system. While the journey of recovery is unique for each person, general patterns can be discerned from the experience of groups of service users. Recovery must be consumer-driven; therefore, transformation of service settings to better facilitate and support personal recovery should focus primarily upon the voice, experiences, and preferences of service recipients.

Development: Consumer/survivors, members of racial and ethnic minority groups, and researchers were involved in the development of the RMQ. The items were developed based upon: (a) consumers' first person accounts of their recovery and the supports that assisted them in this process; (b) an informal review of practices that are believed to promote recovery, i.e. promising practices; and (c) a review of literature on factors that promote resilience or "rebound from adversity" in general. The RMQ measure was pre-tested, refined, and then psychometrically tested and revised before being finalized (Ridgway & Press, 2004).

Items and Domains: The RMQ includes 26 Likert scale items, with a five-point agreement response scale ranging from "strongly agree" to "strongly disagree," regarding the recovery process and intermediate outcomes. This assessment also includes items related to occupational activities and stage of recovery, and, in total, contains 35 items.

Populations: The RMQ is intended for use with adults from diverse racial/ethnic backgrounds who have been diagnosed with a serious mental illness or who have a dual diagnosis. Individuals from several racial/ethnic groups were included in the sample during testing: Black or African American (limited testing), White, Hispanic or Latino (limited testing), and limited testing with members from other minority groups.

Service Settings: The RMQ is intended for use with individuals who receive services in outpatient service settings, peer-run programs, residential service settings, and comprehensive community support programs. Testing of the instrument included data gathered from individuals receiving services in all of the above mentioned settings except for peer-run programs.

Frequency of Administration: The RMQ should be completed by clients within 30 days of their initial intake assessment, every follow-up (usually every six months), and at discharge.

Translations: The RMQ is available in several languages including Arabic, Spanish, Tagalog, and Vietnamese.

Introduction to the Integrated Self-Assessment (to be given by clinician administering questionnaire).
Please answer these questions about how you are feeling right now. The purpose of this questionnaire is to help you and your provider better understand your needs. Remember that you don't have to answer any questions you don't wish to answer, but the more you tell us, the more we can help you. This questionnaire should take about 10 minutes to complete.

INTEGRATED SELF-ASSESSMENT

RECOVERY MARKERS QUESTIONNAIRE (RMQ)

For each of the following questions, please fill in the answer that is true for you now.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. My living situation is safe and feels like home to me.	○	○	○	○	○
2. I have trusted people I can turn to for help.	○	○	○	○	○
3. I have at least one close mutual (give-and-take) relationship.	○	○	○	○	○
4. I am involved in meaningful productive activities.	○	○	○	○	○
5. My psychiatric symptoms are under control.	○	○	○	○	○
6. I have enough income to meet my needs.	○	○	○	○	○
7. I am not working, but see myself working within 6 months.	○	○	○	○	○
8. I am learning new things that are important to me.	○	○	○	○	○
9. I am in good physical health.	○	○	○	○	○
10. I have a positive spiritual life/connection to a higher power.	○	○	○	○	○
11. I like and respect myself.	○	○	○	○	○
12. I am using my personal strengths, skills, or talents.	○	○	○	○	○
13. I have goals I'm working to achieve.	○	○	○	○	○
14. I have reasons to get out of bed in the morning.	○	○	○	○	○
15. I have more good days than bad.	○	○	○	○	○
16. I have a decent quality of life.	○	○	○	○	○
17. I control the important decisions in my life.	○	○	○	○	○
18. I contribute to my community.	○	○	○	○	○
19. I am growing as a person.	○	○	○	○	○
20. I have a sense of belonging.	○	○	○	○	○

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
21. I feel alert and alive.	○	○	○	○	○
22. I feel hopeful about my future.	○	○	○	○	○
23. I am able to deal with stress.	○	○	○	○	○
24. I believe I can make positive changes in my life.	○	○	○	○	○
25. My symptoms are bothering me less since starting services here	○	○	○	○	○
26. I deal more effectively with daily problems since starting services here	○	○	○	○	○

	Yes	No
27. I am working part time (less than 35 hours a week)	○	○
28. I am working full time (35 or more hours per week)	○	○
29. I am in school	○	○
30. I am volunteering	○	○
31. I am in a work training program	○	○
32. I am seeking employment	○	○
33. I am retired	○	○
34. I regularly visit a clubhouse or peer support program	○	○

35. Your involvement in the recovery process: Which of the following statements is most true for you?

- ○ A. I have never heard of, or thought about, recovery from psychiatric disability
- ○ B. I do not believe I have any need to recover from psychiatric problems
- ○ C. I have not had the time to really consider recovery
- ○ D. I've been thinking about recovery, but haven't decided yet
- ○ E. I am committed to my recovery, and am making plans to take action very soon
- ○ F. I am actively involved in the process of recovery from psychiatric disability
- ○ G. I was actively moving toward recovery, but now I'm not because:_____
- ○ H. I feel that I am fully recovered; I just have to maintain my gains
- ○ I. Other (specify):_____

SAMPLE CLIENT-LEVEL REPORT

This is a simulation of an automated client-level report.

Client Recovery Report

Client Username: 1234567 **Program Name: Fake Program**

Current Recovery Ratings

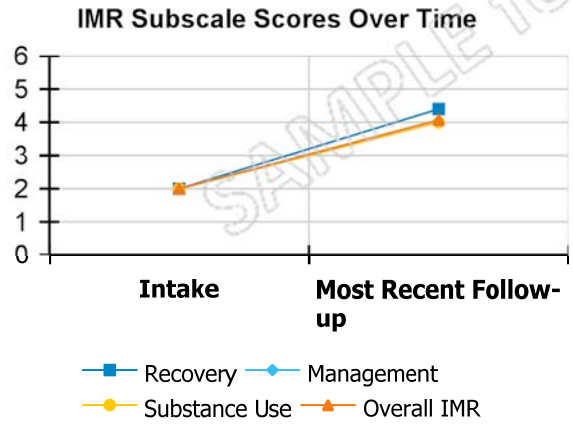
Recovery Subscale: 4.4 out of 5.00

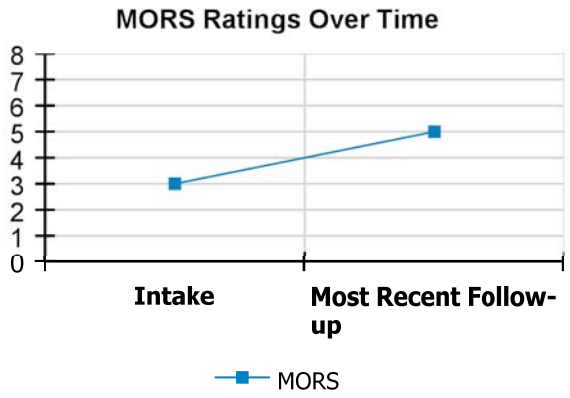
Management Subscale: 4 out of 5.00

Substance Use Subscale: 4 out of 5.00

Overall IMR Score: 4.07 out of 5.00

MORS Rating: 5 out of 8





Higher ratings on the IMR and MORS indicate greater recovery.

Illness Management and Recovery (IMR)

Most Recent Follow-up	5/1/2016
Intake	11/1/2015

Knowledge:

How much do you feel s/he knows about symptoms, treatment, coping strategies (coping methods), and medication?

Most Recent Follow-up	(5) - A great deal
Intake	(3) - Some

Time in Structured Roles:

How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

Most Recent Follow-up	(3) - 6-15 hours/week
Intake	(2) - 3-5 hours/week

Impairment of Functioning:

How much do symptoms get in the way of him/her doing things that s/he would like to do or need to do?

Most Recent Follow-up	(4) - Symptoms get in his/her way very little
Intake	(2) - Symptoms get in his/her way quite a bit

Relapse of Symptoms:

When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

Most Recent Follow-up	(4) - In the past 7 to 12 months
Intake	(2) - In the past 2 to 3 months

Click to Display Additional IMR Data

Client Recovery Report

Progress Towards Personal Goals:

In the past 3 months, s/he has come up with...

Most Recent Follow-up	(5) - A personal goal and has finished it
Intake	(1) - No personal goals

Involvement of Family and Friends in Mental Health Treatment:

How much are people like family, friends, boyfriends/girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his/her mental health treatment?

Most Recent Follow-up	(4) - Much of the time
Intake	(2) - Only when there is a serious problem

Contact with People Outside of my Family:

In a normal week, how many times does s/he talk to someone outside of his/her family (such as a friend, co-worker, classmate, roommate, etc.)?

Most Recent Follow-up	(4) - 5-7 times/week
Intake	(2) - 1-2 times/week

Symptom Distress:

How much do symptoms bother him/her?

Most Recent Follow-up	(4) - Symptoms bother him/her very little
Intake	(2) - Symptoms bother him/her quite a bit

Relapse Prevention Planning:

Which of the following would best describe what s/he knows and has done in order not to have a relapse?

Most Recent Follow-up	(4) - Knows several things to do, but doesn't have a written plan
Intake	(2) - Knows a little, but hasn't made a relapse prevention plan

Coping:

How well do you feel s/he is coping with his/her mental or emotional illness from day to day?

Most Recent Follow-up	(4) - Well
Intake	(2) - Not very well

Client Recovery Report

Psychiatric Hospitalizations:

When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

Most Recent Follow-up	(4) - In the past 7 to 12 months
Intake	(2) - In the past 2 to 3 months

Involvement with Self-Help Activities:

How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

Most Recent Follow-up	(4) - Participates in self-help activities occasionally
Intake	(2) - Knows about some self-help activities, but isn't interested

Impairment of Functioning through Alcohol Use:

Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

Most Recent Follow-up	(4) - Alcohol use gets in his/her way very little
Intake	(2) - Alcohol use gets in his/her way quite a bit

Impairment of Functioning through Drug Use:

Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

Most Recent Follow-up	(4) - Drug use gets in his/her way very little
Intake	(2) - Drug use gets in his/her way quite a bit

Client Recovery Report

Milestones of Recovery Scale (MORS)

Most Recent Follow-up	5/1/2016
Intake	11/1/2015

Milestones of Recovery Scale (MORS)

Most Recent Follow-up	(5) - Not coping successfully/Engaged with mental health providers
Intake	(3) - Experiencing high risk/Engaged with mental health providers

Higher ratings on the IMR and MORS indicate greater recovery.

SAMPLE PROGRAM-LEVEL REPORT

This is a simulation of an automated program-level report.

Ranged Outcomes Report

Date Range: 1/1/2016 through 3/31/2016
Program(s): Fake Program

Number of Client Assessments Reported:

	IMR	MORS	LOCUS	SATS-R	RMQ
Initial Assessment	20	20	17	8	18
Matched	10	10	2	2	7
Unmatched	77	77	33	10	23
Total	**107**	**107**	**52**	**20**	**48**

Changes in Recovery Over Time:

Measure	Unavailable	Worse		Same		Improved	
Functional Status (IMR #7)	0	2	20.00%	3	30.00%	5	50.00%
Clinical Status (IMR #9)	0	1	10.00%	4	40.00%	5	50.00%
MORS	0	1	10.00%	6	60.00%	3	40.00%
LOCUS	0	0	0.00%	1	50.00%	1	50.00%
SATS-R	0	1	50.00%	1	50.00%	0	0.00%
RMQ	0	2	28.57%	3	42.86%	2	28.57%

Ranged Outcomes Report

Measure	Same or Improved	
Functional Status (IMR #7)	8	80.00%
Clinical Status (IMR #9)	9	90.00%
MORS	9	90.00%
LOCUS	2	100.00%
SATS-R	1	50.00%
RMQ	5	71.43%

Progress Towards Treatment Goals

	No Goal on Plan	Unavailable	No Progress		Progress	
Education Goal	5	0	6	42.86%	8	57.14%
Employment Goal	4	0	10	45.45%	12	54.54%
Housing Goal	6	0	4	21.05%	15	78.95%

Ranged Outcomes Report

Frequencies of MORS Ratings

Rating	Number of Clients
1. Extreme Risk	0
2. Experiencing High Risk/Not Engaged with Mental Health Providers	0
3. Experiencing High Risk/Engaged with Mental Health Providers	2
4. Not Coping Successfully/Not Engaged with Mental Health Providers	12
5. Not Coping Successfully/Engaged with Mental Health Providers	82
6. Coping Successfully/Rehabilitating	11
7. Early Recovery	0
8. Advanced Recovery	0
Total Clients	**107**

Ranged Outcomes Report

Frequencies of LOCUS Ratings

Rating	Number of Clients
Recovery Maintenance & Health Maintenance	0
Low Intensity Community Based Services	35
High Intensity Community Based Services	17
Medically Monitored Non-Residential Services	0
Medically Monitored Residential Services	0
Medically Managed Residential Services	0
Total Clients	**52**