



## Strengthening Statewide Mental Health Data Collection, Reporting, and Quality Improvement Systems



WELLNESS • RECOVERY • RESILIENCE

## CSS Tracking, Monitoring, and Evaluation Project

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- **PI:** Dr. Andrew Sarkin
- **Timeframe:** May 2014 – June 2016



## EXECUTIVE SUMMARY

### CSS Tracking, Monitoring, and Evaluation System Project

***All California Counties share with the State an interest in developing a meaningful, systematic approach to CSS outcomes research and reporting. The California Mental Health Services Oversight and Accountability Commission (MHSOAC) is interested in collaborating with Counties and stakeholders to develop the best possible system to help us all collectively strengthen our ability to provide a system of care that meets the needs of all Californians. The purpose of this project is to explore current County resources, needs, and interests in order to come to a consensus regarding a potential statewide outcomes system. A guiding principle throughout the project will be that this effort should benefit all Counties—so the first step will need to be a county level assessment. It is hoped that all Counties will wish to participate to assure that their needs are met.***

The Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Project is being initiated by the MHSOAC to assess the CSS component of the Mental Health Services Act (MHSA) and consider how all aspects of this system, including client outcomes, can best be tracked, monitored, and evaluated. The project will involve the development, piloting, and preliminary use of a data collection and reporting system that will track, monitor, and evaluate the full CSS component. This data collection and reporting system will be designed to enable providers, counties, and the State to understand the clinical and functional status of clients within individual CSS programs/services, and determine whether clients are enrolled in appropriate services. In essence, this system should provide client-level outcomes and data that speak to the appropriateness of a client's current level of care and characteristics of that care.

CSS is the largest component of the MHSA and includes client and family driven services that focus on wellness and integrated service experiences for clients and families, as well as providing services for traditionally unserved and underserved populations. The CSS component includes Full Service Partnerships (FSP), which are designed to provide comprehensive services to the highest-need clients in the system (e.g., those with severe mental illness/emotional disturbance who have co-occurring histories of homelessness, incarceration, and/or institutionalization) as well as services for those who may not qualify for FSP services.

To date, a larger focus has been placed on evaluating outcomes and services for clients served through FSP programs than for clients receiving less comprehensive services from other CSS programs. This project represents MHSOAC's goal to expand the evaluation focus to include clients who receive less comprehensive services than FSP clients. Throughout the project, consideration of currently used methods to track, monitor, and evaluate both FSP and non-FSP clients will be necessary due to the continuum of care that is offered to all clients served through the CSS component.

As part of this project, lessons learned via the development and piloting of a new system for the full CSS component and initial evaluation of services for non-FSP clients will be used to generate policy implications and recommendations for next steps that would facilitate further development and full implementation of a statewide system to track, monitor, and evaluate the full CSS component. The project will also inform policy recommendations regarding current CSS-related statutes and regulations that may hinder the ability to properly place and serve clients within service settings that are appropriate for their needs and current level of care.

This evaluation represents another step toward continuous assessment of the MHSA and the broader public community-based mental health system that is focused on accountability and quality improvement and guided by MHSA values and principles. The ultimate goal of this project is to increase our ability to understand and improve upon the quality of services offered via the CSS component and the system that supports these services.

The overarching questions to be addressed during the course of this project include the following:

- *What statewide methods should be employed to ensure that providers, counties, and the State can track, monitor, and evaluate the status of adults who are receiving CSS services in order to determine the efficacy and appropriateness of those services?*

- *What policies, practices, systems, and infrastructure should be created and/or modified in order to better track, monitor, and evaluate adults who are receiving CSS services?*
- *How effective are services for adults who receive less comprehensive services than what is provided via Full Service Partnerships? (i.e., how effective are services for non-FSP clients?)*
- *What policies, practices, systems, and infrastructure should be created and/or modified in order to better serve adults within the CSS component? (i.e., what new and/or revised methods may further our understanding of CSS client clinical/functional status, current client level of care/service, the most appropriate level of care/service, as well as our ability to provide the most appropriate level of care?)*

In order to address the above listed questions, the evaluation team will work collaboratively with an Evaluation Advisory Group comprising clinicians, providers, county staff, contractors, state staff, persons with lived experience, and end users of the tracking, monitoring, and evaluation system to:

- *Determine what should be measured for adult behavioral health outcomes, how and when it will be measured and by whom, while at the same time maximizing the clinical usefulness of outcomes tracking to enhance people's recovery, and also integrating data that is already collected to minimize burden on staff and clients.*
- *Develop and implement an adult behavioral health outcomes tracking and monitoring system that meets the needs of various stakeholders by providing meaningful data to evaluate the impact of mental health services.*
- *Create policy and practice recommendations for future directions in evaluating mental health services by performing a preliminary evaluation of some MHPA mental health services using the new data collection system.*

Through this project, the MHPAC expects to complete the initial development and piloting of a system, as well as a preliminary evaluation of adult clients being served via CSS in less comprehensive services than FSPs. In addition, an assessment of the policies, regulations, and guidelines that pertain to the CSS component will be carried out in order to better understand potential limitations of current policies and practices that may hinder the provision of effective and appropriate services for CSS clients.

Stakeholder feedback gathered on the initial development, piloting, and evaluation of the system will be used to build a foundation for a future statewide system. A successful statewide system would enable providers, counties, and the State to continuously track, monitor, and evaluate CSS component performance for clients in FSP and non-FSP programs. A successful system may also enable clients, family members, and the general public to better understand the performance of individual providers, as well as the performance of the overarching statewide public community-based mental health system. This tracking, monitoring, and evaluation system can then be used to improve both the quality of services offered to adult clients, and the system through which the services are offered. Paramount to this effort is the creation of data-driven recommendations for improving the capacity of the CSS component to promote positive outcomes in clients, including proper movement of clients through the systems of care and the receipt of appropriate treatment/services.

This project will result in five reports (the project's deliverables), listed below. The expertise and assistance of the Evaluation Advisory Group will be an essential part of the development of all five of these reports:

1. Report of Proposed Tracking, Monitoring, and Evaluation System.
2. Report of Proposed Implementation Plan to Pilot the system in a sample of providers/counties.
3. Report of Proposed Research Design and Analytic Plan to evaluate the efficacy of non-FSP CSS services.
4. Report of Pilot Evaluation Results.
5. Report of Policy and Practice Recommendations for how to Improve upon current CSS services, evaluations, and systems.

## MHSOAC Data Strengthening Efforts

- MHSOAC has committed over \$2.5M over past few years to supporting and strengthening the DHCS-owned data collection and reporting systems
  - Resources, training, and technical assistance to counties
  - Revisions to IT infrastructure
- The state-level systems had not been well maintained for some time during transition from DMH, and they do not fully meet needs of providers, counties, or the State.
- DHCS has done a lot to strengthen these systems, but these attempts were more of a “quick fix” than a long-term solution to the systems’ underlying weaknesses. MHSOAC is attempting to truly strengthen system so that it meets our collective needs of promoting positive outcomes across our mental health system.



## Contract Scope of Work

- Development and implementation of a data collection system for adults receiving MHSA CSS services that allows for evaluation of those clients and services, applicable to both Full Service Partnerships and less intensive programs.
- Propose a system that could replace the current DCR and CSI data collection and eliminate redundancy, and could be integrated into any Electronic Health Record (Avatar, Anasazi, etc.).
- Creation of policy and practice recommendations for how to improve upon current CSS services evaluation and quality improvement systems.



## Developing the Proposed System

- Goal: Identify what data need to be collected (and used by providers, counties, and most importantly the State) to ensure the successful recovery of consumers (i.e., to ensure that access to and quality of our mental health services and systems can be continuously assessed and improved upon)
  - Opportunity for counties and providers and all other stakeholders to provide input regarding system requirements
    - ◆ Utility of current State/County/Provider requirements
    - ◆ Additional needs/desires/preferences
  - Stakeholder survey was disseminated statewide
  - Interviews and focus groups will continue to be conducted



## Contributing Stakeholders

- MHSOAC
- DHCS
- REMHDCO
- California Mental Health Planning Council
- County Administrators and Contract Supervisors
- Clinicians and Staff
- Subject Matter Experts
- Policy Makers (Bruce Bronzan, Rusty Selix, more)
- People with lived experience who use services
- Family members of people with lived experience
- Evaluation Advisory Group



## Data For All Program Assessments

- Personal Characteristics of Participants
- Service Utilization
- Access to Services
- Satisfaction
- Impact of Services
- Level of Care
- Cost Effectiveness
- Accomplishing MHSA Goals
- Recovery-Oriented Outcomes Measures



## Measuring Participant Characteristics

- Access issues: Who are we serving?
  - Demographics:
    - ◆ Improved Ethnicity categories
    - ◆ Improved Gender Identity
    - ◆ Sexual Orientation
    - ◆ Military Status
    - ◆ Languages
    - ◆ Education
    - ◆ Age, etc.
  - Diagnosis
  - Special Needs Served (languages, disabilities)
  - Penetration rates relative to local population



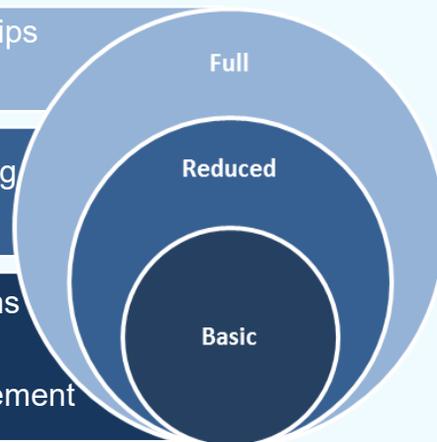
## Measuring Program Characteristics

- Access issues: What are we providing?
  - Access to 24/7 services (could be in partnership)
  - Access to translators
  - Geographically close access
  - Services available for specific needs
  - Services available for specific populations
  - Types of treatment provided to people:
    - ◆ Evidence-based
    - ◆ Recovery-oriented
    - ◆ Integrated care
    - ◆ Culturally appropriate
    - ◆ Complementary and alternative options

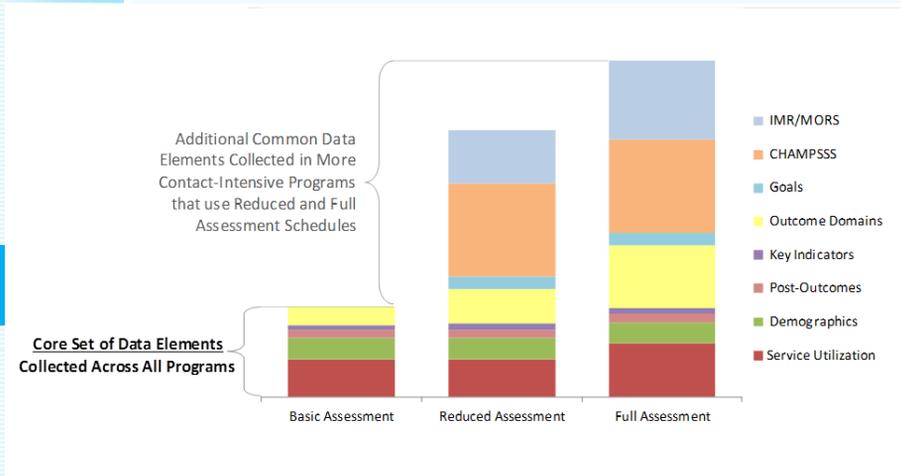


## Three Main Levels of Assessment Based on Program Intensity

- Full service partnerships
- Intensive programs
- Less intensive ongoing treatment programs
- Low intensity programs
- Support programs
- Outreach and Engagement



# Relative Number of Data Elements within Basic, Reduced, and Full Assessments



## Full Assessment Schedule

### Clinician Assessment

Completed by Clinician

Intake	Mini Follow-up (3, 9, 15... months)	Follow-up (6, 12, 18... months)	Discharge
IMR	IMR	IMR	IMR
MORS	MORS	MORS	MORS
Outcome Domains		Outcome Domains	Outcome Domains
Key Indicators			
		Goals	Goals

### Integrated Self-Assessment

Completed by Client

Intake	Mini Follow-up (3, 9, 15... months)	Follow-up (6, 12, 18... months)	Discharge
CHAMPSSS	No client assessments	CHAMPSSS	CHAMPSSS
		Post-Outcomes	Post-Outcomes

### Optional Family Member/Friend Assessment

Completed by Family Member/Friend

Intake	Mini Follow-up (3, 9, 15... months)	Follow-up (6, 12, 18... months)	Discharge
IMR	IMR	IMR	IMR



## Reduced Assessment Schedule

### Clinician Assessment

	Intake	Follow-up (6, 12, 18... months)	Discharge
Completed by Clinician	IMR	IMR	IMR
	MORS	MORS	MORS
	Outcome Domains	Outcome Domains	Outcome Domains
	Key Indicators		
		Goals	Goals

### Integrated Self-Assessment

	Intake	Follow-up (6, 12, 18... months)	Discharge
Completed by Client	CHAMPSSS	CHAMPSSS	CHAMPSSS
		Post-Outcomes	Post-Outcomes

### Optional Family Member / Friend Assessment

	Intake	Follow-up (6, 12, 18... months)	Discharge
Completed by Family Member/Friend	IMR	IMR	IMR



## Basic Assessment Schedule

### Clinician Assessment

	Intake	Follow-up (6, 12, 18... months)	Discharge
Completed by Clinician	MORS	MORS	MORS
	Outcome Domains	Outcome Domains	Outcome Domains

### Integrated Self-Assessment

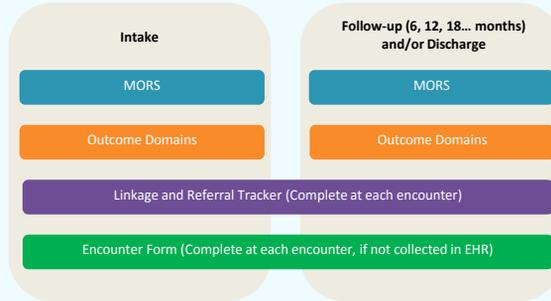
	Intake	Follow-up (6, 12, 18... months)	Discharge
Completed by Client	No client assessment	Post-Outcomes	Post-Outcomes



# Outreach and Engagement Assessment Schedule

## Staff Assessment

Completed by Staff



## Integrated Self-Assessment

Completed by Participant



# Clinician Measures

Instrument	# Items	Collection Frequency	Outcome(s) Addressed
IMR	16	Intake Follow-up Discharge	<ul style="list-style-type: none"> <li>Integration into the community</li> <li>Quality of care received by client</li> <li>Management of symptoms</li> <li>Functional impairment</li> <li>Engagement with therapeutic activities</li> <li>Social support and involvement</li> <li>Time in structured roles</li> <li>Substance and alcohol abuse</li> </ul>
MORS	1	Intake Follow-up Discharge	<ul style="list-style-type: none"> <li>Level of care required</li> <li>Improved mental health outcomes</li> <li>Increased involvement in care</li> </ul>
Outcome Domains	7-21	Intake Follow-up	<p>Possible domains:</p> <ul style="list-style-type: none"> <li>Housing</li> <li>Legal issues</li> <li>Employment</li> <li>Education</li> <li>Acute care setting involvement</li> </ul> <ul style="list-style-type: none"> <li>Substance use</li> <li>Physical health</li> <li>Mental health</li> <li>Social health/Quality of life</li> <li>Independence and benefits</li> </ul>
Key Indicators	0-4	Intake	<p>Possible domains:</p> <ul style="list-style-type: none"> <li>Education</li> <li>Diagnosis</li> </ul> <ul style="list-style-type: none"> <li>Physical health issues</li> <li>Trauma</li> </ul>
Goals	8	Follow-up	<ul style="list-style-type: none"> <li>Housing</li> <li>Education</li> <li>Mental health</li> <li>Substance use</li> </ul> <ul style="list-style-type: none"> <li>Physical health</li> <li>Social health</li> <li>Family unification</li> <li>Employment</li> </ul>



## Additional Clinician Measures

Instrument	# Items	Collection Frequency	Outcome(s) Addressed
Linkage & Referral Tracker	Varies	Each service encounter including Intake, and Follow-up / Discharge	Individual goals: <ul style="list-style-type: none"> <li>• Physical Health</li> <li>• Social Health</li> <li>• Mental Health</li> <li>• Substance Abuse</li> <li>• Housing</li> </ul> <ul style="list-style-type: none"> <li>• Occupation/Education</li> <li>• Financial Assistance/Benefits</li> <li>• Transportation</li> <li>• Identification</li> <li>• Basic Needs</li> </ul>
Encounter Form	13	Each service encounter including Intake, and Follow-up / Discharge	<ul style="list-style-type: none"> <li>• Access and utilization of services</li> <li>• Participant engagement with services</li> <li>• Key events in recovery</li> </ul>



## Integrated Self-Assessment

Instrument	# Items	Collection Frequency	Outcome(s) Addressed
CHAMPSSS	6-30	Intake Follow-up	<ul style="list-style-type: none"> <li>• Mental Health</li> <li>• Physical Health</li> <li>• Social Health and Relationships</li> <li>• Quality of Life</li> </ul> <ul style="list-style-type: none"> <li>• Strengths</li> <li>• Substance use</li> <li>• Anxiety</li> <li>• Depression</li> <li>• Suicidal Ideation</li> </ul>
Post-Outcomes Survey	5	Follow-up Discharge	<ul style="list-style-type: none"> <li>• Symptom reduction and/or Reduced Impact of Symptoms</li> <li>• Mental and Physical Health Improvement</li> <li>• Coping and Ability to Participate in Activities</li> <li>• Satisfaction with Program Services</li> </ul>



### **CHAMPSSS: Combined Health Assessment Mental, Physical, Social, Substance, Suicide**

- Only one page long with simple language.
- For very impaired clients, only 6 items completed.
- Starts with PROMIS Global Health items.
- Data is comparable to a wide variety of state and national data being collected using NIH PROMIS.
- Recovery-oriented and measures strengths.
- More culturally competent than other measures, and available in multiple languages.
- Screens and alerts for suicidality and relapse.
- Optional substance abuse questions.
- The client measure allows for cost effectiveness analysis using Quality Adjusted Life Years.



### **Family and Friend Version of the Illness (Wellness) Management and Recovery Scales**

- Only one page front and back with 16 items.
- Data is comparable to a variety of state and national data being collected using the IMR.
- Recovery-oriented and measures strengths.
- More culturally competent than other measures, and will be available in multiple languages.
- Substance abuse questions and relapse alert.
- Scales combine items to measure:
  - Symptom Management
  - Participation in Wellness Activities
  - Substance Abuse

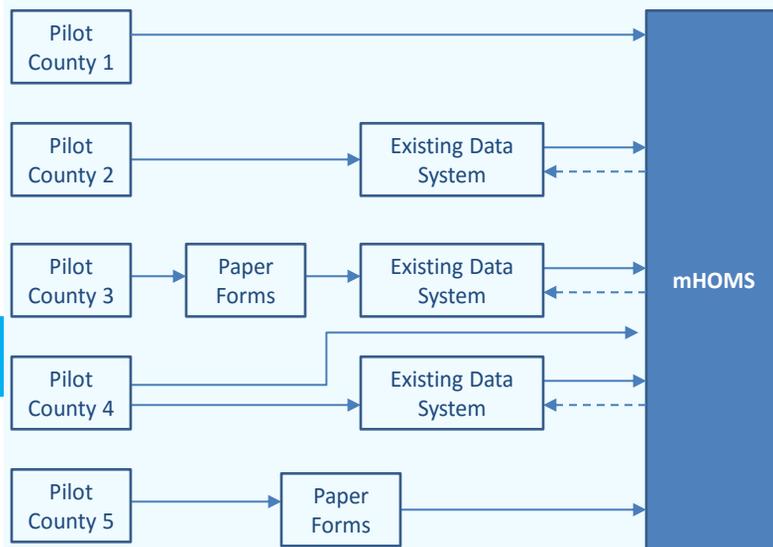


## Other Data Collection

- Biannual Consumer Surveys (MHSIP or RSA)
- Annual Staff Survey (Recovery Self-Assessment)
- Annual Program Survey (MHSA Annual Report)
- Utilization and Cost Data from Health Records
- Connections to Law Enforcement, Hospitals, ER
- Wait times tracking from first contact
  - First offered appointment
  - First taken appointment
  - First assessment
  - First treatment



## Data Flow Variations



## Counties Recruited for Pilot

### ■ Recruited

- Los Angeles
- Marin
- Nevada
- Riverside
- Santa Barbara
- San Bernardino
- San Diego
- Stanislaus

### ■ Likely

- San Francisco
- San Joaquin
- More small counties

### ■ Possibly

- Kern
- Mariposa
- Orange
- Other possibilities



## Thank you!

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**KEY OUTCOMES**

**HOUSING**

**1. Identify the client's current living situation.**

- A = House or apartment (includes trailers, hotels, dorms, barracks, etc.)
- B = House or apartment and requiring some support with daily living activities (applies to adults only)
- C = House or apartment and requiring daily support and supervision (applies to adults only)
- D = Supported housing (applies to adults only)
- E = Foster family home
- F = Group Home (includes Levels 1-12 for children)
- G = Residential Treatment Center (includes Levels 13-14 for children)
- H = Residential Treatment Facility (applies to adults only): Community Treatment Facility, Adult Residential Facility, Social Rehabilitation Facility, Crisis Residential, Transitional Residential, Drug Facility, Alcohol Facility
- I = Board and Care
- J = Mental Health Rehabilitation Center (24 hour)
- K = Skilled Nursing Facility/Intermediate Care Facility/Institute of Mental Disease (IMD)
- L = Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs (VA) Hospital
- M = State Hospital
- N = Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
- O = Homeless, Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings)
- P = Homeless, Sheltered (staying in emergency shelters or transitional housing)
- Q = Homeless, Double-Up (staying with friends or family temporarily)
- R = Other
- Unknown/Not Reported
- Item not assessed

**2. What date did the current living situation begin?**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(MM/DD/YYYY)

- Unknown/Not Reported
- Item not assessed

**3. COMPLETE IF ANSWER TO #2 ABOVE is less than 6 months OR if #1 = Homeless (Codes O, P, or Q). In the past 6 months, how many days (out of 180 possible days) did the client spend in each of the following homeless settings?**

Homeless Setting	# Days
Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings):	_____
Sheltered (staying in emergency shelters or transitional housing):	_____
Double-Up (staying with friends or family temporarily):	_____

Unknown/Not reported  
 Item not assessed

**EMPLOYMENT**

**1. Identify the client's current and past 6 months (26 weeks) of employment. Mark all that apply.**

- Item not assessed

	Past 6 months	Current employment situation	Average hours per week IF CURRENT
Competitive Employment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transitional Employment / Enclave	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paid In-House Work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-paid (volunteer) Work Experience	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Gainful / Employment Activity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Job Training / Employment Service Program	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unknown / Not Reported	<input type="checkbox"/>	<input type="checkbox"/>	_____
UNEMPLOYED - <u>Complete #2 below if current.</u>	<input type="checkbox"/>	<input type="checkbox"/>	

**Reduced Follow-up**

**2. COMPLETE IF ANSWER TO #1 ABOVE = "UNEMPLOYED" for current employment situation.**

**Select the response that best describes the client's current employment seeking activities:**

- Actively looking for employment, non-paid (volunteer) work experience, or other gainful / employment activity
- Not actively looking for employment, non-paid (volunteer) work experience, or other gainful / employment activity

**Please specify why:**

- Retired
- Homemaker
- Student
- Disabled
- Incarcerated or institutionalized
- Can't legally work in the U.S. or CA
- Other: \_\_\_\_\_
- Unknown / Not reported
- Item not assessed

**ACUTE SETTING INVOLVEMENT**

**1. Please indicate the number of emergency interventions (e.g., emergency room visits, crisis stabilization unit) the client had during the past 6 months that were:**

	# Emergency Interventions		
Physical Health Related	_____	<input type="radio"/> Unknown/Not reported	<input type="radio"/> Item not assessed
Mental Health/Substance Abuse Related	_____	<input type="radio"/> Unknown/Not reported	<input type="radio"/> Item not assessed
Physical AND Mental Health/Substance Abuse Related	_____	<input type="radio"/> Unknown/Not reported	<input type="radio"/> Item not assessed

**2. In the past 6 months, how many times AND how many days was the client in...**

	# Times in Past 6 Months	# Days in Past 6 Months (out of 182 days)		
Psychiatric Hospitalization	_____	_____	<input type="radio"/> Unknown/Not reported	<input type="radio"/> Item not assessed
Crisis Residential	_____	_____	<input type="radio"/> Unknown/Not reported	<input type="radio"/> Item not assessed
Non-Psychiatric Hospitalization	_____	_____	<input type="radio"/> Unknown/Not reported	<input type="radio"/> Item not assessed

Reduced Follow-up

**ILLNESS MANAGEMENT AND RECOVERY SCALE**

<b>1. Progress towards personal goals: In the past 3 months, s/he has come up with...</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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
<b>2. Knowledge: How much do you feel s/he knows about symptoms, treatment, coping strategies (coping methods), and medication?</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not very much	A little	Some	Quite a bit	A great deal
<b>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?</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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
<b>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.)?</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0 times/week	1-2 times/week	3-4 times/week	5-7 times/week	8 or more times/week
<b>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.)</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/wk
<b>6. Symptom distress: How much do symptoms bother him/her?</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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
<b>7. 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?</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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
<b>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?</b>				
<input type="radio"/> Item not assessed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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

**Reduced Follow-up**

**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)?

Item not assessed

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?

Item not assessed

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?

Item not assessed

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?

Item not assessed

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?

Item not assessed

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

\_\_\_\_\_ Check here if the client is not prescribed psychiatric medications.

**14. Medication Working Effectively:** (Don't answer this question if his/her doctor has not prescribed medication). How often does the medication s/he takes work effectively?

Item not assessed

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

\_\_\_\_\_ Check here if the client is not prescribed psychiatric medications.

**15. 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?

Item not assessed

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

**16. 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?

Item not assessed

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)**

Milestones of Recovery Scale (MORS) Score: \_\_\_\_\_

**Reduced Follow-up**

**GOALS**

<i>Since the last formal treatment plan update six months ago...</i>		<b>Yes</b>	<b>No</b>	<b>No goal on client's plan</b>
1.	Has the client demonstrated progress towards achieving his/her <b>employment goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	Has the client demonstrated progress towards achieving his/her <b>housing goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	Has the client demonstrated progress towards achieving his/her <b>education goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	Has the client demonstrated progress towards achieving his/her <b>mental health goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	Has the client demonstrated progress towards achieving his/her <b>substance use goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	Has the client demonstrated progress towards achieving his/her <b>family reunification goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	Has the client demonstrated progress towards achieving his/her <b>social health goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	Has the client demonstrated progress towards achieving his/her <b>physical health goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Client Follow-up – Reduced and Full**

**COMBINED HEALTH ASSESSEMENT: MENTAL, PHYSICAL, SOCIAL, SUBSTANCE, STRENGTHS**

**Only the first 6 items required if client cannot complete form.**

Please complete the following questions about your health and activities.

	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is	<input type="radio"/>				
2. In general, how would you rate your quality of life?	<input type="radio"/>				
3. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="radio"/>				
4. In general, how would you rate your physical health?	<input type="radio"/>				
5. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="radio"/>				
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, responsibilities as a parent, child, spouse, employee, friend, etc.)	<input type="radio"/>				

In the past 7 days...	Never	Rarely	Sometimes	Often	Always
7. How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	<input type="radio"/>				
8. I had goals and worked towards achieving them.	<input type="radio"/>				
9. I felt hopeful about the future.	<input type="radio"/>				
10. I had contact with people that care about me.	<input type="radio"/>				
11. I lived in a home that was safe and comfortable.	<input type="radio"/>				
12. I felt spiritually connected.	<input type="radio"/>				
13. I felt depressed.	<input type="radio"/>				
14. I felt hopeless.	<input type="radio"/>				
15. I felt little interest or pleasure in things I used to enjoy.	<input type="radio"/>				
16. I felt angry.	<input type="radio"/>				
17. I felt fearful.	<input type="radio"/>				
18. My worries overwhelmed me.	<input type="radio"/>				
19. I had disturbing memories or images of a stressful experience.	<input type="radio"/>				
20. I used substances (alcohol, illegal drugs, etc.) too much.	<input type="radio"/>				
21. I felt that I should cut down on my alcohol or substance use.	<input type="radio"/>				
22. I had memory problems, such as forgetting names or appointments.	<input type="radio"/>				
23. I had difficulty thinking clearly while doing familiar tasks.	<input type="radio"/>				
24. I had thoughts of ending my life or harming myself.	<input type="radio"/>				

**Client Follow-up – Reduced and Full**

In the past 7 days...	Completely	Mostly	Moderately	A little	Not at all
25. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	<input type="radio"/>				

In the past 7 days...	Not difficult at all	Somewhat Difficult	Very difficult	Extremely difficult
26. How difficult have any problems reported here made it for you to do your daily activities, work (including school, take care of things at home, or get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

During the last 7 days...	Never	Less than once a week	1-3 times per week	4 or more times per week	Every day
27. How often did you have any kind of drink containing alcohol, such as beer, wine, or liquor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. How often did you use an illegal drug or use a prescription medication for nonmedical reasons?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the past 7 days...	None	Mild	Moderate	Severe	Very severe
29. How would you rate your fatigue on average?	<input type="radio"/>				

In the past 7 days...	No Pain					Worst Imaginable Pain					
30. How would you rate your pain on average? (Circle one.)	0	1	2	3	4	5	6	7	8	9	10

**Client Follow-up – Reduced and Full**

**PROMIS SUBSTANCE USE (OPTIONAL)**

**If you have not used any alcohol or illegal drugs in the past six months, please skip these questions.**

In the past 7 days...	Never	Rarely	Sometimes	Often	Almost Always
1. I used alcohol or substances throughout the day.	<input type="radio"/>				
2. I had an urge to continue drinking or using substances once I started.	<input type="radio"/>				
3. I felt I needed help for my alcohol or substance use.	<input type="radio"/>				
4. I took risks when I used alcohol or substances.	<input type="radio"/>				
5. I felt guilty when I used alcohol or substances.	<input type="radio"/>				
6. Others complained about my alcohol or substance use.	<input type="radio"/>				
7. Alcohol or substance use created problems between me and others.	<input type="radio"/>				
8. Others had trouble counting on me when I used alcohol or substances.	<input type="radio"/>				
9. I felt dizzy after I used alcohol or substances.	<input type="radio"/>				
10. Alcohol or substance use made my physical or mental health symptoms worse.	<input type="radio"/>				

**POST-OUTCOMES (FOR FOLLOW-UP ONLY)**

**If you have not yet gotten services from this program, please skip these 6 questions.**

As a direct result of the services I received...	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. My symptoms are not bothering me as much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. My physical health symptoms are not bothering me as much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I deal more effectively with daily problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I am better able to take care of my needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I am better able to do things that I want to do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Overall, I am satisfied with the services I received.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>