Supported Employment

Implementation Resource Kit

DRAFT VERSION
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Monitoring Client Outcomes

What are client outcomes?

Client outcomes are those aspects of clients' lives that we seek to improve or to manage successfully through the delivery of mental health services. Medications help clients manage their symptoms. Supported employment programs help clients find work in the community. Dual disorders groups help clients reduce their dependence on alcohol and illicit drugs. Relapse prevention programs help clients stay out of the hospital. Some outcomes are the direct result of an intervention, such as getting a job through participation in a vocational program, whereas others are indirect, such as improvements in quality of life due to having a job. Some outcomes are concrete and observable, such as the number of days worked in a month, whereas others are subjective and private, such as satisfaction with vocational services. Every mental health service intervention, whether considered treatment or rehabilitation, has both immediate and long-term client goals. In addition, clients have goals for themselves, which they hope to attain through the receipt of mental health services. These goals translate into outcomes, and the outcomes translate into specific measures. For example, the goal of a supported employment program is community integration through employment. The outcome for clients is obtaining and holding regular jobs in the community. The outcome measure for a supported employment program may be the number of weeks that a client has worked at competitive jobs during the past quarter.

Why monitor client outcomes?

Client outcomes are the bottom-line for mental health services, like profit is in business. No successful businessperson would assume that the business was profitable just because the enterprise was producing a lot of widgets (e.g. cars, clothes) or employees were working hard. This does not mean that the owner does not need to pay attention to productivity, but rather one would not make the assumption that productivity necessarily leads to profit. In mental health, productivity measures, such as the number of counseling sessions or the number of clients served, tell us very little, if anything, about the effects of services on clients and their welfare.

This fact has led to a broad-based call for outcome monitoring. At the policy and systems level, the Government Performance and Results Act of 1993 requires that all federal agencies measure the results of their programs and restructure their management practice to improve these results. In a parallel fashion, there is a significant movement in human service management toward client outcome-based methods (Rapp & Poertner, 1992). Studies have shown that an outcome orientation of managers leads to increased service effectiveness in mental health (Gowdy & Rapp, 1989). This has led Patti (1985) to argue that effectiveness, meaning client outcomes, should be the "philosophical linchpin" of human services organizations.

Recovery and client outcomes

Recovery means more than controlling symptoms. It's about getting on with life beyond the mental health system. As Pat Deegan (1988) wrote:

> The need is to meet the challenge of the disability and to reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (p.15).

While the goals of each individual are unique in detail, people with severe mental illness generally desire the same core outcomes that we all want:

1. To live independently in a place called home
2. To gain an education, whether for career enhancement or personal growth
3. To have a job that enhances our income, provides a means to make a contribution, and en ables us to receive recognition
4. To have meaningful relationships
5. To avoid the spirit-breaking experiences of hospitalization, incarceration, or substance abuse

If this is true, then mental health services should be focused on the most powerful methods available to help consumers achieve these outcomes. The evidence-based practice that is described in this resource kit was chosen for its ability to achieve one or more of these outcomes.

A powerful resource for program leaders

If funds are the lifeblood of an organization, then information is its intelligence. Collecting and using client outcome data can improve organizational performance. Consider the following vignette.

> Participants in a partial hospitalization program sponsored by a community mental health center were consistently showing very little vocational interest or activity. Program staff began gathering data monthly on clients' vocational status and reporting this to their program consultant. He returned these data to program staff using a simple bar graph every three months. The result of gathering and using information on clients' vocational activity was evident almost immediately. Three months after instituting this monitoring system, the percentage of the program's clients showing no interest or activity in vocational areas declined from an original 64 percent to 34 percent. Three months later this percentage decreased an additional 6 percent, so that 72 percent of program participants were now involved in some form of vocational activity.

This example shows that when information is made available, people respond to it. Peters and Waterman (1982) in their study of successful companies observed:

> We are struck by the importance of available information as the basis for peer comparison. Surprisingly, this is the basic control mechanism in the excellent companies. It is not the military model at all. It is not a chain of command wherein nothing happens until the boss tells somebody to do something. General objectives and values are set forward and information is shared so widely that people know quickly whether or not the job is getting done-and who's doing it well or poorly (p. 266).

They observed that the data were never used to "browbeat people with numbers" (p.267). The information alone seemed to motivate people.

What is clear from these examples is this: *The collection and feedback of information influences behavior*. Current research suggests several principles to improve organizational effectiveness:

- The role of information in an organization is to initiate action and influence organizational behavior.
- The act of collecting information (measurement) generates human energy around the activity being measured.
- To ensure that information directs human energy toward enhanced performance, data collection and feedback must be used:
  - to foster and reinforce desired behaviors;
  - to identify barriers to performance and ways to overcome them; and
  - to set goals for future performance.

- Feedback directs behavior toward performance when it provides "cues" to workers to identify clear methods for correction and when it helps workers learn from their performance.
- Feedback motivates behavior toward performance when it is used to create expectations for external and internal rewards, is linked to realistic standards for performance, and is directed toward the future versus used punitively to evaluate past performance.

Managers who are committed to enhancing client outcomes have a powerful tool. By proactively and systematically collecting and using client outcome information, managers can enhance the goal-directed performance of program staff, as well as increase their motivation, professional learning, and sense of reward. Minimally, supervisors and managers should distribute (or post) the outcome data reports and discuss them with staff. Team meetings are usually the best time. Numbers reflective of above average or exceptional performance should trigger recognition, compliments, or other rewards. Data reflecting below average performance should provoke a search for underlying reasons and the generation of strategies that offer the promise of improving the outcome. By doing this on a regular basis the manager has begun to create a "learning organization" characterized by consistently improving client outcomes.

Outcomes and evidence-based practices

The foundation of evidence-based practices is client outcomes. The decision to implement an evidence-based practice is based on its ability to help clients achieve the highest rates of positive outcomes. Therefore, one key component of the implementation of an evidence-based practice is the careful monitoring and use of client outcome data. The problem for many mental health providers is that current data systems do not capture relevant client outcomes or are unable to produce meaningful and timely reports. Providers must find ways to develop evidence-based practices information systems that are easy to implement and to maintain.

The following material is designed to guide programs that are implementing an evidence-based practice in developing a practical and useful information system. Some programs may go their own way and develop a system anew. Other programs may adapt existing information systems to suit their needs for monitoring client outcomes. These guidelines will help programs to make such beginnings and adaptations. In addition, programs may wish to expand the evidence-based practices information systems that we describe, to build on the success they have had using a basic system or to customize a system to their needs and context. We encourage such expansion once a basic system has been implemented successfully, and we make recommendations for such enhancements at the end of this section.

We begin with advice on getting started, and then we describe a simple, yet comprehensive, system for monitoring evidence-based practice outcomes. We follow this with ideas on using tables and graphs of outcome data to improve practice and on expanding basic systems.

Guidelines for an evidence-based practices information system

Many practitioners feel overwhelmed by the demands of their jobs and cannot imagine adding the burden of collecting client outcomes. Reporting systems already exist in many mental health settings, but they are time-consuming, and they do not provide useful feedback to improve practice. Thus, resistance is likely when implementing a new system to monitor client outcomes. To overcome this resistance we recommend starting with a very simple system and making the system practical and immediately useful.

Start simply

At the outset, the system must be simple to implement, use, and maintain. Complexity has doomed numerous well-intended attempts to collect and use client outcome data. One way to keep it simple is to limit the amount and sources of information that it contains. Begin with a few key client outcomes and build the system around them. Collect data from practitioners, without the initial need for data collection from clients and families. Start with simple reports that tabulate results for the past quarter and show time trends, and then let experience with the system determine what additional reports are needed.

Fit the needs of practitioners

The system must not create undue burden for practitioners, and it must provide information to them that is useful in their jobs. If possible, the system should collect already known information about clients, and it should require little time to record the data. The system should fit into the workflow of the organization, whether that means, for example, making ratings on paper or directly into a computer. It should collect information on participation in evidence-based services and on client outcomes. Program leaders and practitioners can then keep track of what services clients are using and how they are doing on key outcomes. It should produce easy-to-read and timely reports that contribute to planning and lead to action, for individual clients, for treatment teams, and for the program as a whole.

These two guidelines may lead to a system that consists of a single outcome measure that is collected regularly and used by the program leader and practitioners to monitor their progress toward stated goals for an evidence-based practice. For example, a supported employment program may decide to monitor the rate of competitive employment among those clients who have indicated a

desire to work. Practitioners may be asked to indicate whether each client has worked in a competitive job during the past quarter. These data can then be tallied for the entire program to indicate the employment rate during the past quarter, which can be compared to prior quarters and can be used to develop performance goals based on client choices for the upcoming quarter.

The system suggested by these two guidelines can be implemented in a variety of ways, from paper and pencil to multi-user computer systems. Begin with whatever means you have available and expand the system from there. In the beginning, data may be collected with a simple report form, and hand-tallied summaries can be reported to practitioners. A computer with a spreadsheet program (e.g., EXCEL) makes data tabulation and graphing easier than if it is done by hand. A computerized system for data entry and report generation presents a clear advantage, and it may be the goal, but do not wait for it. Feedback does not have to come from a sophisticated computer system to be useful. It is more important that it is meaningful and frequent.

As a client outcome monitoring system develops, program leaders and practitioners will weave it into the fabric of their day-to-day routines. Its reports provide tangible evidence of the use and value of services, and they will become a basis for decision-making and supervision. At some point, the practitioners may wonder how they did their job without an information system, as they come to view it as an essential ingredient of well-implemented evidence-based practices.

Once a basic system has been implemented for a single evidence-based practice, we encourage programs to consider expanding to a comprehensive system for monitoring multiple evidence-based practices. We provide two additional guidelines for developing such a system.

Include all evidence-based practices in one system

The system should monitor the participation of clients in all evidence-based practices. This can be as simple as recording whether clients are eligible for each practice, and in which practices they have participated during the past quarter. For those practices that are implemented, participation rates can be monitored over time, as a means of monitoring the penetration of the practices in the population of eligible clients. For those practices that are not yet implemented, the system will create incentive to do so.

Likewise, the system should monitor a core set of outcomes that apply across evidence-based practices and that are valued by clients and families, as well as by providers and policymakers. For example, keeping people with mental illness in stable community housing, rather than in institutions or homeless settings, is an agreed-upon outcome for several evidence-based practices. Consequently, keeping track of quarterly rates of hospitalization, incarceration, and homelessness will enable evaluation of the effectiveness of a range of services.

Make the data reliable and valid

For an information system to be useful, the data must reliable and valid. That is, the data must be collected in a standardized way (reliability), and the data must measure what it is supposed to measure (validity). Thus, the outcomes must be few in number and concrete, in order for practitioners to stay focused on key outcomes, to understand them in a similar way, and to make their ratings in a consistent and error-free fashion. To enhance reliability and validity, we recommend simple ratings (e.g., Did the client hold a competitive job in this quarter?), rather than more detailed ones (e.g., How many hours during this quarter did the client work competitively?). In addition, reliability will be enhanced if the events to be reported are easy to remember, and thus we recommend collecting data at regular and short intervals, such as quarterly at the outset, and we recommend collecting data for salient events. We recommend the following outcomes:

- psychiatric or substance abuse hospitalization
- incarceration
- homelessness
- independent living
- competitive employment
- educational involvement
- stage of substance abuse treatment

These few outcomes reflect the primary goals of the evidence-based practices. Assertive community treatment, family psychoeducation, and illness management and recovery share the goal of helping clients to live independently in the community. Thus, their goal is to reduce hospitalization, incarceration, and homelessness, and to increase independent living. Supported employment and integrated dual disorders treatment have more direct outcomes, and thus it is important to assess work/school involvement and progress toward substance abuse recovery, respectively. A Quarterly Report Form is presented at the end of this section as an example of a simple, paper-based way to collect participation and outcome data on a regular basis.

A stand-alone computerized client outcome monitoring system has been developed for the Evidence-Based Practices Project. It follows the above guidelines closely and is available to those programs who wish to start with such a system.

Using tables and graphs in reports

The single factor that will most likely determine the success of an information system is its ability to provide useful and timely feedback to practitioners. It is all well and good to worry about what to enter into a system, but ultimately its worth is in converting data into information. For example, the data may show that twenty consumers worked in a competitive job during the past quarter, but it is more informative to know that this represents only 10 percent of the consumers in the supported employment program and only three of these were new jobs. For information to influence practice, it must be understandable and meaningful, and it must be delivered in a timely way. In addition, the monitoring system must tailor the information to suit the needs of various users and to answer the queries of each of them.

The outcome monitoring system should format data for a single client into a summary report that tracks participation in practices and outcomes over time. This report could be entered in the client's chart, and it could be the basis for a discussion with the client of treatment and rehabilitation progress and options. Further value of a monitoring system comes in producing tables and graphs that summarize the participation and outcomes of groups of clients. Below are some examples of tables and graphs that are useful when implementing and sustaining an evidence-based practice.

Quarterly summary tables

Whether for an entire program, for a specific team, or for a single practitioner's caseload, rates of participation in practices and client outcomes should be displayed for the past quarter. Such a table can address the following kinds of questions.

- How many of my clients participated in our supported employment program last quarter?
- How many of my clients worked competitively during the last quarter?
- What proportion of clients in our program for persons with severe mental illness were hospitalized last quarter?
- How did the hospitalization rate for those on assertive community treatment teams compare to the rate for clients in standard case management?
- How many clients with a substance use disorder have yet to participate in our integrated dual diagnosis treatment program?

Simple percentages or proportions, based on quarterly tallies, provide important feedback for both program management and clinical service provision.

Movement tables

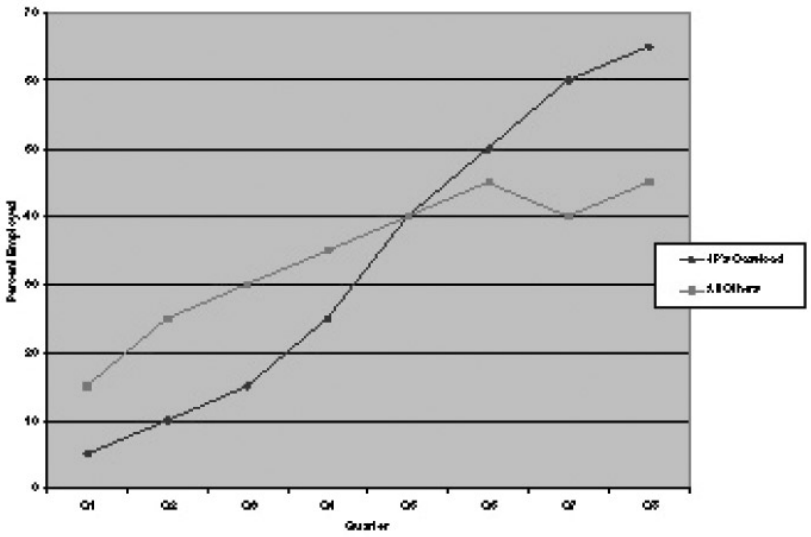
Movement tables summarize changes from the previous quarter. They are created by cross-tabulating the same variable from two successive quarters. For example, participation in the family psychoeducation program can be cross-tabulated as shown below.

		Participation during Q2	
		no	yes
Participation during Q1	no	50	20
	yes	10	40

This table indicates that, out of 120 clients overall, 50 clients did not participate in the program during either quarter (no/no), 40 participated during both quarters (yes/yes), 20 began participation during Quarter 2 (no/yes), and 10 stopped participation after Quarter 1 (yes/no). Thus, there was a net gain of 10 clients in the family psychoeducation program from Quarter 1 to Quarter 2. The same kind of table can show changes in outcomes between quarters as well. This would answer a question such as, "Were more clients working in competitive jobs during the most recent quarter, as compared to the previous quarter?" Movement tables can be prepared for various groupings of clients. For example, the net gain in competitive employment could be compared across caseloads from multiple case managers or across multiple vocational specialists.

Longitudinal plots

A longitudinal plot is an efficient and informative way to display participation or outcome data for more than two successive periods. The idea is to plot a participation or outcome variable over time, to view performance in the long term. A longitudinal plot can be for an individual, a caseload, a specific evidence-based practice, or an entire program. A single plot can also contain longitudinal data for multiple clients, caseloads, or programs, for comparison. Below is an example comparing one case manager's caseload to all other clients in a supported employment program over a two-year period.



This plot reveals that JP's clients were slower to find employment in the first year (Quarters 1-4), when compared to other clients in the program, but they made continued progress throughout year two (Quarters 5-8), whereas the rate of employment for the other clients has leveled off. Longitudinal plots are powerful feedback tools, as they permit a longer-range perspective on participation and outcome, whether for a single client or a group of clients. They enable a meaningful evaluation of the success of a program, and they provide a basis for setting goals for future performance.

Recommendations for additions to the basic evidence-based practices information system

Mental health service programs that are sophisticated in using information systems or that have been successful in implementing a start-up system may want to collect and use more information than we recommend for a basic system. For example, programs may want more detailed participation data, such as the number of group sessions attended or the number of contacts with a case manager. They may want to include additional client outcomes or to collect them in a more detailed way.

Programs may also want to collect feedback directly from consumers and family members. Recipients of services are important informants for programs seeking to improve outcomes. Programs may want to know if clients are satisfied with their services and the outcomes they have achieved. They may seek input from consumers about how to improve the services, practically and clinically. Programs may want to know if the services are helping consumers and families to achieve their goals. These are worthy ambitions, and such data have become part of many monitoring and quality improvement systems.

We did not recommend collecting data from consumers and family members as part of a basic system for monitoring client outcomes for a number of reasons. First, we recommend starting with a set of outcomes that practitioners can reported quickly and accurately. The task of collecting data from clients and families could impede progress and distract focus. Second, there are no well-validated questionnaires to assess many of the constructs that are frequently included in consumer and family surveys. Outcomes such as satisfaction, quality of life, and recovery are multifaceted and difficult to measure objectively. Third, it is hard to obtain a representative sample of respondents. Mailed surveys are often not returned. Interviews may be done with those individuals who are easy to reach and cooperative. Questions may be asked only of those who show up for routine appointments. Unless the data are collected from a representative sample, it is difficult to interpret the findings, because it is not clear to whom they generalize. Fourth, there may be better ways to get feedback from consumers than by trying to collect quantitative data from them. A program may be better off holding focus groups for consumers or families to discuss a specific evidence-based practice with the practitioners or with quality improvement personnel. Likewise, a program may learn more about consumer perceptions of services and their feelings about recovery from qualitative interviews with a small group of consumers. Fifth, quality improvement personnel may be better able and qualified to collect, analyze, and interpret data from consumers and families. A treatment team may collect informal feedback from consumers through their day-to-day contacts, but it may be better left to others to collect systematic data. In many agencies, formal reporting systems already include client-based assessments, and it may be possible to build on these efforts rather than to duplicate them.

Yet, programs may want to collect data from the recipients of their services. If a basic outcome monitoring system has been implemented, then expanding data collection to include consumers and family members may be appropriate and feasible. Programs are encouraged to explore their options, although it is important to remain mindful of the issues discussed above. We include the *Kansas Consumer Satisfaction Survey*, and a *Quality of Life Self-Assessment* developed in New York, as examples for programs to consider.

When thinking about expanding data collection beyond the basic set of outcomes, it is important to realize that more is not necessarily better. Unless the data can be reported reliably and validly, the value of adding more data to the monitoring system is illusory. The old adage, "garbage in, garbage out," must be kept in mind when the temptation is present to expand a working system. Feedback that is based on unreliable, invalid, or unrepresentative data may be no better for a system than no feedback at all. Nevertheless, the thoughtful and gradual expansion of a working system for collecting and using client outcome can increase the value of the feedback. The litmus test is not what and how much data a program collects, but rather whether the program uses the data to inform and improve the practice.

References

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Client Outcomes—Quarterly Report Form

Client ID: _____ Reported by: _____

Date: _____ Quarter: _____

Indicate the client's status during the *past 3 months*. Check all that apply:

Evidence-Based Practice	**Eligible**	**Enrolled**
Integrated Dual Disorders Treatment	▼	▼
Supported Employment	▼	▼
Assertive Community Treatment	▼	▼
Illness Management & Recovery	▼	▼
Family Psychoeducation	▼	▼

In the *past 3 months*, how many *weeks* has the client:

Held a competitive job?

Been homeless?

Been incarcerated?

Been hospitalized for psychiatric reasons?

Been hospitalized for substance use reasons?

What has been the client's stage of substance abuse treatment during the *past 3 months*? Circle one.

N/A Engagement Persuasion Active treatment Relapse prevention

What is the client's current living arrangement? Circle one.

1. Psychiatric hospital
2. Substance use hospitalization
3. General hospital psychiatric ward
4. Nursing home or IC-MH
5.Family care home
6. Lives with relatives (heavily dependent for personal care)
7.Group home
8. Boarding house
9. Lives with relatives (but is largely independent)
10. Supervised apartment program
11. Independent living
12. Other (specify)
13. Emergency shelter
14. Homeless

What is the client's current educational status? Circle one.

1. No educational participation
2. Avocational/educational involvement
3. Pre-educational explorations
4. Working on GED
5. Working on English as second language
6. Basic educational skills
7. Attending vocational school or apprenticeship, vocational program (CNA training) or attending high school
8. Attending college—1-6 hours
9. Attending college —7 or more hours
10. Other (specify)

Definitions for Quarterly Report Form

Each person completing the form should become familiar with the definitions of the data elements in order to provide consistency among reporters.

Heading information

Client ID

The client ID that is used at your agency. This is usually a name or an identifying number. This information will only be accessible to the agency providing the service.

Reported by

The name of the person who completed the form—the case manager or other staff member from the mental health agency who have access to the desired information.

Date

The date the report was completed.

Quarter

The time frame for the reporting period. For example, January–March, April–June, July–September, October–December.

Evidence-based practice

Eligible

Does the client meet the participation criteria for a specific EBP?

For example, all persons who have a severe mental illness and a drug/alcohol diagnosis are eligible for participation in integrated dual disorders treatment. Each EBP has criteria for program participation that should be used to determine eligibility.

Enrolled

Is the client participating in a particular EBP service? Note: aggregate data about eligibility and enrollment can be used to determine the penetration of services to eligible persons served by a mental health agency.

For the following incidents, the quarterly report should record the number of weeks the client spent in the specific incident category during the 3 months of the reporting period.

Employment

In the past 3 months, how many weeks has the client held a competitive job?

Competitive employment is viewed as working in a paid position (almost always outside the mental health center) that would be open to *all* community members to apply. This would exclude persons working in sheltered workshops, transitional employment positions, or volunteering. It may include persons who are self-employed but the person must work regularly and be paid for the work.

Incidents reporting

Been homeless?

Record the number of weeks the client spent homeless during the reporting period. This refers to individuals who lack a fixed, regular, and adequate nighttime residence.

Been incarcerated?

Record the number of weeks the client spent incarcerated in jails or other criminal justice lock-ups during the reporting period.

Been hospitalized for psychiatric reasons?

Record the number of weeks the client spent hospitalized primarily for treatment of psychiatric disorder(s) during the reporting period. This includes both public and private hospitals whose primary function is the treatment of mental disorders.

Been hospitalized for substance use reasons?

Record the number of weeks the client spent hospitalized primarily for treatment of substance use disorder(s) during the reporting period. This includes those both public and private hospitals whose primary function is the treatment of substance use disorders.

Stage of substance abuse treatment

What has been the client's stage of substance abuse treatment during the past 3 months?

For those persons participating in integrated dual disorders treatment, please indicate the appropriate stage of substance abuse treatment. N/A is used for persons who do not have a substance use problem or diagnosis.

Engagement. This category includes Pre-engagement and Engagement.

- The person does not have any regular contacts with an assigned case manager, mental health counselor, or substance abuse counselor. The lack of regular contact implies lack of a working alliance.

Persuasion. This category includes Early Persuasion and Late Persuasion.

- The client has regular contacts with a counselor but has not yet reduced substance use for more than a month (early persuasion), or has reduced substance use for at least one month while discussing substance use issues or attending groups (late persuasion). Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

Active Treatment. This category includes Early Active Treatment and Late Active Treatment.

- The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month and is working toward abstinence as a goal, even though he or she may still be abusing (early active treatment). This category also includes persons engaged in treatment, who have acknowledged that substance abuse is a problem, and have achieved abstinence but for less than 6 months (late active treatment)

Relapse Prevention. This category includes Relapse Prevention, and In Remission or Recovery.

- The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence for at least 6 months. Occasional lapses, not days of problematic use, are allowed (relapse prevention). This category also includes clients who have had no problems related to substance use for over one year and are no longer in any type of substance abuse treatment (in remission or recovery).

Residential and educational status

These data provide your agency with an ongoing record of the client's residential and educational status. Record the status that applies to the client on the last day of the reporting period.

What is the client's current living arrangement?

1. Psychiatric hospital. This includes those hospitals, both public and private, whose primary function is the treatment of mental disorders. This includes state hospitals and other freestanding psychiatric hospitals.

2. Substance use hospitalization. This includes those hospitals, both public and private, whose primary function is the treatment of substance use disorders.

3. General hospital psychiatric ward. This category includes psychiatric wards located in general medical centers that provide short-term, acute crisis care.

4. Nursing home or IC-MH. This category includes facilities that are responsible for the medical and physical care of a client and have been licensed as such by the state.

5. Family care home. This category is for situations in which a client is living in a single family dwelling with a non-relative who provides substantial care. Here (as with #8), substantial care is determined by the degree that the nonrelative(s) is responsible for the daily care of the individual. Such things as medication management, transportation, cooking, cleaning, restrictions on leaving the home, and money management are considered. The non-relative may have guardianship responsibilities. If the client is not able to do a *majority* of the daily living tasks without the aid of the caretaker, the caretaker(s) is providing substantial care.

6. Lives with relatives (heavily dependent for personal care). Here the individual client and relatives should be consulted to the degree that family members are responsible for the daily care of the individual client. An important distinction between this status and #9 is to ask, "If the family was not involved, would the person be living in a more restrictive setting?" In assessing the extent to which the members provide substantial care, such things as taking medication, transportation, cooking, cleaning, control of leaving the home, and money management can be considered. If the client is unable to independently perform a *majority* of the daily living functions, the family member(s) is providing substantial care.

7. Group home. A group home is defined here as a residence that is run by staff who provide many functions (shopping, meal preparation, laundry, etc.) that are essential to independent living.

8. Boarding house. A boarding home is a facility that provides for a place to sleep and meals, but it is not seen as an extension of a mental health agency, nor is it staffed with mental health personnel. These facilities are largely privately run, and clients have a high degree of autonomy.

9. Lives with relatives (but is largely independent). As with status #8, an assignment to this category requires information provided by the client and family. The key consideration relates to the degree that the individual is able to perform the *majority* of tasks essential to daily living without the supervision of a family member.

10. Supervised apartment program. Here, the client is living (fairly independently) in an apartment sponsored by a mental health agency. In determining whether someone fits in this category, look at the extent to which mental health staff have control over key aspects of the living arrangements. Example characteristics of control include:

- the mental health agency signs the lease,
- the mental health agency has keys to the house or apartment,
- . the mental health agency provides onsite day or evening staff coverage, or
- the mental health agency mandates client participation in certain mental health services—medication clinic, day program, etc.—in order to reside in the house or apartment. Clients only receiving case management support or financial aid are NOT included in this category; they are considered to be living independently (#11).

11. Independent living. This category describes clients who are living independently and are capable of self-care. It includes clients who live independently with case management support. This category also includes clients who are largely independent and choose to live with others for reasons not related to mental illness. They may live with friends, a spouse, or other family members.

The reasons for shared housing could include personal choice related to culture and/or financial considerations.

12. Other. This status should be clearly defined in the space provided by those completing the form.

13. Emergency shelter. This category includes temporary arrangements due to a crisis or misfortune that are not specifically related to a recurrence of the client's illness. While many emergency shelters provide emotional support, the need for emergency shelter is due to an immediate crisis not related to the client's mental illness.

14. Homeless. This category includes individuals who lack a fixed, regular, and adequate nighttime residence.

What is the client's current educational status?

1. No educational participation.

2. Avocational/educational involvement. These are organized classes in which the client enrolls consistently and expects to take part for the purpose of life enrichment, hobbies, recreation, etc. These classes must be community based, not run by the mental health center. Classes are those that any citizen could participate in, not just persons with severe mental illness. If any of these activities involve college enrollment, use status #8 or #9.

3. Pre-educational explorations. Individuals in this status are engaged in educational activities with the specific purpose of working towards an educational goal. This includes individuals who attend a college orientation class with the goal of enrollment, meet with the financial aid office to apply for scholarships, or apply for admission for enrollment. This status also includes those persons who attend a mental health center sponsored activity focusing upon an educational goal, e.g., campus visits with a case manager to survey the location of classrooms; meetings with the case manager and college staff to secure entitlements.

4. Working on GED. This status includes people who are taking classes to obtain their GED.

5. Working on English as second language. This includes those who are taking classes in English as a second language in a community setting.

6. Basic educational skills. This includes those who are taking adult educational classes focused on basic skills such as math and reading.

7. Attending vocational school or apprenticeship, vocational program (CAN training), or attending high school. This status includes those participating in community based vocational schools; learning skills through an apprenticeship, internship, or in a practicum setting; involved in on–the-job training to acquire more advanced skills; participating in correspondence courses which lead to job certification; and young adults attending high school.

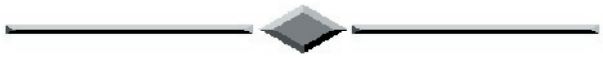
8. Attending college: 1–6 hours. This individual attends college for 6 hours or less per term. This status continues over breaks, etc., if the individual plans to continue his/her enrollment. This status suggests regular attendance by the individual. Includes correspondence, TV, or video courses for college credit.

9. Attending college: 7 or more hours. This individual attends college for more than 7 hours per term. This status continues over breaks, etc., if the individual plans to continue his/her enrollment. Regular attendance with expectations of completion of course work is essential for assignment to this status.

10. Other. This status should be clearly defined in the space provided by those completing the form.

Kansas Consumer Satisfaction Survey

KANSAS CONSUMER SATISFACTION SURVEY



Mental Health Agency: _____ County Where You Live: _____

This survey asks for your opinions about the mental health services you receive. Your feedback will be used to help improve the services that are available to you and others. No names are attached to the survey forms, so the information you provide is strictly confidential. Your answers will not be shown to staff at the agency where you receive your services.

Below are listed age, gender, and race/ethnic group categories. Please place a check mark by the categories that fit you. (Note: You may leave this section blank if you prefer not to give this information.)

Age:
____ 16 - 25
____ 26 - 35
____ 36 - 45
____ 46 - 55
____ 56 - 65
____ Over 65

Gender:
____ Female
____ Male

Race or Ethnic group:
____ American Indian or Alaskan Native
____ Asian/Pacific Islander
____ Black/African American
____ Hispanic
____ White
____ Multiple Race/Ethnicity

Some services offered by the Mental Health Center are listed below. Please make a check mark by the services that you have used:

____ Case Management
____ Partial Hospital
____ Educational Services
____Medication Services
____ Vocational Services
____ Compeer
____ Psychosocial Services
____ Attendant Care
____ Other

INSTRUCTIONS: There are no right or wrong answers. Please answer each question by CIRCLING the number of the choice which matches your opinion at the present time. (Note: The response, "Does Not Apply", means that you have not used this service or the service is not available where you live.)

Please circle the one choice that best describes your opinion for each statement.	5 Strongly Agree	4 Agree	3 In Between	2 Disagree	1 Strongly Disagree	0 Does Not Apply
1. I have good access to the program (distance, public transportation, parking, etc.)	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
2. As a result of the services I have received here, I deal more effectively with daily problems.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
3. I believe that the staff have my best interest in mind.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
4. If I am having a problem with my case manager, the program will make staff changes.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
5. I am rarely lonely or bored.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
6. The doctor here listens to my concerns and values my opinion.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
7. The program's services and staff help me to stay out of the hospital.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
8. As a result of the services I have received here, I am better able to deal with crisis.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
9. I am free to make choices about my life without fear of losing the help I get from the program.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
10. If I have an emergency at night or on the weekend, I am able to get help from the program	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
11. Staff follow through on promises they make.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
12. I can choose where I live.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
13. Staff do a good job of telling me about my rights as a consumer.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..

Please circle the one choice that best describes your opinion for each statement.	5 Strongly Agree	4 Agree	3 In Between	2 Disagree	1 Strongly Disagree	0 Does Not Apply
14. My opinions and ideas are included in my treatment plan.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
15. The staff here treat me like an adult, not a child.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
16. The staff help to overcome the problems that go along with getting and keeping a job.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
17. To the best of my knowledge, staff have kept my personal information confidential.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
18. As a result of the services I have received here, I do better with my leisure time.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
19. Overall, I am satisfied with the services I receive.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
20. If I don't want the services the staff recommend, they will give me other choices.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
21. The staff I work with are competent and knowledgeable.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
22. Staff have helped me to maintain a home or apartment in the community.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
23. I know who the consumer representative is on the Mental Health Center's Governing Board.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
24. As a result of the services I have received here, I do better in social situations.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
25. Staff are willing to see me as often as I feel it is necessary.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..
26. My doctor tries to find the medications that work best for me.	..…5……	…..4…..	…..3…..	…..2…..	…..1…..	…..0…..

In the space below, please give us any comments you would like to make about what you like and dislike about the services you receive, and suggestions for how to make things better.
(You may attach additional pages if more space is needed for comments.)

Quality of Life Self-Assessment

This survey asks you to tell us how things are going for you these days. It should take you about 5 minutes to complete. When finished, please give the survey to your care Coordinator so that you can review the results together.

Please print your name, your Care Coordinator's name and today's date below.
Your name (please print): _____
Your Care Coordinator's name: _____
Today's date: _____
In this section, we ask you to rate how things are going in different areas of your life. For each statement below, circle the answer that best matches your experience.

Overall, how would you rate …	(Circle one choice for each statement)				
	0	1	2	3	Should this be on your service plan?
The place where you live (your housing).	Poor	Fair	Good	Excellent	Yes or No
The amount of money you have to buy what you need.	Poor	Fair	Good	Excellent	Yes or No
Your involvement in work, employment.	Poor	Fair	Good	Excellent	Yes or No
Your level of education.	Poor	Fair	Good	Excellent	Yes or No
Your access to transportation to get around.	Poor	Fair	Good	Excellent	Yes or No
Your social life.	Poor	Fair	Good	Excellent	Yes or No
Your participation in community activities (leisure, sports, spiritual, volunteer work).	Poor	Fair	Good	Excellent	Yes or No
Your ability to have fun and relax.	Poor	Fair	Good	Excellent	Yes or No
Your physical health.	Poor	Fair	Good	Excellent	Yes or No
Your level of independence.	Poor	Fair	Good	Excellent	Yes or No
Your ability to take care of yourself (staying healthy, eating right, avoiding danger).	Poor	Fair	Good	Excellent	Yes or No
Your self-esteem (how you feel about yourself).	Poor	Fair	Good	Excellent	Yes or No
The effect of Alcohol & other drugs on your life.	Severe	Moderate	Minimal	None	Yes or No
Your mental health symptoms.	Severe	Moderate	Minimal	None	Yes or No
Overall, how things are going in your life?	Poor	Fair	Good	Excellent	Yes or No
Is there anything else that you want on your service plan?					

DRAFT VERSION
2003

Simple Employment Outcome Measures

The following gives an outline for measuring employment outcomes at a program level. Staff and/or administrators in a supported employment program or in an agency seeking to monitor its own progress over time could be assigned to collect the information. The methods are also suitable for a state agency seeking to monitor a group of programs across the state.

Monitoring outcomes is important for any evidence-based practice. For supported employment, the main outcome is competitive employment. Although there are many aspects of competitive employment that would be desirable to know, the primary outcome of interest is whether or not a consumer is working or not in competitive employment.

The definition of competitive employment includes the following:

- pays at least minimum wage
- the employment setting includes co-workers who are not disabled
- the position can be held by anyone, that is, one does not need to be a member of a population with a disability to hold the job

Some employment programs may choose to measure other types of employment in addition to competitive employment. The system below can be adapted to do so (e.g., use different codes for agency-run business), but every addition to a reporting database compounds the complexity of one's method.

The employment reporting database

We strongly recommend the prospective collection of data. Although in theory one can retrospectively collect program activity over a prior period of time, our experience is that retrospective data collection, especially when the time period is long and the number of consumers to track is large, is susceptible to clerical and data entry errors. We recommend that the reporting grid be updated at a regularly scheduled meeting, ideally at least weekly. To minimize data entry errors one individual should be assigned the responsibility to update the database. This person obtains the information directly from the employment specialists.

The basic format for recording employment data is an EXCEL spreadsheet, (see Employment Reporting Grid), with the rows consisting of consumer names (or ID #s, depending on issues of confidentiality) and the columns consisting of weeks. The second column gives the admission date into the program and the third column gives the termination date if the consumer is closed.

A start date must be chosen for data collection. The names consist of all active consumers in the program as of the start date. In each cell is recorded a "W" for *working* or a "N" for *not working* in a particular week. Working means that the person actually worked in that week. New names are entered at the bottom of the list as they are added to the roster. An end date for data reporting—e.g., one year after the start date—must also be chosen and then comparisons can be made.

A prototype for the database is attached.

Employment outcomes

The Employment Reporting Grid permits the calculation of the following:

Percentage of consumers who were employed at any time during follow-up.

The numerator consists of the number of people who worked at least one week during follow-up. Denominator consists of the number of people who were active at least one week during the follow-up.

Percentage of consumers employed at follow-up.

Numerator = all employed at follow-up. Denominator = all active at follow-up.

Average weeks worked among clients enrolled in program.

Numerator = total number of weeks of employment across all consumers. Denominator = total number of consumers enrolled at any time.

Refinements to the database

As described above, the database captures very basic information about employment outcomes. For agencies seeking more detailed information, the methodology can be modified to record *number of hours worked each week* as the cell entry, rather than simply Work/No Work. If this information is recorded, then average hours employed during follow-up can be calculated. Another refinement would be to record *types of jobs held*. For many purposes, a running list of each new job obtained would be adequate.

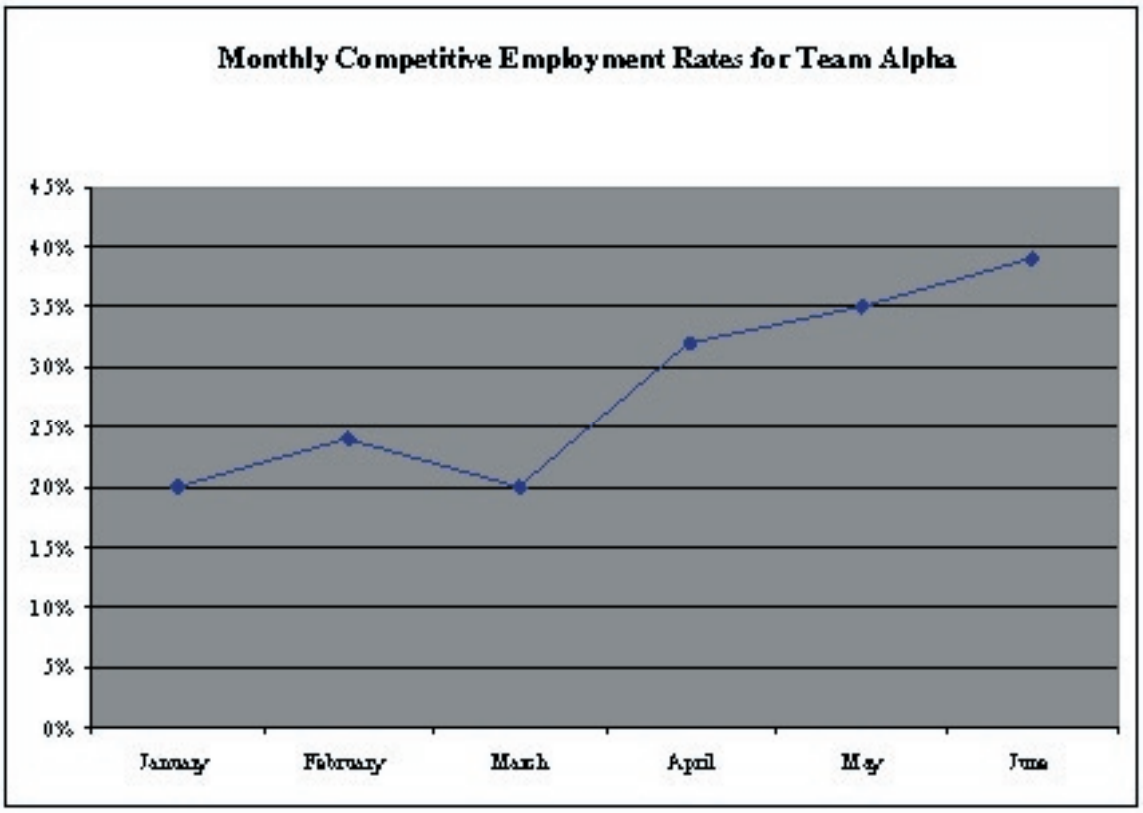
Further points to consider

The calculations of rates are sensitive to admissions and dropouts. For example, if there are many admissions just prior to the end date for the evaluation, and most are not employed, then the employment rate may be artificially low. There could be statistical corrections that could be made (that is, adjust for total time available to work), but the calculations can be complicated and defeat the goal of "simple" employment measures.

In some cases programs or agencies may choose to assess employment rates beyond the supported employment program and may choose to select consumers based upon such variables as program participation, diagnosis, functional assessment. For example, a center may choose to study the total population of consumers with severe mental illness attending the community support program. If this is the case, the Employment Reporting Database should be adjusted accordingly, and the method of data collection may need to be adapted.

Graphing employment outcomes

We recommend that programs implementing an EBP graph their employment outcomes over time using the data from the grid.



Employment Reporting Grid

Name/ ID #	Admission Date	Termination Date	Week Starting					
			1/1/03	1/8/03	1/15/03	1/22/03	1/29/03	etc.