Australian Mental Health Outcomes and Classification Network

'Sharing Information to Improve Outcomes'

An Australian Government funded initiative

Review of Recovery Measures

Version 1.01

Philip Burgess, Jane Pirkis, Tim Coombs, Alan Rosen

February 2010

A joint Australian, State and
Territory Government Initiative

Table of contents

Acknowledgements

We would like to acknowledge the assistance of a number of our national and international colleagues in preparing this report. In particular, we would like to thank Dr Marianne Farkas (Boston University Center for Psychiatric Rehabilitation, USA), Dr Mike Slade & Julie Williams (Institute of Psychiatry, UK) and Lindsay Oades, University of Wollongong (Australia).

Executive summary

Background

Australia, like many other western countries, has increasingly recognised the importance of the concept of recovery in the treatment of mental illness. Australia's *Fourth National Mental Health Plan* makes explicit reference to the concept of recovery, with the first of its five priority areas being *'Social Inclusion and Recovery'*. Australia's *National Standards for Mental Health Services* are currently undergoing a revision which will result in a new standard on the recovery orientation of services, based on principles of individual uniqueness, real choices, attitudes and rights, dignity and respect, partnership and communication, and evaluating recovery.

The Australian Mental Health Outcomes and Classification Network (AMHOCN) was tasked with undertaking a review of available recovery measures and providing a report to the Mental Health Information Strategy Subcommittee (MHISS) for consideration at its February 2010 meeting. The review explicitly considered both instruments designed to measure individuals' recovery and instruments designed to assess the recovery orientation of services.

Aims

The overarching aims of the review were as follows:

- To identify instruments designed to measure individual's recovery that could be useful to individual consumers, carers and service providers in monitoring recovery status and change, and in detecting opportunities for improving aspects of recovery by the individual by their own means and/or collaboratively with the support of family, friends and services;

- To explore the desirability and feasibility of adopting a measure of individual recovery as part of the NOCC suite of consumer outcome measures;

- To identify instruments designed to measure the recovery orientation of services that could be useful to consumers, carers, service providers and managers in co-operatively monitoring the status and change of the recovery orientation of particular teams or services, in comparing services, and in detecting opportunities for improving the recovery orientation of services and improving aspects of recovery for consumers of those services; and

- To explore the desirability and feasibility of incorporating a measure of the recovery orientation of services into the *National Standards for Mental Health Services.*

Method

Our identification of potential instruments drew on a series of existing reviews of recovery measures, a search of Medline and PsycInfo, and recourse to local and international colleagues who were regarded as experts in the field.

We used a hierarchical criterion-based approach to assess whether given instruments might be candidates for measuring recovery in a routine fashion in Australian public sector mental health services. In the case of instruments designed to measure recovery at an individual level, the criteria were as follows:

- Explicitly measures domains related to personal recovery;
- Is brief and easy to use (≤50 items);
- Takes a consumer perspective;
- Yields quantitative data;

- Has been scientifically scrutinised;
- Demonstrates sound psychometric properties (e.g., of internal consistency, validity, reliability and sensitivity to change);
- Is applicable to the Australian context; and
- Is acceptable to consumers.

In the case of instruments designed to assess the recovery orientation of services, the following, somewhat less strict criteria were applied:

- Measures domains directly relevant to the recovery orientation of services;
- Is manageable and easy to use in terms of administration (≤100 items);
- Has undergone appropriate processes of development, piloting and documentation, and ideally been scientifically scrutinised;
- Includes a consumer perspective;
- Is applicable to the Australian context; and
- Is acceptable to consumers.

In both cases, the criteria were used in a hierarchical fashion to exclude instruments. This meant that an instrument that was excluded on the basis of one of the early criteria was not assessed against any subsequent criteria.

Results

Our search yielded 33 instruments, of which 22 were designed to measure individuals' recovery and 11 were designed to assess the recovery orientation of services (or providers). Assessing these instruments against the hierarchical criteria identified four instruments designed to measure individuals' recovery and four designed to measure the recovery orientation of services that might be candidates for routine use in Australian public sector mental health services.

The four candidate instruments designed to measure individuals' recovery are:

- Recovery Assessment Scale (RAS)
- Illness Management and Recovery (IMR) Scales
- Stages of Recovery Instrument (STORI)
- Recovery Process Inventory (RPI).

The four candidate instruments designed to measure the recovery orientation of services are:

- Recovery Oriented Systems Indicators Measure (ROSI)
- Recovery Self Assessment (RSA)
- Recovery Oriented Practices Index (ROPI)
- Recovery Promotion Fidelity Scale (RPFS)

Discussion

Before discussing the findings of the current review in detail, it is worth reflecting on some of the macro issues associated with measuring recovery in the Australian context. Firstly, to reiterate one of the points made above, consideration needs to be given to the differences between measuring recovery (or the recovery orientation of services) and reductions in symptomatology or increases in levels of functioning (or services' ability to foster these). Secondly, it should be noted that, at an individual level, the measurement of recovery is relevant across the lifespan and across phases of illness and episodes of care. Thirdly, there is a lack of consistency in the way in which recovery is viewed in mental health circles. Finally, the review was undertaken on the assumption that, if Australia were to embrace the notion of routinely measuring recovery at an individual level or at a service level, it would be preferable to draw on existing, validated instruments. It may, however, be the case that identified instruments are not ideal for the Australian context and that developing a locally-specific instrument is seen as desirable.

With these macro issues in mind, we would recommend that a series of steps be followed to refine the above list of identified instruments further. All of these steps should involve extensive consultation with key stakeholders, particularly consumers. They should also involve collaboration with the developers of the relevant instruments. Firstly, a decision needs to be made about whether the emphasis should be on the measurement of individuals' recovery or on the measurement of the recovery orientation of services, or both. Secondly, and depending on the outcome of the earlier decision, nuances about which aspects of recovery to measure at the individual level or the service level will need to be teased out. Thirdly, further development and testing of the instruments will be required for the Australian context. Finally, consideration will need to be given to issues related to the administration of the chosen instruments.

To conclude, it is apparent that there are several recovery instruments available which, perhaps with minor modifications, could be used for the purpose of the routine measurement of recovery in Australian public sector mental health services. Further work is required to isolate the specific instrument or instruments which might best be used for this purpose, and the possibility that none is suitable should not be ruled out.

Chapter 1: Introduction

Background

Australia, like many other western countries, has increasingly recognised the importance of the concept of recovery in the treatment of mental illness. Slade and colleagues have compiled several excellent overviews of perspectives on recovery, noting that there has been a gradual shift from an emphasis on 'clinical' or 'service-based' definitions of recovery to 'personal' or 'user-based' definitions.[1 2] The former is located within a medical model and relates to sustained remission, typically evidenced by reduction of symptoms and/or improvements in functioning. The latter has emerged from the ever-strengthening consumer movement in mental health, and draws on the documented 'life journeys' of people experiencing mental illness. These accounts share in common a theme which forms the basis of the alternative definition of recovery which suggests that recovery is much more than the absence of symptoms and functional impairment, and is more akin to a change in outlook that is related to leading a meaningful, purposeful life, with or without ongoing episodes of illness. At most, the typically-sought-after reduction in symptoms and improvement in functioning might be thought of as clinical recovery, whereas the more nuanced attitudinal change can be considered as personal recovery.

This more social view of recovery is encompassed in the following definitions by Anthony and Deegan, both of which are widely used:

> *'Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.'*[3]

> *'Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again… The need is to meet the challenge of the disability and to re-establish 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.'*[4]

These social perspectives on recovery have, in turn, led to consideration of what mental health services might most appropriately do to promote recovery for the consumers they serve. The New Zealand Mental Health Advocacy Coalition, in its document entitled *Destination Recovery*, offers a further definition of recovery from this perspective:

> *'Recovery is a philosophy and approach to services focusing on hope, self determination, active citizenship and a holistic range of services.'*[5]

Although the role of a recovery orientation in mental health services is seen as crucial, there is a recognition that many factors outside mental health services will foster or impinge on an individual's recovery process. Government and non-government agencies from other sectors have an impact on how people with mental illness can maximise their quality of life, including those involved in employment, education and housing. Communities also have an important role to play – their collective attitudes towards people with mental illness will shape the extent to which an individual's goals, as they relate to recovery, can be realised.

Relevant policy and practice developments in Australia

The Fourth National Mental Health Plan

Australia's *Fourth National Mental Health Plan* makes explicit reference to the concept of recovery, with the first of its five priority areas being *'Social Inclusion and Recovery'*. It outlines five indicators against which to measure desired change in this priority area, namely:

- Participation rates by people with mental illness of working age in employment;
- Participation rates by young people aged 16-30 with mental illness in education and employment;
- Rates of stigmatizing attitudes within the community;
- Percentage of mental health consumers living in stable housing; and
- Rates of community participation by people with mental illness.[6]

These indicators are laudable, but by themselves may not be sufficient to glean an accurate picture of the extent to which the *Fourth National Mental Health Plan's* recovery-related outcomes are achieved over the next five years. In general, they relate most closely to sectors outside the mental health sector, and do not gauge the performance of mental health services themselves in offering recovery-oriented care. In addition, they may be of less relevance to recovery than to the albeit-related notion of social inclusion. They are also relatively blunt, offering only an aggregated picture which may not provide an accurate gauge of the nuanced stages of recovery for individuals.

National Standards for Mental Health Services

One of the primary quality assurance mechanisms in mental health services is the *National Standards for Mental Health Services*.[8] The *National Standards for Mental Health Services* are currently used in a range of ways: as a checklist for service quality; as a guide for service enhancement and continuous quality improvement; for the development of new services; and as a tool to inform consumers and carers about what to expect from a mental health service.

Until now, the *National Standards for Mental Health Services* have not made explicit reference to the extent to which services foster and support recovery, but they are currently undergoing a revision which will result in a new standard on the recovery orientation of services. The draft standard on supporting recovery (Standard 10.1) is referenced in Box 1. The principles on which this standard is based are similar to those articulated elsewhere, and are summarised in Box 2.

Box 1: Draft standard on supporting recovery

Standard 10. Delivery of Care

10.1 Supporting Recovery

The Mental Health Service incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

Criteria

10.1.1 The MHS actively supports and promotes recovery oriented values and principles in its policies and practices.

10.1.2 The MHS treats consumers and carers with respect and dignity.

10.1.3 The MHS recognises the lived experience of consumers and carers and supports their personal resourcefulness, individuality, strengths and abilities.

10.1.4 The MHS encourages and supports the self determination and autonomy of consumers and carers.

10.1.5 The MHS provides education that supports consumer and carer participation in goal setting, treatment, care and recovery planning, including the development of advance directives.

10.1.6 The MHS supports and promotes opportunities to enhance consumers' positive social connections with family, children, friends and their valued community.

10.1.7 The MHS promotes the social inclusion of consumers with mental illness and advocates for their rights of citizenship and freedom from discrimination.

10.1.8 The MHS demonstrates systems and processes for consumer and carer participation in the development, delivery and evaluation of the services.

10.1.9 The MHS has a comprehensive knowledge of community services and resources and collaborates with consumers and carers to identify and access relevant services.

10.1.10 The MHS provides access for the consumer and their carer(s) to a range of carer-inclusive approaches to service delivery and support.

Box 2: Draft recovery principles for Australian mental health services and programs

Recovery principles: Australian mental health services and programs

Australians have a right to expect a high standard of health care. Citizens can reasonably expect to recover from mental illness. Even with chronic or persistent illness, there is a general and reasonable expectation that the person will be able to resume and to maintain a quality of life that they deem acceptable. This principle applies to both mental illness and physical illness.

From the perspective of the person with mental illness, recovery means/includes gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

The principles of recovery oriented practice underpin all forms of mental health care.

1. Individual uniqueness:
Recovery oriented mental health practice:

- Recognises that recovery is not necessarily about cure but is about achieving a meaningful and satisfying life.
- Accepts that recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an emphasis on social inclusion and quality of life.
- Empowers individuals so they recognise that they are at the centre of the care they receive.

2. Real choices:
Recovery oriented mental health practice:

- Supports and empowers people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
- Ensures that individuals can build on their strengths and take as much responsibility for their lives as they can at any given time.
- Ensures that there is a balance between duty of care and support for people to take positive risks and make the most of new opportunities.

3. Attitudes and rights:
Recovery oriented mental health practice:

- Involves listening to, learning from and acting upon communications from the individual, their relatives and others about what is important to each person.
- Promotes and protects people's legal and citizenship rights.
- Supports people to maintain and develop meaningful social, recreational, occupational and vocational activities which enhance mental wellbeing.

4. Dignity and respect:
Recovery oriented mental health practice:

- Consists of being courteous, respectful and honest in all interactions.
- Involves sensitivity and respect for each individual's own values and culture.
- Challenges discrimination and stigma whether it exists within our own services or the broader community.

5. Partnership and communication:
Recovery oriented mental health practice:

- Acknowledges each person is an expert on their own life and that recovery involves working in partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.
- Values the importance of sharing appropriate information and the need to communicate clearly and effectively to enable effective engagement with services.
- Involves working in positive and realistic ways with individuals, their families and carers to help them realise their own hopes, goals and aspirations.

6. Evaluating recovery:
Recovery oriented mental health practice:

- Ensures and enables evaluation of recovery at several levels
    - individuals and their families can track their own progress;
    - services are seen to use the individual's experiences of care to inform quality improvement activities;
    - there is a public reporting of key recovery indicators including (but not limited to) housing, employment and education outcomes, not merely health.

The current review

The Australian Mental Health Outcomes and Classification Network (AMHOCN) was tasked with undertaking a review of available recovery measures and providing a report to the Mental Health Information Strategy Subcommittee (MHISS) for consideration at its February 2010 meeting.

The review explicitly considered both instruments designed to measure individuals' recovery and instruments designed to assess the recovery orientation of services.

- The instruments designed to measure individuals' recovery were considered with a view to potentially adding them to the National Outcomes and Casemix Collection (NOCC) suite of measures, which is currently used in public sector mental health services to assess a range of consumer outcomes related to symptomatology and functioning, but not personal recovery.[7] These outcome measures are collected according to the NOCC protocol (see Appendix 1), which articulates the collection occasions (admission; review; discharge) within mental health service settings (inpatient; community residential; ambulatory) at which given measures should be administered for consumers in particular age groups (children and adolescents; adults; older persons). The outcome measures include clinician-rated and consumer self-report measures. The clinician-rated measures are standard across jurisdictions and completion rates are relatively high; the consumer self-report measures vary between jurisdictions and completion rates are lower (because offering them to consumers has not yet become standard practice).

- The instruments designed to assess the recovery orientation of services were considered with a view to aligning them with the *National Standards for Mental Health Services*.[8]

Our approach to the review was similar to the one we adopted in two previous reviews – one of the NOCC suite of consumer outcome measures,[9] and one of outcome measures for carers of people with mental illness.[10] It involved recourse to both the published scientific literature and the 'grey' literature, as well as some limited consultation with experts in the field.

Overarching aims

The overarching aims of the review were as follows:

- To identify instruments designed to measure individual's recovery that could be useful to individual consumers, carers and service providers in monitoring recovery status and change, and in detecting opportunities for improving aspects of recovery by the individual by their own means and/or collaboratively with the support of family, friends and services;

- To explore the desirability and feasibility of adopting a measure of individual recovery as part of the NOCC suite of consumer outcome measures;

- To identify instruments designed to measure the recovery orientation of services that could be useful to consumers, carers, service providers and managers in co-operatively monitoring the status and change of the recovery orientation of particular teams or services, in comparing services, and in detecting opportunities for improving the recovery orientation of services and improving aspects of recovery for consumers of those services; and

- To explore the desirability and feasibility of incorporating a measure of the recovery orientation of services into the *National Standards for Mental Health Services.*

Structure of the current report

The remainder of this report outlines our approach in more detail, describes our findings, and makes suggestions about future directions. Chapter 2 describes our methodology. Chapter 3 presents an overview of the identified instruments, and Chapters 4 and 5 review the instruments designed to measure individuals' recovery and instruments designed to assess the recovery orientation of services, respectively. Chapter 6 discusses the findings in the context of progressing the recovery measurement agenda.

Chapter 2: Method

Identification of instruments to be included in the review

The starting point for our review was a series of existing reviews undertaken by the Human Services Research Institute in Boston in the United States. These reviews served a somewhat different purpose to our own, in that they were designed to provide an overview of the recovery instruments that might be used for research and evaluation purposes, whereas our review was designed to consider recovery instruments that might be used in routine practice in Australian public sector mental health services.

The first of the Human Services Research Institute reviews was compiled by Ralph, Kidder and Phillips in 2000.[11] The second was conducted by Campbell-Orde, Chamberlin, Carpenter and Leff in 2005.[12] The third is currently underway and is being led by Farkas.[13] Each successive review represents an update of the earlier work(s), providing detailed information about new instruments or instruments that have undergone additional developments, and referring the reader back to the previous report(s) for older and unchanged instruments. All three reviews involve systematic identification of articles on given instruments by formal means (e.g., searches of PubMed and PsycInfo using terms such as 'recovery', 'empowerment' and 'self-determination') and informal means (e.g., identification of articles through colleagues who were aware of the review, and input from experts in mental health recovery and its measurement).

We conducted a further search of Medline and PsycInfo to identify any additional instruments, using the following search string: (('mental' OR 'psychiatr*') AND 'recovery')). We also made contact with various international colleagues working in the field to seek information on any additional developments in the area.

Evaluation of identified instruments

We used a hierarchical criterion-based approach to assess whether given instruments might be candidates for measuring recovery in a routine fashion in Australian mental health services.

In the case of instruments designed to measure recovery at an individual level, the criteria were as follows. The instrument had to explicitly measure domains directly related to recovery, and has to be brief (containing 50 items or fewer), on the grounds that briefer instruments would minimise the data collection burden if they were to be implemented on a routine basis, and would therefore be more likely to be completed. It had to assess recovery from the consumer's perspective. It had to yield quantitative data. It had to have been subject to scientific scrutiny, as evidenced by its having been referenced in at least one peer-reviewed journal article (although this rule was relaxed in the case of a few of the more recently-developed instruments). On a related note, it had to have performed well in psychometric testing (e.g., of internal consistency, validity, reliability and sensitivity to change). It also had to be applicable to the Australian context, be acceptable to consumers, and promote dialogue between individual consumers and providers.

In the case of instruments designed to assess the recovery orientation of services, somewhat different and more relaxed criteria were applied. The instrument had to measure domains directly relevant to the recovery orientation of services. It had to be manageable in terms of administration, although not necessarily as brief as the measures of individual recovery (with instruments containing up to 100 items being considered acceptable). It had to have undergone an appropriate process of development and piloting, and ideally been scientifically scrutinised (as evidenced by being the subject of at least one peer-reviewed journal article), although the more recent nature of the majority of these instruments meant that this criterion was often difficult to achieve. Although the perspective should include that of the consumer, other stakeholders' views might also be considered. Again, it had to be applicable to the Australian context, and be acceptable to consumers.

In both cases, the criteria were used in a hierarchical fashion to exclude instruments. This meant that an instrument that was excluded on the basis of one of the early criteria was not assessed against any subsequent criteria. Table 1 summarises the criteria used to evaluate the two types of recovery instruments.

Table 1: Hierarchical criteria used to evaluate recovery instruments

INSTRUMENTS DESIGNED TO MEASURE INDIVIDUALS' RECOVERY	INSTRUMENTS DESIGNED TO ASSESS THE RECOVERY ORIENTATION OF SERVICES OR PROVIDERS
• Explicitly measures domains related to personal recovery • Is brief and easy to use (≤50 items) • Takes a consumer perspective • Yields quantitative data • Has been scientifically scrutinised • Demonstrates sound psychometric properties (e.g., of internal consistency, validity, reliability and sensitivity to change) • Is applicable to the Australian context • Is acceptable to consumers • Promotes dialogue between consumers and providers	• Measures domains directly relevant to the recovery orientation of services • Is manageable and easy to use in terms of administration (≤100 items) • Has undergone appropriate processes of development, piloting and documentation, and ideally been scientifically scrutinised • Includes a consumer perspective • Is applicable to the Australian context • Is acceptable to consumers

Chapter 3: Overview of identified instruments

Together, the Human Services Research Institute's reviews identified 31 instruments that have been developed to evaluate recovery. Through our own search strategy, we identified a further two instruments, bringing the total number to 33. Twenty two of these are designed to measure individuals' recovery and 11 are designed to assess the recovery orientation of services (or providers). None of the instruments measures *both* individual's recovery and the recovery orientation of services. Table 2 shows these instruments.

Table 2: Identified recovery instruments

INSTRUMENTS DESIGNED TO MEASURE INDIVIDUALS' RECOVERY	INSTRUMENTS DESIGNED TO ASSESS THE RECOVERY ORIENTATION OF SERVICES (OR PROVIDERS)
• Crisis Hostel Healing Scale (CHHS)[14] • Recovery Assessment Scale (RAS)[15 16] • Rochester Recovery Inquiry (RRI)[17] • Recovery Interview (RI)[18] • Recovery Attitudes Questionnaire (RAQ-16; RAQ-7)[19] • Personal Vision of Recovery Questionnaire (PVRQ)[20 21] • Agreement with Recovery Attitudes Scale (ARAS)[22] • Mental Health Recovery Measure (MHRM)[23] • Consumer Recovery Outcomes System (CROS)[24] • Illness Management and Recovery (IMR) Scales[25] • Ohio Mental Health Consumer Outcomes System (OMHCOS)[26] • Peer Outcomes Protocol (POP)[27-29] • Reciprocal Support Scale (RSS)[30] • Recovery Measurement Tool (RMT)[31] • Relationships and Activities that Facilitate Recovery Survey (RAFRS)[32] • Stages of Recovery Instrument (STORI)[33] • Recovery Process Inventory (RPI)[34] • Milestones of Recovery Scale (MORS)[35] • Multi-Phase Recovery Measure (MPRM)[36] • Mental Health Recovery Star (MHRS)[37] • Self-Identified Stage of Recovery (SISR)[33] • Recovery Orientation (RO)[38]	• Recovery Oriented Service Evaluation (AACP ROSE) • Recovery Enhancing Environment Measure (REE)[39] • Recovery Oriented Systems Indicators Measure (ROSI)[40] • Recovery Self Assessment (RSA)[41] • Recovery Knowledge Inventory (RKI)[42] • Staff Attitudes to Recovery Scale (STARS)[43] • Recovery Promoting Relationships Scale (RPRS)[44] • Recovery Based Program Inventory (RBPI)[45] • Magellan Recovery Culture Report Card (MRCRC) • Recovery Oriented Practices Index (ROPI)[46] • Recovery Promotion Fidelity Scale (RPFS)[47]

Chapter 4: Instruments designed to measure individuals' recovery

Table 3 profiles the 22 instruments designed to measure individuals' recovery, describing them in terms of the perspective they take, the domains they assess, and their item structure. As a general rule, these instruments are concerned with mental health service consumers as a broad group, and do not target specific sub-groups of consumers.

Table 3: Profile of instruments designed to measure individuals' recovery

INSTRUMENT	DATE	COUNTRY	DESCRIPTION
Crisis Hostel Healing Scale (CHHS)	1998	United States	The CHHS was designed as an evaluation tool for the New York Crisis Hostel Project. It contains 40 items, each of which is rated on a 4-point Likert scale. These items measure 10 domains relevant to the concept of recovery from the perspective of the consumer, namely: *self-esteem, confidence and internal self-control; feelings/hopefulness; altered states; self- and other-inflicted violence; spiritual awareness; physical well-being; medications; giving and getting care in relationships; perceptions/self-acceptance;* and *comfort and pleasure.*[11 14]
Recovery Assessment Scale (RAS)	1995	United States	The RAS was developed as an evaluation measure, and has been used to assess the impact of a range of programs. It is designed to assess various aspects of recovery from the perspective of the consumer, with a particular emphasis on hope and self-determination. The original instrument comprises 41 items, and a shorter version containing 24 items is also available. In both versions, each item is rated on a 5-point Likert scale. It covers five domains: *personal confidence and hope; willingness to ask for help; goal and success orientation; reliance on others;* and *no domination by symptoms.*[11-13 15 16] A 24-item Japanese version of the RAS has recently been developed.[48]
Rochester Recovery Inquiry (RRI)	1996	United States	The RRI is an open-ended, qualitative questionnaire which assesses consumers' views about: *their psychiatric hospitalisations; their own illness; their relationships with other people;* and *the way in which they cope with stressful situations.* It comprises 32 questions.[11 17]
Recovery Interview (RI)	1998	United States	The RI is an open-ended, qualitative questionnaire designed to examine recovery from a personal perspective, by eliciting rich information that can be analysed for themes. It comprises 31 questions.[11 18]
Recovery Attitudes Questionnaire (RAQ-16; RAQ-7)	1998	United States	The RAQ was developed to compare attitudes about recovery across different groups, particularly consumers, providers, family members and carers, and members of the general community. The RAQ-16 comprises 16 items, and the RAQ-7 comprises seven. The items in both versions are rated on a 5-point Likert scale.[11 13 19]
Personal Vision of Recovery Questionnaire (PVRQ)	1998	United States	The PVRQ was designed to assess consumers' beliefs about their own recovery, and assesses the following five factors: *support; personal challenges; professional assistance; action and help-seeking;* and *affirmation.* It comprises 24 items, each of which is rated on a 5-point Likert scale.[11 13 20 21]
Agreement with Recovery Attitudes Scale (ARAS)	1996	United States	The ARAS was developed to assess consumers' changes in attitudes with respect to movement towards a recovery process. It comprises 22 items, each of which is rated on a 5-point Likert scale.[11 22]
Mental Health Recovery Measure (MHRM)	1999	United States	The MHRM is designed to assess the recovery process for people with psychiatric disabilities via seven domains: *overcoming stuckness; self-empowerment; learning and self-redefinition; basic functioning; overall well-being; new potentials;* and *advocacy/enrichment.* It consists of 30 items, each of which is rated on a 5-point Likert scale.[12 13 23]
Consumer Recovery Outcomes System (CROS)	1997	United States	The CROS was designed to measure elements of recovery over and above reduction in symptoms. It has three versions, each of which measure a consumer's recovery from a different perspective: the consumer him/herself (consumer version); a family member or carer ('very important person' version); and a provider (staff version). Each of the three versions assesses the following domains of recovery: *hope for the future; daily function; coping with clinical symptoms;* and *quality of life*. All three versions also contain an additional three items about *medication and substance use.* The consumer version also assesses *satisfaction with treatment,* and the staff version also assesses *service use.* The consumer and staff versions each contain 38 items, and the very important person version contains 33. All items in all versions are rated on a 4-point Likert scale.[12 24]
Illness	2004	United	The development of the IMR Scales took place within the context of evaluating the IMR

INSTRUMENT	DATE	COUNTRY	DESCRIPTION
Management and Recovery (IMR) Scales		States	program, which is designed to promote illness management and advancement towards personal goals. The instrument does not purport to measure cohesive domains, but rather to assess a variety of aspects of illness management and recovery. It has two versions, allowing for an assessment of recovery from the perspective of the consumer him/herself (client version) and a provider (clinician version). Both versions contain 15 items, each of which is rated on a 5-point Likert scale.[12 13 25]
Ohio Mental Health Consumer Outcomes System (OMHCOS)	2004	United States	The OMHCOS comprises three forms designed to capture consumer outcome information and includes a total of 138 items – Consumer Adult Form A (67 items), Consumer Adult Form B (39 items), and Provider Adult Form A (32 items). All draw heavily on existing instruments, and Adult Form A includes recovery-related items from the Making Decisions Empowerment Scale and the Quality of Life Interview.[12 13 26]
Peer Outcomes Protocol (POP)	2004	United States	The POP was developed in the context of the Peer Outcomes Protocol Project, the remit of which was to provide mental health peer support programs with a validated evaluation protocol to measure domains of significants to people recovering from a mental illness. It is organised into seven modules covering: *demographics; service use; employment; community life; quality of life; well-being;* and *program satisfaction.* In total, it contains 241 items which take the form of closed-ended and open-ended questions and Likert scales.[12 27-29]
Reciprocal Support Scale (RSS)	2002	United States	The RSS was designed to measure mutual support from the perspective of consumers taking part in a specific recovery-oriented mentoring and education program known as Leadership Class. It is made up of 14 items, each of which is rated on a 5-point Likert scale. [12 30]
Recovery Measurement Tool (RMT)	2004	United States	The RMT was developed to measure recovery from the perspective of individual consumers, and is based on a model of recovery that incorporates elements such as stages and external influences. It comprises 91 items, each of which is rated on a 5-point Likert scale.[12 31]
Relationships and Activities that Facilitate Recovery Survey (RAFRS)	2002	United States	The RAFRS was developed by researchers to identify the influences that consumers consider most significant in their recovery process. The RAFRS comprises 18 items, each of which is rated on a 4-point Likert scale. In addition, it contains two additional open-ended items. It assesses two domains related to recovery: *relationships;* and *activities.*[12 32]
Stages of Recovery Instrument (STORI)	2006	Australia	The STORI is designed to capture the following stages of recovery from the consumer's perspective: *moratorium (a time of withdrawal characterised by a profound sense of loss and hopelessness); awareness (realisation that all is not lost, and that a fulfilling life is possible); preparation (taking stock of strengths and weaknesses regarding recovery, and starting to work on developing recovery skills); rebuilding (actively working towards a positive identity, setting meaningful goals and taking control of one's life);* and *growth (living a full and meaningful life, characterised by self-management of the illness, resilience and a positive sense of self).* The STORI comprises 50 items, each of which is rated on a 6-point Likert scale. [13 33]
Recovery Process Inventory (RPI)	2006	United States	The RPI measures the following domains of recovery from the consumer's perspective: *anguish; connectedness to others; confidence/purpose; others care/help; living situation;* and *hopeful/cares for self.* It comprises 22 items, each of which is rated on a 5-point Likert scale.[13 34]
Milestones of Recovery Scale (MORS)	n. d.	United States	The MORS is a provider-rated measure of a consumer's level of recovery. The stated rationale for the provider perspective is that recovery is highly subjective, and that observable behavioural correlates of recovery may be more objective. The MORS requires providers to indicate the point the given consumer has reached in his or her recovery, based on an 8-point scale that considers levels of risk, engagement and skill.[13 35]
Multi-Phase Recovery Scale (MPRM)[a]	2009	United States	This instrument was developed specifically for a study and assesses four phases of recovery: *mourning and grief; awareness and recognition; redefinition and transformation;* and *enhanced well-being and quality of life.* It comprises 11 items, each of which is rated on a 4-point Likert scale.[13 36]
Mental Health Recovery Star (MHRS)	2008	United Kingdom	The MHRS assesses consumers' progress towards recovery from their own perspective. It does this across 10 dimensions, namely: *managing mental health; self-care; living skills; social networks; work; relationships; addictive behaviour; responsibilities; identity and self-esteem;* and *trust and hope.* Each dimension is equivalent to a single item, and is rated on a 10-point Likert scale.[37]
Self-Identified Stage of Recovery (SISR)	2003	Australia	The SISR assesses the stage of recovery which a given consumer has reached, from the consumer's own perspective. It consists of two parts. Part A requires respondents to choose one of five statements reflecting the five stages of the model

INSTRUMENT	DATE	COUNTRY	DESCRIPTION
			that best reflects their current experience. Part B consists of four statements reflecting processes of recovery, each of which is rated on a 6-point Likert scale.[33]
Recovery Orientation (RO)[a]	2005	United States	The RO was an attempt to empirically conceptualise the recovery orientation which yielded four domains: *empowerment; hope and optimism; knowledge;* and *life satisfaction.* It consists of 56 items, each of which is rated by the consumer on a 4-point, 5-point or 7-point Likert Scale.[13 38]

a. Note that this instrument was developed for a specific study designed to conceptualise recovery, and was not named by its developers. We have named it on the basis of its content and aims, for the purposes of this review.

Criterion 1: Explicitly measures domains related to personal recovery

Table 3 shows that 20 of the 22 instruments explicitly measure domains related to personal recovery. The exceptions are the Recovery Attitudes Questionnaire (RAQ-16; RAQ-7), which measures attitudes to recovery more generally, and the Reciprocal Support Scale (RSS), which was designed to measure mutual support from the perspective of consumers taking part in a specific recovery-oriented program. These instruments are excluded from further consideration.

Criterion 2: Is brief and easy to use (≤50 items)

Table 3 shows that the majority of the remaining 20 instruments satisfy this criterion. The exceptions are Ohio Mental Health Consumer Outcomes System (OMHCOS), the Peer Outcomes Protocol (POP) and the Recovery Measurement Tool (RMT). These instruments are excluded from further analysis on the grounds that they are too long, leaving 17 instruments.

Criterion 3: Takes a consumer perspective

Table 3 shows that all of the remaining 17 instruments take a consumer perspective, with the exception of the Milestones of Recovery Scale (MORS), which is a provider-rated measure of a consumer's level of recovery. The MORS is excluded from further consideration, leaving 16 instruments.

Criterion 4: Yields quantitative data

Table 3 shows that most of the remaining 16 instruments yield quantitative data. There are two exceptions, however. These are the Rochester Recovery Inquiry (RRI) and the Recovery Interview (RI), which both employ open-ended questions which generate qualitative data. Such data could be extremely informative for some purposes – for example, in encouraging dialogue between consumers and providers – but could not realistically form part of a suite of measures designed to assess progression through stages of recovery for large numbers of individuals across large numbers of service settings. For this reason, the RRI and the RI are excluded from further consideration as candidate instruments for measuring recovery in a routine fashion, leaving 14 instruments.

Criterion 5: Has been scientifically scrutinised

A number of the remaining instruments have not been subject to scientific scrutiny, having never been published as peer-reviewed journal articles. Specifically, nine of the remaining instruments fall into this category. The Crisis Hostel Healing Scale (CHHS), the Agreement with Recovery Attitudes Scale (ARAS), the Consumer Recovery Outcomes System (CROS), the Relationships and Activities that Facilitate Recovery Survey (RAFRS) and the Mental Health Recovery Star (MHRS) were the outputs of specific projects and have only ever been presented in the form of unpublished reports or manuals; none of them have undergone further testing since their development. The Personal Vision of Recovery Questionnaire (PVRQ) emerged from a doctoral thesis published in 1998; its development and psychometric properties have never been published in the scientific literature, although a small number of peer-reviewed journal articles have made reference to the instrument in the context of evaluations of programs (e.g.,

Hutchinson et al[49]). The Mental Health Recovery Measure (MHRM), the Multi-Phase Recovery Scale (MPRS) and Self Identified Stage of Recovery (SISR) all flowed from peer-reviewed journal articles articulating models of recovery,[50 51] but the instruments themselves have not actually been published in the scientific literature, except in the context of acting as a comparator for other instruments (e.g., Andresen et al[33]). Excluding these nine instruments leaves five for consideration against the remaining criteria.

Criterion 6: Demonstrates sound psychometric properties (e.g., of internal consistency, validity, reliability and sensitivity to change)

Table 4 summarises the psychometric properties of the remaining five instruments. Specifically, it considers their:

- Internal consistency (refers to the extent to which items that reflect the same construct yield similar results);
- Validity (refers to the extent to which the instrument measures what it intends to measure);
- Reliability (refers to the extent to which a given instrument gives stable, consistent results, or the inverse of the degree of error obtained from any measurement);
- Sensitivity to change (related to both validity and reliability – an instrument that is both valid and reliable, and which demonstrates change over time, can be regarded as being sensitive to change).

Four of the five remaining instruments have been shown to have relatively sound psychometric properties, although the Stages of Recovery Instrument (STORI) and the Recovery Process Inventory (RPI) have undergone less testing than the Recovery Assessment Scale (RAS) and the Illness Management and Recovery (IMR) Scales. Notably, none of these instruments has been assessed in terms of its sensitivity to change, which is important in the context of routine measurement of the recovery process at an individual level. Further work is required in this regard, but none of these instruments is excluded on the basis of this criterion.

The final remaining instrument, the Recovery Orientation (RO), has undergone minimal psychometric testing since its sound internal consistency was established when it was developed in 2005. Its validity, reliability and sensitivity to change have not been assessed, despite its having been available for more than four years. The RO is excluded from further consideration.

Table 4: Psychometric properties of instruments meeting Criteria 1-5

INSTRUMENT	PSYCHOMETRIC PROPERTIES	
Recovery Assessment Scale (RAS)	**Internal consistency**	The RAS has been shown to have good internal consistency (α = 0.93).[16]
	Validity	The RAS has been shown to have good concurrent validity. It has demonstrated significant correlations in the expected direction with the Rosenberg Self-Esteem Scale (RSES), the self-orientation domain of the Empowerment Scale (ES), the Social Support Questionnaire (SSQ), the Social Networks Scale (SNS), the Herth Hope Index (HHI), the Resilience Scale (RS), the Mental Health Recovery Measure (MHRM) and the Self-Identified Stage of Recovery (SISR). It has demonstrated non-significant or negative correlations with the consumer-rated Kessler-10 (K-10) and the clinician-rated Brief Psychiatric Rating Scale (BPRS) and Health of the Nation Outcome Scales (HoNOS).[16 52-55]
	Reliability	The RAS has been shown to have good test-retest reliability (r = 0.88) over a period of 14 days.[16]
	Sensitivity to change	The sensitivity to change of the RAS has not been tested.
Illness Management and Recovery (IMR) Scales	**Internal consistency**	The client and clinician version of the IMR have both been shown to have good internal consistency (α = 0.68-0.72 and 0.71-0.80, respectively).[25 56]
	Validity	The client version of the IMR has been shown to have good concurrent validity, as evidenced by its significant positive correlations with self-reported symptom distress on the Colorado Symptom Inventory (CSI), the Recovery Assessment Scale (RAS), the Coping Efficacy Scale (CES) and the Multidimensional Scale for Perceived Social Support (MSPSS). The clinician version of the IMR has also demonstrated good concurrent validity, via its correlation with clinician-rated functioning on the Multnomah Community Ability Scale (MCAS). The client and consumer versions of the IMR also correlate well with each other.[25 56 57]
	Reliability	The client and clinician versions of the IMR have both demonstrated good test-retest reliability (r = 0.81-0.82 and 0.78-0.81, respectively) over a period of two weeks. [25 56]
	Sensitivity to change	The sensitivity to change of the IMR has not been tested.
Stages of Recovery Instrument (STORI)	**Internal consistency**	The STORI has been shown to have good internal consistency (α = 0.88-0.94), although psychometric analysis of the STORI identified three clusters, rather than the expected five (representing the five stages of recovery), suggesting that the items do not discriminate sufficiently between stages.[33]
	Validity	The STORI has been shown to have moderate to good concurrent validity. At one extreme, the first subscale (representing the stage of *moratorium*) has been shown to have significant negative correlations with other recovery-related measures such as the Self Identified Stages of Recovery Instrument (SISR), the Recovery Assessment Scale (RAS), the Psychological Well-Being Scales (PWB), the Connor-Davidson Resilience Scale (CD-RISC) and the Adult State Hope Scale (HOPE), as well as with the Mental Health Inventory (MHI-5). At the other extreme, the fifth subscale (representing the stage of *growth*) has been shown to have significant positive correlations with these comparison instruments. The middle subscales (representing the stages of *awareness, preparation* and *rebuilding,* respectively) have generally been shown to have weaker, non-significant correlations with these comparison measures.[33]
	Reliability	The reliability of the STORI has not been tested.
	Sensitivity to change	The sensitivity to change of the STORI has not been tested.
Recovery Process Inventory (RPI)	**Internal consistency**	The RPI has been shown to have good internal consistency (α = 0.71-0.81).[34]
	Validity	The RPI has been shown to have good concurrent validity, as evidenced by the significant positive correlations between the majority of its domains and various subscales of the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey, namely those related to service access, quality and appropriateness and perceived outcomes.[34]
	Reliability	The RPI has been shown to have fair to moderate test-retest reliability (r = 0.36-0.63) over a period of 2-4 weeks.[34]
	Sensitivity to change	The sensitivity to change of the RPI has not been tested.
Recovery Orientation (RO)	**Internal consistency**	The RO has been shown to have good internal consistency (α = 0.75-0.92).[38]
	Validity	The validity of the RO has not been tested.
	Reliability	The reliability of the RO has not been tested.
	Sensitivity to change	The sensitivity to change of the RO has not been tested.

Criterion 7: Is applicable to the Australian context

Of the four remaining instruments, the Stages of Recovery Instrument (STORI) is most immediately applicable to the Australian context, having been developed here. The other three instruments might require at least minor modifications to their language to make them applicable to public sector mental health services in Australia. For example, one of the questions on the Illness Management and Recovery (IMR) Scales asks, *'how involved are you in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or similar self-help programs?* Australian examples of self-help programs would need to be considered here. Further exploration is required in this regard, but none of the remaining four instruments is excluded on the basis of this criterion.

Criterion 8: Is acceptable to consumers

All of the four remaining instruments were developed in consultation with consumers. The original Recovery Assessment Scale (RAS) was based on narrative analysis of four consumers' recovery stories, and revised with input from an independent group of consumers. The original items for the Illness Management and Recovery (IMR) Scales were generated by one group of consumers and providers, and feedback on these items was obtained from a second group of consumers and providers. The draft and final versions of the Stages of Recovery Instrument (STORI) were piloted with groups of consumers and consumer-researchers. The Recovery Process Inventory (RPI) developed with input from four consumer focus groups, and piloted and revised with input from individual consumers.

The involvement of consumers in the development of the four instruments is positive and none of these instruments is excluded on the basis of this criterion. However, further work is required to determine the broader acceptability of these instruments to consumers.

Criterion 9: Promotes dialogue between consumers and providers

There is an argument that instruments that are completed via a discussion between a provider and a consumer are more likely to promote dialogue between the two than instruments that are completed by the consumer in isolation. This collaborative process of completing the instrument might alleviate any problems with language, particularly for consumers who might otherwise struggle to understand the meaning of particular items. More importantly, it might facilitate providers' engagement with consumers, improve providers' recognition of the consumer's recovery process, and create further dialogue about individual consumers' concerns.

The Recovery Process Inventory (RPI) was explicitly designed to be completed via an interview between the consumer and provider. The Recovery Assessment Scale (RAS) can be completed via an interview, or can be self-completed by the consumer. The Illness Management and Recovery (IMR) Scales and the Stages of Recovery Instrument (STORI) were designed for consumer self-administration, but it is possible that they could be adapted for interview administration if required. All four instruments remain in consideration for routine use as measures of individual recovery.

Summary

Figure 1 summarises the instruments that met criteria at each level of the hierarchy, and shows that by the end of the elimination process they were reduced to four: the Recovery Assessment Scale (RAS); the Illness Management and Recovery (IMR) Scales; the Stages of Recovery Instrument (STORI); and the Recovery Process Inventory (RPI). Each is presented in its full form in Appendices 2-6.

All are worthy of consideration as candidate instruments for routinely assessing recovery at an individual level in Australian public sector mental health services, but it is likely that all would require some further development and testing for the Australian context.

Figure 1: Summary of individual-level instruments meeting criteria at each level of the hierarchy

All instruments	Crisis Hostel Healing Scale (CHHS) Recovery Assessment Scale (RAS) Rochester Recovery Inquiry (RRI) Recovery Interview (RI) Recovery Attitudes Questionnaire (RAQ-16; RAQ-7) Personal Vision of Recovery Questionnaire (PVRQ) Agreement with Recovery Attitudes Scale (ARAS) Mental Health Recovery Measure (MHRM) Consumer Recovery Outcomes System (CROS) Illness Management and Recovery (IMR) Scales Ohio Mental Health Consumer Outcomes System (OMHCOS)	Peer Outcomes Protocol (POP) Reciprocal Support Scale (RSS) Recovery Measurement Tool (RMT) Relationships and Activities that Facilitate Recovery Survey (RAFRS) Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI) Milestones of Recovery Scale (MORS) Muti-Phase Recovery Measure (MPRM) Mental Health Recovery Star (MHRS) Self-Identified Stage of Recovery (SISR) Recovery Orientation (RO)
1. Measures domains related to personal recovery	Crisis Hostel Healing Scale (CHHS) Recovery Assessment Scale (RAS) Rochester Recovery Inquiry (RRI) Recovery Interview (RI) Personal Vision of Recovery Questionnaire (PVRQ) Agreement with Recovery Attitudes Scale (ARAS) Mental Health Recovery Measure (MHRM) Consumer Recovery Outcomes System (CROS) Illness Management and Recovery (IMR) Scales Ohio Mental Health Consumer Outcomes System (OMHCOS)	Peer Outcomes Protocol (POP) Recovery Measurement Tool (RMT) Relationships and Activities that Facilitate Recovery Survey (RAFRS) Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI) Milestones of Recovery Scale (MORS) Muti-Phase Recovery Measure (MPRM) Mental Health Recovery Star (MHRS) Self-Identified Stage of Recovery (SISR) Recovery Orientation (RO)
2. Is brief	Crisis Hostel Healing Scale (CHHS) Recovery Assessment Scale (RAS) Rochester Recovery Inquiry (RRI) Recovery Interview (RI) Personal Vision of Recovery Questionnaire (PVRQ) Agreement with Recovery Attitudes Scale (ARAS) Mental Health Recovery Measure (MHRM) Consumer Recovery Outcomes System (CROS)	Illness Management and Recovery (IMR) Scales Relationships and Activities that Facilitate Recovery Survey (RAFRS) Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI) Milestones of Recovery Scale (MORS) Muti-Phase Recovery Measure (MPRM) Mental Health Recovery Star (MHRS) Self-Identified Stage of Recovery (SISR) Recovery Orientation (RO)
3. Takes a consumer perspective	Crisis Hostel Healing Scale (CHHS) Recovery Assessment Scale (RAS) Rochester Recovery Inquiry (RRI) Recovery Interview (RI) Personal Vision of Recovery Questionnaire (PVRQ) Agreement with Recovery Attitudes Scale (ARAS) Mental Health Recovery Measure (MHRM) Consumer Recovery Outcomes System (CROS)	Illness Management and Recovery (IMR) Scales Relationships and Activities that Facilitate Recovery Survey (RAFRS) Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI) Muti-Phase Recovery Measure (MPRM) Mental Health Recovery Star (MHRS) Self-Identified Stage of Recovery (SISR) Recovery Orientation (RO)
4. Is suitable for routine use	Crisis Hostel Healing Scale (CHHS) Recovery Assessment Scale (RAS) Personal Vision of Recovery Questionnaire (PVRQ) Agreement with Recovery Attitudes Scale (ARAS) Mental Health Recovery Measure (MHRM) Consumer Recovery Outcomes System (CROS) Illness Management and Recovery (IMR) Scales	Relationships and Activities that Facilitate Recovery Survey (RAFRS) Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI) Muti-Phase Recovery Measure (MPRM) Mental Health Recovery Star (MHRS) Self-Identified Stage of Recovery (SISR) Recovery Orientation (RO)
5. Has been scientifically scrutinised	Recovery Assessment Scale (RAS) Illness Management and Recovery (IMR) Scales Stages of Recovery Instrument (STORI)	Recovery Process Inventory (RPI) Recovery Orientation (RO)
6. Demonstrates sound psychometric properties	Recovery Assessment Scale (RAS) Illness Management and Recovery (IMR) Scales	Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI)
7. Is applicable to the Australian context	Recovery Assessment Scale (RAS) Illness Management and Recovery (IMR) Scales	Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI)
8. Is acceptable to consumers	Recovery Assessment Scale (RAS) Illness Management and Recovery (IMR) Scales	Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI)
9. Promotes dialogue between consumers and providers	Recovery Assessment Scale (RAS) Illness Management and Recovery (IMR) Scales	Stages of Recovery Instrument (STORI) Recovery Process Inventory (RPI)

Chapter 5: Instruments designed to measure the recovery orientation of services

Table 5 profiles the 11 instruments designed to assess the recovery orientation of services (or providers), describing them in terms of the domains they assess, and their item structure.

Table 5: Profile of instruments designed to assess the recovery orientation of services (or providers)

INSTRUMENT	DATE	COUNTRY	DESCRIPTION
Recovery Oriented Service Evaluation (AACP ROSE)	n. d.	United States	The AACP ROSE was designed as tool to enable services to assess their progress towards promoting recovery. It contains 46 items, all of which are scored using a 5-point Likert scale. Together, the items cover four domains: *service provider-clinician; service provider-administrator; stakeholder advocate;* and *other.*[12]
Recovery Enhancing Environment Measure (REE)	2003	United States	The REE (also known as the Developing Recovery Enhancing Environment Measure, or DREEM) was developed as a tool for services to use in strategic planning and organisational change processes to ensure a recovery focus. It elicits service-level information across eight domains: *demographics; stage of recovery; importance ratings on elements of recovery; program performance indicators; special needs; organisational climate; recovery markers;* and *consumer feedback.* It has a total of 166 items, but individuals respond to up to 20 fewer items if there are questions in the *special needs* section that do not apply to them. The response formats vary across domains, and include closed-ended questions, Likert scales and open-ended questions.[12 39]
Recovery Oriented Systems Indicators Measure (ROSI)	2005	United States	The ROSI is designed to assess the recovery orientation of a mental health system, and examines factors which assist and hinder recovery. It comprises two data sources, the Adult Consumer Self-Report Survey (42 items) and the Administrative Data Profile (23 items). The former examines the following domains: *person-centred decision-making and choice; invalidated personhood; self-care and wellness; basic life resources; meaningful activities and roles; peer advocacy; staff treatment and knowledge;* and *access.* The latter profiles the following areas: *peer support; choice; staffing ratios; system culture and orientation; consumer inclusion in governance;* and *coercion.* The ROSI uses a combination of response formats, including closed-ended questions, Likert scales and open-ended questions.[12 40]
Recovery Self Assessment (RSA)	2005	United States	The RSA is designed to measure the extent to which recovery-supporting practices are evident in mental health services. It contains 36 items which collectively assess five domains: *life goals; involvement; diversity of treatment options; choice;* and *individually-tailored services.* Each item is rated on a 5-point Likert scale. There are four versions, one for each of the following stakeholder groups: consumers (person in recovery version); family members or carers (family/significant others/advocates version); providers (provider version); and managers (CEO/Agency director version).[12 41]
Recovery Knowledge Inventory (RKI)	2006	United States	The RKI was developed to gauge recovery-oriented practices among providers. It assesses four domains of understanding: *roles and responsibilities in recovery; non-linearity of the recovery process; roles of self-definition and peers in recovery;* and *expectations regarding recovery*. It comprises 20 items, each of which is rated on a 5-point Likert scale.[13 42]
Staff Attitudes to Recovery Scale (STARS)	2006	Australia	STARS was developed as an evaluation tool to assess the impact of a recovery-based training program on staff attitudes towards recovery. It measures attitudes and hopefulness related to consumers' goal striving and recovery possibilities. It comprises 19 items, each of which is rated on a 5-point Likert scale.[13 43]
Recovery Promoting Relationships Scale (RPRS)	2006	United States	The RPRS measures generic components of mental health care providers' recovery-promoting professional competence: *core interpersonal skills;* and *skills to utilise recovery-promoting strategies*. It specifically considers the concepts of: *hopefulness; empowerment;* and *self-acceptance.*[13 44] It consists of 24 items, each of which is rated on a 5-point Likert scale.
Recovery Based Program Inventory (RBPI)	n. d.	United States	The RBPI was developed as a program evaluation tool to assess the recovery orientation of the mental health system. It takes the form of a checklist of 148 items which, together, cover the following domains: *recovery beliefs and implementation; recovery relationship and leadership; recovery culture;* and *recovery treatment.*[13 45]

INSTRUMENT	DATE	COUNTRY	DESCRIPTION
Magellan Recovery Culture Report Card (MRCRC)	n. d.	United States	The MRCRC assesses mental health program elements against the following criteria: *welcoming and accessibility; growth orientation; consumer inclusion; emotionally healing; environments and relationships; quality of life focus; community integration; staff morale and recovery.* It contains 102 items.[13]
Recovery Oriented Practices Index (ROPI)	2005	United States	The ROPI measures practice in relation to recovery-promoting values. It comprises 20 items, each of which is assessed on a 5-point Likert scale. It covers the following domains: *meeting basic needs; comprehensive services; customisation and choice; consumer involvement/participation; network supports/community integration; strengths-based approach; client source of control/self-determination;* and *recovery focus.*[13 46] The ROPI was adapted for the Scottish setting, where it is known as the Scottish Recovery Indicator (SRI).[58]
Recovery Promotion Fidelity Scale (RPFS)	2009	United States	The RPFS was developed to evaluate the extent to which public mental health services incorporate recovery principles into their practice. It consists of 12 items organised around five domains, namely: *collaboration; participation and acceptance; self-determination and peer support; quality improvement;* and *development.* Each item is rated on a 5-point Likert scale, and some items attract bonus points.[13 47]

Criterion 1: Measures domains directly relevant to the recovery orientation of services

Table 5 shows that all but three of the 11 instruments measure domains directly relevant to the recovery orientation of services. The exceptions are the Recovery Knowledge Inventory (RKI), the Staff Attitudes to Recovery Scale (STARS) and the Recovery Promoting Relationships Scale (RPRS) which assess the knowledge of and attitudes towards recovery of individual providers. Although this is important, it is beyond the scope of the service-level assessments that could potentially be introduced into routine practice alongside the National Mental Health Standards. All of the other components of the National Mental Health Standards relate to services as a whole, rather than to individual providers working within them. Excluding the RKI, the STARS and the RPRS reduces the number of potentially eligible instruments to eight.

Criterion 2: Is manageable and easy to use in terms of administration (≤100 items)

Table 5 shows that three of the remaining eight instruments contain more than 100 items. These are the Recovery Enhancing Environment Measure (REE), the Recovery Based Program Inventory (RBPI) and the Magellan Recovery Culture Report Card (MRCRC). Excluding the REE, the RBPI and the MRCRC on the grounds of their length leaves five potential candidate instruments.

Criterion 3: Has undergone appropriate processes of development, piloting and documentation, and ideally been scientifically scrutinised

The documentation surrounding one of the remaining five instruments designed to assess the recovery orientation of services is insufficient to make a judgement about the appropriateness of its development. The Recovery Oriented Service Evaluation (AACP ROSE) was reported by personal communication only for inclusion in Campbell-Orde's 2005 review,[12] and has undergone no further development since this time.[13] This instrument is excluded from further examination.

By contrast, the documentation relating to the remaining four instruments is quite comprehensive. The Recovery Self Assessment (RSA) and the Recovery Promotion Fidelity Scale (RPFS) both underwent appropriate processes of item development (drawing on stakeholders' input) and testing (using techniques such as concept mapping, principal components analysis and factor analysis), and both have been published in peer-reviewed journals.[41 47] The Recovery Oriented Systems Indicators Measure (ROSI) also underwent an appropriate process of item development (involving consumers) and testing of both

the factor structure of the instrument and issues to do with its implementation. The Recovery-Oriented Practices Index (ROPI) underwent a similar development process.[46] Although the ROSI and the ROPI have not been published in the peer-reviewed literature, they are the subject of comprehensive, publicly-available technical reports and conference presentations.[40 46] Although none of these instruments appears to have undergone much additional psychometric testing beyond the initial development phase, all are retained for analysis against subsequent criteria.

Criterion 4: Includes a consumer perspective

All of the four remaining instruments include a consumer perspective. The Recovery Self Assessment (RSA) and the Recovery Promotion Fidelity Scale (RPFS) both draw on the views of consumers, as well as the views of service managers/administrators, providers, and family members or carers. The Recovery Oriented Systems Indicators Measure (ROSI) seeks input from consumers and providers, and supplements this with administrative data. The Recovery Oriented Practices Index (ROPI) involves conducting interviews with consumers, family members or carers, service managers and service providers, and carrying out a document review. None of the remaining four instruments is excluded on the basis of the consumer perspective criterion.

Criterion 5: Is applicable to the Australian context

All of the remaining four instruments were developed in the United States, but there is no prima facie reason why they could not be adapted to the Australian setting. Consideration would need to be given to some of the terminology that relates to the United States mental health system, and translating it to the Australian system. For example, the Recovery-Oriented Practices Index (ROPI) uses terms like 'representative payee' and 'outpatient commitment', which are not used here.

There are precedents for adapting at least some of these instruments to cross-national settings. For example, the Recovery-Oriented Practices Index (ROPI) formed the basis of the Scottish Recovery Instrument (SRI).[58] All four instruments are retained for analysis against the final criterion.

Criterion 6: Is acceptable to consumers

All of the four remaining instruments were developed in consultation with consumers. Development of the Recovery Oriented Systems Indicators Measure (ROSI) began with a series of structured focus groups with consumers about what helps and what hinders mental health recovery.[59] Development of the Recovery Oriented Practices Index (ROPI) began with the establishment of a working group with consumer representation to examine existing tools and evidence on recovery and to consider what form the tool should take.[46] Early development of the Recovery Self Assessment (RSA) and the Recovery Promotion Fidelity Scale (RPFS) relied more on recourse to the scientific literature, [41 47] but draft versions of all four instruments were extensively piloted for feedback with consumers before they were finalised.

Summary

Figure 2 summarises the instruments that met criteria at each level of the hierarchy, and shows that by the end of the elimination process they were reduced to four: the Recovery Oriented Systems Indicators Measure (ROSI); the Recovery Self Assessment (RSA; the Recovery Oriented Practices Index (ROPI); and the Recovery Promotion Fidelity Scale (RPFS). Each is presented in its full form in Appendices 7-17.

All are worthy of consideration as candidate instruments for routinely assessing the recovery orientation of Australian public sector mental health services, but it is likely that all would require some further development and testing for the Australian context.

Figure 2: Summary of service-level instruments meeting criteria at each level of the hierarchy

All instruments	Recovery Oriented Service Evaluation (AACP ROSE) Recovery Enhancing Environment Measure (REE) Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA) Recovery Knowledge Inventory (RKI) Staff Attitudes to Recovery Scale (STARS)	Recovery Promoting Relationships Scale (RPRS) Recovery Based Program Inventory (RBPI) Magellan Recovery Culture Report Card (MRCRC) Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)
1. Measures domains relevant to the recovery orientation of services	Recovery Oriented Service Evaluation (AACP ROSE) Recovery Enhancing Environment Measure (REE) Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA)	Recovery Based Program Inventory (RBPI) Magellan Recovery Culture Report Card (MRCRC) Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)
2. Is manageable in terms of administration	Recovery Oriented Service Evaluation (AACP ROSE) Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA)	Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)
3. Has undergone an appropriate process of development, piloting and documentation, and ideally been scientifically scrutinised	Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA)	Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)
4. Includes a consumer perspective	Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA)	Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)
5. Is applicable to the Australian context	Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA)	Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)
6. Is acceptable to consumers	Recovery Oriented Systems Indicators Measure (ROSI) Recovery Self Assessment (RSA)	Recovery Oriented Practices Index (ROPI) Recovery Promotion Fidelity Scale (RPFS)

Chapter 6: Discussion

Macro issues to consider in assessing recovery

Before discussing the findings of the current review in detail, it is worth reflecting on some of the macro issues associated with measuring recovery in the Australian context. Firstly, to reiterate one of the points made in Chapter 1, consideration needs to be given to the differences between measuring recovery (or the recovery orientation of services) and reductions in symptomatology or increases in levels of functioning (or services' ability to foster these). Although recovery may be associated with these sorts of clinical improvements, it may be completely independent of them. Measuring recovery alongside these clinical constructs is important from the perspective of broadening the range of individual-level outcomes and service-level processes that equate to good quality care.

Secondly, it should be noted that, at an individual level, the measurement of recovery is relevant across the lifespan and across phases of illness and episodes of care. The majority of the instruments designed to assess individuals' recovery that were identified in the current review explicitly or implicitly focus on recovery for adults with severe and persistent mental illness. Only a few of the identified instruments have been used to measure broad aspects of recovery across a range of age groups and with deteriorating disorders such as dementia. The Scottish version of the short-listed Recovery-Oriented Practices Index (ROPI), the Scottish Recovery Instrument (SRI), is one notable exception and was used this way in a pilot in five Health Board Areas in Scotland.[58] The applicability of existing recovery instruments to people from culturally and linguistically diverse backgrounds, people with comorbid mental health and drug and alcohol problems, and other groups with particular needs, also warrants further exploration.

Thirdly, there is a lack of consistency in the way in which recovery is viewed in mental health circles. Although there are several commonly-used definitions of the term 'recovery', including those cited in Chapter 1, these have not been operationalised particularly satisfactorily. This lack of clarity about what the term 'recovery' means in practice may explain the variability in the domains measured by the instruments we identified in the current review. The developers of different instruments may have made divergent assumptions about the salient factors which contribute to the core processes of recovery.

Finally, the review was undertaken on the assumption that, if Australia were to embrace the notion of routinely measuring recovery at an individual level or at a service level, it would be preferable to draw on existing, validated instruments. Although the review succeeded in identifying eight instruments that show potential, it may still be the case that these instruments are not ideal for the Australian context and that developing a locally-specific instrument is seen as desirable.

Interpreting the findings of the current review

As noted, our analysis has identified eight instruments that might be potential candidates for routine use in measuring recovery in Australian public sector mental health services: four that are designed to assess individuals' recovery; and four that are designed to assess the recovery orientation of services. These instruments are listed in Table 6.

Table 6: Potential candidate instruments for routine use in measuring recovery

INSTRUMENTS DESIGNED TO MEASURE INDIVIDUALS' RECOVERY	INSTRUMENTS DESIGNED TO ASSESS THE RECOVERY ORIENTATION OF SERVICES
• Recovery Assessment Scale (RAS) • Illness Management and Recovery (IMR) Scales • Stages of Recovery Instrument (STORI) • Recovery Process Inventory (RPI)	• Recovery Oriented Systems Indicators Measure (ROSI) • Recovery Self Assessment (RSA) • Recovery Oriented Practices Index (ROPI) • Recovery Promotion Fidelity Scale (RPFS)

The key features of the instruments designed to assess individuals' recovery are summarised in Table 7, and the key features of the instruments designed to assess the recovery orientation of services are summarised in Table 8.

We would recommend that a series of steps be followed to refine this list further. All of these steps should involve extensive consultation with key stakeholders, particularly consumers. They should also involve collaboration with the developers of the relevant instruments. As noted above, it is conceivable that the final conclusion of these deliberations about the instruments might be that none is ultimately suitable for the Australian context. This should not be ruled out as a possibility.

As the first step, a decision needs to be made about whether the emphasis should be on the measurement of individuals' recovery or on the measurement of the recovery orientation of services, or both.

Secondly, and depending on the outcome of the earlier decision, nuances about which aspects of recovery to measure at the individual level or the service level will need to be further explored. For example, in the case of measures of individuals' recovery, if emphasis was to be given to assessing consumers' progress through stages of recovery, the Stages of Recovery Instrument (STORI) would be selected as the instrument of choice. By contrast, if multiple perspectives on recovery were considered important, the Illness Management and Recovery (IMR) Scales would be selected on the grounds of their having a consumer version and a provider version.

Thirdly, further development and testing of the instruments will be required for the Australian context. This process will require careful examination of the individual items, to ensure that they are linguistically and culturally appropriate to Australia. The psychometric properties of the instruments designed to measure individuals' recovery have been fairly well established (although less so in the case of sensitivity to change than some other parameters), and several of these instruments are now being used as evaluation tools, but if individual items are refined for the Australian context further field testing and psychometric evaluation may be required. The psychometric properties of the instruments designed to measure the recovery orientation of services have been less well tested, and there is a need to establish their validity and reliability, particularly as they relate to the Australian context. A question that remains regarding their validity, for example, is whether consumers in services that rate well on their recovery orientation experience greater rates of individual recovery than those in services that rate poorly.[60]

Finally, consideration will need to be given to issues related to the administration of the chosen instruments. In the case of the individual-level instruments, it would presumably be the case that the process would be incorporated into that surrounding the National Outcomes and Casemix Collection (NOCC).[7] A number of issues would have to be resolved before this could occur, including whether individual measures of recovery should complement or replace the existing consumer self-report measures in the NOCC suite. Either way, there would be significant implications for training and information infrastructure. Particular efforts might be needed to encourage good data quality since the existing consumer self-report measures in the NOCC suite have typically experienced low return rates. There are also questions as to how a selected recovery instrument might fit with the existing NOCC protocol, such as whether it would be applicable to collection occasions, service settings and age groups. The candidate instruments have not been considered in this context to date, and consequently further exploration would be required in this regard.

In the case of the service-level instruments, consideration would have to be given as to how the selected instrument would align with the *National Standards for Mental Health Services*.[8] Over and above this, thought would need to be given to some of the additional administrative complexities associated with the service-level instruments. For example, it is often not entirely clear which specific stakeholders should complete them (i.e., which individual consumer(s), which individual provider(s), which individual service manager(s)), nor how the views of different stakeholders should be weighted if there are divergent views.

Table 7: Summary of key features of candidate instruments designed to assess individuals' recovery

INSTRUMENT	DATE	COUNTRY	VERSIONS	AREAS OF ASSESSMENT	NO. OF ITEMS	RESPONSE FORMAT	ADMINISTRATION	PSYCHOMETRIC PROPERTIES
Recovery Assessment Scale (RAS)	1995	United States	• Original • Short	Both versions – 5 domains: • *Personal confidence and hope* • *Willingness to ask for help* • *Goal and success orientation* • *Reliance on others* • *No domination by symptoms*	Original: • 41 Short version • 24	Both versions: • 5-point Likert scale	Both versions: • Provider interview • Consumer self-report	• Internal consistency: Good • Validity: Good • Reliability: Good • Sensitivity to change: Untested
Illness Management and Recovery (IMR) Scales	2004	United States	• Client • Clinician	Does not purport to measure cohesive domains, but rather to assess a variety of aspects of illness management and recovery	Both versions: • 15	Both versions: • 5-point Likert scale	Client version: • Consumer self-report Clinician version: • Clinician report	• Internal consistency: Good • Validity: Good • Reliability: Good • Sensitivity to change: Untested
Stages of Recovery Instrument (STORI)	2006	Australia		5 stages of recovery: • *Moratorium* • *Awareness* • *Preparation* • *Rebuilding* • *Growth*	• 50	• 6-point Likert scale	• Consumer self-report	• Internal consistency: Good • Validity: Moderate to good • Reliability: Not tested • Sensitivity to change: Untested
Recovery Process Inventory (RPI)	2006	United States		6 domains: • *Anguish* • *Connectedness to others* • *Confidence/purpose* • *Others care/help* • *Living situation* • *Hopeful/cares for self*	• 22	• 5-point Likert scale	• Provider interview	• Internal consistency: Good • Validity: Good • Reliability: Fair to moderate • Sensitivity to change: Untested

Table 8: Summary of key features of candidate instruments designed to assess recovery orientation of services

INSTRUMENT	DATE	COUNTRY	SOURCES OF INFORMATION	AREAS OF ASSESSMENT	NO. OF ITEMS	RESPONSE FORMAT
Recovery Oriented Systems Indicators Measure (ROSI)	2005	United States	• Survey of consumers (Adult Consumer Self-Report Survey • Review of administrative data (Administrative Data Profile)	Adult Consumer Self-Report Survey: • *Person-centred decision-making and choice* • *Invalidated personhood* • *Self-care and wellness* • *Basic life resources* • *Meaningful activities and roles* • *Peer advocacy* • *Staff treatment and knowledge* • *Access* Administrative Data Profile • *Peer support* • *Choice* • *Staffing ratios* • *System culture and orientation* • *Consumer inclusion in governance* • *Coercion*	Adult Consumer Self-Report Survey: • 42 items Administrative Data Profile: • 23 items	Combination of response formats: • Closed-ended questions • Likert scales • Open-ended questions
Recovery Self Assessment (RSA)	2005	United States	• Four versions of the same survey designed to elicit the views of consumers, family members and carers, providers and agency directors	5 domains: • *Life goals* • *Involvement* • *Diversity of treatment options* • *Choice* • *Individually-tailored services*	Each version • 36 items	Each version: • 5-point Likert scale
Recovery Oriented Practices Index (ROPI)	2005	United States	• Interviews with consumers, family members or carers, service managers and service providers • Document review	8 domains: • *Meeting basic needs* • *Comprehensive services* • *Customisation and choice* • *Consumer involvement / participation* • *Network supports / community integration* • *Strengths-based approach* • *Client source of control / self-determination* • *Recovery focus*	• 20 items	• 5-point Likert scale
Recovery Promotion Fidelity Scale (RPFS)	2009	United States	• Survey which draws on the views of consumers, service managers / administrators, providers and family members or carers	5 domains: • *Collaboration* • *Participation and acceptance* • *Self-determination and peer support* • *Quality improvement* • *Development*	• 12	• 5-point Likert scale (with some items attracting bonus points)

Conclusion

To conclude, it is apparent that there are several recovery instruments available which, perhaps with minor modifications, could be used for the purpose of the routine measurement of recovery in Australian public sector mental health services. Further work is required to isolate the specific instrument or instruments which might best be used for this purpose, and the possibility that none is suitable should not be ruled out.

References

1. Schrank B, Slade M. Recovery in psychiatry. *Psychiatric Bulletin* 2007;31:321-325.
2. Slade M, Amering M, Oades L. Recovery: An international perspective. *Epidemiologia e Psichiatria Sociale* 2008;17(2):128-137.
3. Anthony WA. Recovery from mental illness: The guiding vision of the mental health system in the 1990s. *Innovations and Research* 1993;2:17-24.
4. Deegan PE. Recovery: The lived experience of rehabilitation. *Psychiatric Rehabilitation Journal* 1988;11:11–19.
5. Mental Health Advocacy Coalition. Destination: Recovery. Auckland: Mental Health Foundation of New Zealand, 2008.
6. Australian Health Ministers. Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–2014. Canberra: Commonwealth of Australia, 2009.
7. National Mental Health Working Group. Mental Health National Outcomes and Casemix Collection: Technical Specification of State and Territory Reporting Requirements for the Outcomes and Casemix Components of 'Agreed Data', Version 1.50. Canberra: Commonwealth Department of Health and Ageing, 2003.
8. AHMAC National Mental Health Working Group. Draft Revised National Standards for Mental Health Services. Canberra: Commonwealth of Australia, 2008.
9. Pirkis J, Burgess P, Kirk P, Dodson S, Coombs T. Review of Standardised Measures used in the National Outcomes and Casemix Collection (NOCC) - Version 1.2. Brisbane: Australian Mental Health Outcomes and Classification Network, 2005.
10. Dare A, Hardy J, Burgess P, Coombs T, Williamson M, Pirkis J. Carer Outcome Measurement in Mental Health Services: Scoping the Field. Brisbane: Australian Mental Health Outcomes and Classification Network, 2008.
11. Ralph RO, Kidder K, Phillips D. Can We Measure Recovery? A Compendium of Recovery and Recovery-related Instruments. Cambridge, MA: Human Services Research Institute, 2000.
12. Campbell-Orde T, Chamberlin J, Carpenter J, Leff HS. Measuring the Promise: A Compendium of Recovery Measures. Cambridge, MA: Human Services Research Institute, 2005.
13. Farkas M. Personal communication, 2009.
14. New York Crisis Hostel Project. Crisis Hostel Healing Scale. New York: New York Crisis Hostel Project, 1988.
15. Giffort D, Schmook A, Woody C, Vollendorf C, Gervain M. Recovery Assessment Scale. Chicago, IL: Illinois Department of Mental Health, 1995.
16. Corrigan PW, Giffort D, Rashid F, Leary M, Okeke I. Recovery as a psychological construct. *Community Mental Health Journal* 1999;35(3):231-239.
17. Hopper K, Blanch A, Carpinello S, Johnson S, Knight E, Kovasznay B, et al. Rochester Recovery Inquiry. Orangeburg, NY: Center for the Study of Public Issues in Mental Health, 1996.
18. Heil J, Johnson LK. Recovery Interview. Athens, OH: Institute for Local Government Administration and Rural Development, 1998.
19. Borkin JR. Recovery Attitudes Questionnaire: Development and Evaluation. *Psychiatric Rehabilitation Journal* 2000;24(2):95-103.
20. Ensfield LB. The Personal Vision of Recovery Questionnaire: The Development of a Consumer-derived Scale. University of Cincinnati, 1998.
21. Ensfield LB, Steffen JJ, Borkin JR, Schafer JC. Personal Vision of Recovery Questionnaire. Cincinnati, OH: University of Cincinnati, 1998.
22. Murnen SK, Smolak L. Agreement with Recovery Attitudes Scale, 1996.
23. Young SL, Bullock WA. The Mental Health Recovery Measure. Toledo, OH: University of Toledo, 2003.

24. Bloom BL, Miller A. The Consumer Recovery Outcomes System (CROS 3.0): Assessing Clinical Status and Progress in Persons with Severe and Persistent Mental Illness. Colorado Springs, CO: CROS, LLC / Colorado Health Networks, 2004.
25. Mueser KT, Gingerich S, Salyers MP, McGuire AB, Reyes RU, Cunningham H. The Illness Management and Recovery (IMR) Scales (Client and Clinician Versions). Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center, 2004.
26. Ohio Department of Mental Health. Procedural Manual (6th Edition Revised). The Ohio Mental Health Consumer Outcomes System, 2004: Ohio Department of Mental Health, 2004.
27. Campbell J, Cook J, Jonikas J, Einspahr K. Peer Outcomes Protocol Questionnaire. Chicago, IL: University of Illinois, 2004.
28. Campbell J, Cook J, Jonikas J, Einspahr K. Peer Outcomes Protocol (POP): Administration Manual. Chicago, IL: University of Illinois, 2004.
29. Campbell J, Einspahr K, Evenson R, Adkins R. Peer Outcomes Protocol (POP): Psychometric Properties of the POP. Chicago, IL: University of Illinois, 2004.
30. Silver T, Bricker B, Pesta Z, Pugh D. Impact of teaching mental health best practices and recovery processes on constituent populations of the mental health system. In: Roth D, editor. *New Research in Mental Health*. Columbus, OH: Ohio Department of Mental Health, 2002.
31. Ralph RO. At the individual level: A personal measure of recovery. *NASMHPD/NTAC e-Report on Recovery (Fall 2004)*, 2004.
32. Leavy RL, McGuire AB, Rhoades C, McCool R. Predictors of subjective quality of life in mental health consumers: Baseline results. In: Roth D, editor. *New Research in Mental Health*. Columbus, OH: Ohio Department of Mental Health, 2002.
33. Andresen R, Caputi P, Oades L. Stages of recovery instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry* 2006;40:972-980.
34. Jerrell JM, Cousins VC, Roberts KM. Psychometrics of the Recovery Process Inventory. *The Journal of Behavioral Health Services and Research* 2006;33(4):464-473.
35. Pilon D, Ragins M. Milestones of Recovery Scale (MORS), n.d.
36. Beeble ML, Salem DA. Understanding the phases of recovery from serious mental illness: The roles of referent and expert power in a mutual-help setting. *Journal of Community Psychology* 2009;37(2):249-267.
37. MacKeith J, Burns S. Mental Health Recovery Star. London: Mental Health Providers Forum and Triangle Consulting, 2008.
38. Resnick SG, Fontana A, Lehman A, Rosenheck RA. An empirical conceptualization of the recovery orientation. *Schizophrenia Research* 2005;75(1):119-128.
39. Ridgeway P, Press A. Assessing the Recovery-orientation of your mental health program: A User's Guide for the Recovery-Enhancing Environment Scale (REE). Kansas: University of Kansas, 2004.
40. Dumont JM, Ridgeway P, Onken SJ, Dornan DH, Ralph RO. Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators. Phase II Technical Report: Development of the Recovery Oriented System Indicators (ROSI) Measures to Advance Mental Health System Transformation. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, 2005.
41. O'Connell M, Tondora J, Croog G, Evans AL, Davidson L. From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal* 2005;28(4):378-386.
42. Bedregal LE, O'Connell M, Davidson L. The Recovery Knowledge Inventory: Assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation Journal* 2006;30(2):96-103.

43. Crowe TP, Deane FP, Oades L, Caputi P, Morland KG. Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery. *Psychiatric Services* 2006;57(10):1497-1500.
44. Russinova Z, Rogers ES, Ellison ML. Recovery Promoting Relationships Scale Manual. Boston: Center for Psychiatric Rehabilitation, 2006.
45. Ragins M. A Recovery-based Program Inventory, n. d.
46. Mancini AD, Finnerty MT. Recovery-Oriented Practices Index. New York, NY: New York State Office of Mental Health, 2005.
47. Armstrong NP, Steffen JJ. The Recovery Promotion Fidelity Scale: Assessing the organisational promotion of recovery. *Community Mental Health Journal* 2009;45:163-170.
48. Chiba R, Miyamoto Y, Kawakami N. Reliability and validity of the Japanese version of the Recovery Assessment Scale (RAS) for people with chronic mental illness: Scale development. *International Journal of Nursing Studies* In press.
49. Hutchinson DS, Anthony WA, Ashcraft L, Johnson E, Dunn EC, Lyass A, et al. The personal and vocational impact of training and employing people with psychiatric disability as providers. *Psychiatric Rehabilitation Journal* 2006;29(3):205-213.
50. Andrews G, Erskine A. Reducing the burden of anxiety and depressive disorders: The role of computerized clinician assistance. *Current Opinion in Psychiatry* 2003;16(1):41-44.
51. Young SL, Ensing DS. Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal* 1999;22(3):291.
52. Corrigan PW, Phelan SM. Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal* 2004;40(6):513-523.
53. Corrigan PW, Salzer M, Ralph RO, Sangster Y, Keck L. Examining the factor structure of the Recovery Assessment Scale. *Schizophrenia Bulletin* 2004;30(4):1035-1041.
54. Flinn S. Reliability and Validity of the Recovery Assessment Scale for Consumers with Severe Mental Illness Living in Group Home Settings. Kent State University, 2005.
55. McNaught M, Caputi P, Oades L, Deane FP. Testing the validity of the Recovery Assessment Scale using an Australian sample. *Australian and New Zealand Journal of Psychiatry* 2007;41(5):450-457.
56. Salyers MP, Godfrey JL, Mueser KT, Labriola S. Measuring illness management outcomes: A psychometric study of clinician and consumer rating scales for illness self management and recovery. *Community Mental Health Journal* 2007;43(5):459-480.
57. Hasson-Ohayon I, Roe D, Kravetz S. The psychometric properties of the illness management and recovery scale: Client and clinician versions. *Psychiatry Research* 2007;160:228-235.
58. McLean J, Whitehead I. Evaluation of the Scottish Recovery Indicator Pilot in Five Health Board Areas in Scotland. Edinburgh: Scottish Development Centre for Mental Health, 2008.
59. Onken SJ, Dumont JM, Ridgeway P, Dornan DH, Ralph RO. Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators. Phase I Research Report. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, 2002.
60. Meehan TJ, King RJ, Beavis PH, Robinson JD. Recovery-based practice: Do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry* 2008;42:177-182.

Appendix 1: National Outcomes and Casemix Collection (NOCC) protocol: Data collected at each collection occasion within each mental health service setting, for consumers in each age group

Mental Health Service Setting	INPATIENT			COMMUNITY RESIDENTIAL			AMBULATORY		
Collection Occasion	A	R	D	A	R	D	A	R	D
Children and Adolescents									
HoNOSCA	●	●	●	●	●	●	●	●	●
CGAS	●	●	✖	●	●	✖	●	●	✖
FIHS	✖	●	●	✖	●	●	✖	●	●
Parent / Consumer self report (SDQ)	●	●	●	●	●	●	●	●	●
Principal and Additional Diagnoses	✖	●	●	✖	●	●	✖	●	●
Mental Health Legal Status	✖	●	●	✖	●	●	✖	●	●
Adults									
HoNOS	●	●	●	●	●	●	●	●	●
LSP-16	✖	✖	✖	●	●	●	✖	●	●
Consumer self-report (MHI, BASIS32, K10+)	✖	✖	✖	●	●	●	●	●	●
Principal and Additional Diagnoses	✖	●	●	✖	●	●	✖	●	●
Focus of Care	✖	✖	✖	✖	✖	✖	✖	●	●
Mental Health Legal Status	✖	●	●	✖	●	●	✖	●	●
Older persons									
HoNOS 65+	●	●	●	●	●	●	●	●	●
LSP-16	✖	✖	✖	●	●	●	✖	●	●
RUG-ADL	●	●	✖	●	●	✖	✖	✖	✖
Consumer self-report (MHI, BASIS32, K10+)	✖	✖	✖	●	●	●	●	●	●
Principal and Additional Diagnoses	✖	●	●	✖	●	●	✖	●	●
Focus of Care	✖	✖	✖	✖	✖	✖	✖	●	●
Mental Health Legal Status	✖	●	●	✖	●	●	✖	●	●

Abbreviations and Symbols

A Admission to Mental Health Care
R Review of Mental Health Care
D Discharge from Mental Health Care

● Collection of data on this occasion is mandatory
✖ No collection requirements apply

Source: National Mental Health Working Group (2003)[7]

Appendix 2: Recovery Assessment Scale (RAS)

Instructions: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and circle the number to the right that best describes the extent to which you agree or disagree with the statement. Circle only one number for each statement and do not skip any items.

		Strongly Disagree	Disagree	Not sure	Agree	Strongly Agree
1.	I have a desire to succeed	1	2	3	4	5
2.	I have my own plan for how to stay or become well	1	2	3	4	5
3.	I have goals in life that I want to reach	1	2	3	4	5
4.	I believe I can meet my current personal goals	1	2	3	4	5
5.	I have a purpose in life	1	2	3	4	5
6.	Even when I don't care about myself, other people do	1	2	3	4	5
7.	I understand how to control the symptoms of my mental illness	1	2	3	4	5
8.	I can handle it if I get sick again	1	2	3	4	5
9.	I can identify what triggers the symptoms of my mental illness	1	2	3	4	5
10.	I can help myself become better	1	2	3	4	5
11.	Fear doesn't stop me from living the way I want to	1	2	3	4	5
12.	I know that there are mental health services that do help me	1	2	3	4	5
13.	There are things that I can do that help me deal with unwanted symptoms	1	2	3	4	5
14.	I can handle what happens in my life	1	2	3	4	5
15.	I like myself	1	2	3	4	5
16.	If people really knew me, they would like me	1	2	3	4	5
17.	I am a better person than before my experience with mental illness	1	2	3	4	5
18.	Although my symptoms may get worse, I know I can handle it	1	2	3	4	5
19.	If I keep trying, I will continue to get better	1	2	3	4	5
20.	I have an idea of who I want to become	1	2	3	4	5
21.	Things happen for a reason	1	2	3	4	5
22.	Something good will eventually happen	1	2	3	4	5
23.	I am the person most responsible for my own improvement	1	2	3	4	5
24.	I'm hopeful about the future	1	2	3	4	5
25.	I continue to have new interests	1	2	3	4	5
26.	It is important to have fun	1	2	3	4	5
27.	Coping with my mental illness is no longer the main focus of my life	1	2	3	4	5
28.	My symptoms interfere less and less with my life	1	2	3	4	5
29.	My symptoms seem to be a problem for shorter periods of time each time they occur	1	2	3	4	5
30.	I know when to ask for help	1	2	3	4	5
31.	I am willing to ask for help	1	2	3	4	5
32.	I ask for help, when I need it	1	2	3	4	5
33.	Being able to work is important to me	1	2	3	4	5
34.	I know what helps me get better	1	2	3	4	5
35.	I can learn from my mistakes	1	2	3	4	5
36.	I can handle stress	1	2	3	4	5
37.	I have people I can count on	1	2	3	4	5
38.	I can identify the early warning signs of becoming sick	1	2	3	4	5
39.	Even when I don't believe in myself, other people do	1	2	3	4	5
40.	It is important to have a variety of friends	1	2	3	4	5
41.	It is important to have healthy habits	1	2	3	4	5

Appendix 3: Illness Management and Recovery (IMR) Scales – Client Self-rating

ID Number:_____ Date:_____

Please take a few minutes to fill out this survey. We are interested in the way things are for you, so there is no right or wrong answer. If you are not sure about a question, just answer it as best as you can.

Just circle the number of the answer that fits you best.

1. Progress towards personal goals: In the past 3 months, I have come up with …

1	2	3	4	5
No personal goals	A personal goal, but have not done anything to finish my goal	A personal goal and made it a little way towards finishing it	A personal goal and have gotten pretty far in finishing my goal	A personal goal and have finished it

2. Knowledge: How much do you feel like you know about symptoms, treatment, coping strategies (coping methods), and medication?

1	2	3	4	5
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in my mental health treatment: How much are family members, friends, boyfriend/girlfriend, and other people who are important to you (outside your mental health agency) involved in your mental health treatment?

1	2	3	4	5
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 me with my mental health

4. Contact with people outside of my family: In a normal week, how many times do you talk to someone outside of your family (like a friend, co-worker, classmate, roommate, etc.)

1	2	3	4	5
0 times/week	1-2 times/week	3-4 times/week	6-7 times/week	8 or more times/week

5. Time in structured roles: How much time do you 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 do you spend in doing activities for or with another person that are expected of you? (This would not include selfcare or personal home maintenance.)

1	2	3	4	5
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/week

6. Symptom distress: How much do your symptoms bother you?

1	2	3	4	5
My symptoms *really* bother me *a lot*	My symptoms bother me *quite a bit*	My symptoms bother me *somewhat*	My symptoms bother me *very little*	My symptoms don't bother me *at all*

7. Impairment of functioning: How much do your symptoms get in the way of you doing things that you would like to or need to do?

1	2	3	4	5
My symptoms *really* get in my way *a lot*	My symptoms get in my way *quite a bit*	My symptoms get in my way *somewhat*	My symptoms get in my way *very little*	My symptoms don't get in my way *at all*

8. Relapse prevention planning: Which of the following would best describe what you know and what you have done in order not to have a relapse?

1	2	3	4	5
I don't know how to prevent relapses	I know a little, but I haven't made a relapse prevention plan	I know 1 or 2 things I can do, but I don't have a written plan	I have several things that I can do, but I don't have a written plan	I have a written plan that I have shared with others

9. Relapse of symptoms: When is the last time you had a relapse of symptoms (that is, when your symptoms have gotten much worse)?

1	2	3	4	5
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	I haven't had a relapse in the past year

10. Psychiatric hospitalizations: When is the last time you have been hospitalized for mental health or substance abuse reasons?

1	2	3	4	5
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	I haven'

11. Coping: How well do feel like you are coping with your mental or emotional illness from day to day?

1	2	3	4	5
Not well at all	Not very well	Alright	Well	Very well

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

1	2	3	4	5
I don't know about any self-help activities	I know about some self-help activities, but I'm not interested	I'm interested in self-help activities but I have not participated in the past year	I participate in self-help activities occasionally	I participate in self-help activities regularly

13. Using medication effectively: (Don't answer this question if your doctor has not prescribed medication for you). How often do you take your medication as prescribed?

1	2	3	4	5
Never	Occasionally	About half the time	Most of the time	Every day

14. Functioning affected by alcohol use: Drinking can interfere with functioning when it contributes to conflict in relationships, or to money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drinking get in the way of your functioning?

1	2	3	4	5
Alcohol use really gets in my way a lot	Alcohol use gets in my way quite a bit	Alcohol use gets in my way somewhat	Alcohol use gets in my way very little	Alcohol use is not a factor in my functioning

15. Functioning affected by 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 money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drug use get in the way of your functioning?

1	2	3	4	5
Drug use really gets in my way a lot	Drug use gets in my way quite a bit	Drug use gets in my way somewhat	Drug use gets in my way very little	Drug use is not a factor in my functioning

Appendix 4: Illness Management and Recovery (IMR) Scales – Clinician rating

Clinician/team name:_____ Date:_____

ID Number:_____

Please take a few moments to fill out the following survey regarding your perception of your client's ability to manage her or his illness, as well as her or his progress toward recovery. We are interested in the way **you** feel about how things are going for your client, so please answer with your honest opinion. If you are not sure about an item, just answer as best as you can.

Please circle the answer that fits your client the best.

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

1	2	3	4	5
No personal goals	A personal goal, but has not done anything to finish my goal	A personal goal and made it a little way towards finishing it	A personal goal and has gotten pretty far in finishing my goal	A personal goal and have finished it

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

1	2	3	4	5
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in his/her mental health treatment: How much are family members, friends, boyfriend/girlfriend, and other people who are important to your client (outside your mental health agency) involved in your mental health treatment?

1	2	3	4	5
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 me with my mental health

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

1	2	3	4	5
0 times/week	1-2 times/week	3-4 times/week	6-7 times/week	8 or more times/week

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

1	2	3	4	5
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/week

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

1	2	3	4	5
Symptoms *really* bother him/her *a lot*	Symptoms bother him/her *quite a bit*	Symptoms bother him/her *somewhat*	Symptoms bother him/her *very little*	Symptoms don't bother him/her *at all*

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

1	2	3	4	5
Symptoms *really* get in her/his way *a lot*	Symptoms get in his/her way *quite a bit*	Symptoms get in his/her way *somewhat*	Symptoms get in his/her way *very little*	Symptoms don't get in his/her way *at all*

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

1	2	3	4	5
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 plan and has shared with others

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

1	2	3	4	5
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	I haven'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?

1	2	3	4	5
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	I haven'

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

1	2	3	4	5
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?

1	2	3	4	5
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?

1	2	3	4	5
Never	Occasionally	About half the time	Most of the time	Every day

_____ Check here if the client is not prescribed psychiatric medication

14. Functioning affected by alcohol use: Drinking can interfere with functioning when it contributes to conflict in relationships, or to money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drinking get in the way of his/her functioning?

1	2	3	4	5
Alcohol use really gets in her/his way a lot	Alcohol use gets in his/her way quite a bit	Alcohol use gets in his/her way somewhat	Alcohol use gets in his/her way very little	Alcohol use is not a factor in his/her functioning

15. Functioning affected by 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 money, housing and legal concerns, to difficulty showing up at appointments or paying attention during them, or to increased symptoms. Over the past 3 months, how much did drug use get in the way of his/her functioning?

1	2	3	4	5
Drug use really gets in her/his 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

Appendix 5: Stages of Recovery Instrument (STORI)

The following questionnaire asks about how you feel about your life and yourself since the illness. Some of the questions are about times when you don't feel so good. Others ask about times when you feel quite good about life.

If you find some of the questions upsetting, and you need to talk to someone – please take a break and talk to a friend or support person.

The questions are in groups of five.
Read all five questions in a group, and then answer those five questions.
Circle the number from 0 to 5 to show how much each statement is true of you now.
Then move on to the next group.

When you choose your answer, think about **how you feel now**, not how you have felt some time in the past. For example:

Q.38 says "I am beginning to learn about mental illness and how I can help myself."
Q.39 says "I now feel fairly confident about managing the illness."

If you are now fairly confident about managing the illness, you would give a higher score to Q.39 than you would to Q.38, which says you are just *beginning* to learn.

The questions are about how you feel about your life *on the whole* these days.
Try not to let things that might be affecting your mood just at the moment affect your answers.

Read all 5 questions in Group 1, then answer those five questions.

Circle the number from 0 to 5 that shows how much each statement is true of you *now*.
Then move on to Group 2, and so on.
When you choose your answer, think about ***how you feel now***, not how you have felt in the past.

Group 1		*Not at all true now*					*Completely true now*
1.	I don't think people with a mental illness can get better	0	1	2	3	4	5
2.	I've ***only recently*** found out that people with a mental illness *can* get better	0	1	2	3	4	5
3.	I am ***starting*** to learn how I can help myself get better	0	1	2	3	4	5
4.	I am working hard at staying well, and it will be worth it in the long run	0	1	2	3	4	5
5.	I have a sense of "inner peace" about life with the illness now	0	1	2	3	4	5
Group 2		*Not at all true now*					*Completely true now*
6.	I feel my life has been ruined by this illness	0	1	2	3	4	5
7.	I'm ***just starting*** to realize my life doesn't have to be awful forever	0	1	2	3	4	5
8.	I have ***recently*** started to learn from people who are living well in spite of serious illness	0	1	2	3	4	5
9.	I'm starting to feel ***fairly*** confident about getting my life back on track	0	1	2	3	4	5
10.	My life is really good now, and the future looks bright	0	1	2	3	4	5
Group 3		*Not at all true now*					*Completely true now*
11.	I feel like I'm nothing but a sick person now	0	1	2	3	4	5
12.	Because others believe in me, I've ***just started*** to think maybe I can get better	0	1	2	3	4	5
13.	I am **just beginning** to realize that illness doesn't change who I am as a person	0	1	2	3	4	5
14.	I am ***now beginning*** to accept the illness as part of the whole person that is me	0	1	2	3	4	5
15.	I am happy with who I am as a person	0	1	2	3	4	5
Group 4		*Not at all true now*					*Completely true now*
16.	I feel as though I don't know who I am any more	0	1	2	3	4	5
17.	I have ***recently begun*** to recognize a part of me that is not affected by the illness	0	1	2	3	4	5
18.	I am ***just starting*** to realize that I *can* still be a valuable person	0	1	2	3	4	5
19.	I am learning new things about myself as I work towards recovery	0	1	2	3	4	5
20.	I think that working to overcome the illness has made me a better person	0	1	2	3	4	5
Group 5		*Not at all true now*					*Completely true now*
21.	I'll never be the person I thought I would be	0	1	2	3	4	5
22.	I've ***just begun*** to accept the illness as part of my life I'll have to learn to live with	0	1	2	3	4	5
23.	I am **starting** to figure out what I am good at and what my weaknesses are	0	1	2	3	4	5
24.	I'm **starting** to feel that I am making a valuable contribution to life	0	1	2	3	4	5
25.	I am accomplishing worthwhile and satisfying things in my life	0	1	2	3	4	5

Group 6		*Not at all true now*					*Completely true now*
26.	I am angry that this had to happen to *me*	0	1	2	3	4	5
27.	I'm just ***starting*** to wonder if some good could come out of this	0	1	2	3	4	5
28.	I am ***starting*** to think about what my special qualities are	0	1	2	3	4	5
29.	In having to deal with illness, I am learning a lot about life	0	1	2	3	4	5
30.	In overcoming the illness I have gained new values in life	0	1	2	3	4	5
Group 7		*Not at all true now*					*Completely true now*
31.	My life seems completely pointless now	0	1	2	3	4	5
32.	I am ***just starting*** to think maybe I *can* do something with my life	0	1	2	3	4	5
33.	I am ***trying*** to think of ways I might be able to contribute in life	0	1	2	3	4	5
34.	These days I am working on some things in life that are personally important to me	0	1	2	3	4	5
35.	I am working on important projects that give me a sense of purpose in life	0	1	2	3	4	5
Group 8		*Not at all true now*					*Completely true now*
36.	I can't do anything about my situation	0	1	2	3	4	5
37.	I'm ***starting*** to think I could do something to help myself	0	1	2	3	4	5
38.	I am ***starting*** to feel more confident about learning to live with the illness	0	1	2	3	4	5
39.	Sometimes there are setbacks, but I come back and keep trying	0	1	2	3	4	5
40.	I look forward to facing new challenges in life	0	1	2	3	4	5
Group 9		*Not at all true now*					*Completely true now*
41.	Others know better than I do what's good for me	0	1	2	3	4	5
42.	I want to ***start*** learning how to look after myself properly	0	1	2	3	4	5
43.	I am ***beginning*** to learn about mental illness and how I can help myself	0	1	2	3	4	5
44.	I now feel ***reasonably*** confident about managing the illness	0	1	2	3	4	5
45.	I can manage the illness well now	0	1	2	3	4	5
Group 10		*Not at all true now*					*Completely true now*
46.	I don't seem to have any control over my life now	0	1	2	3	4	5
47.	I want to ***start*** learning how to cope with the illness	0	1	2	3	4	5
48.	I am ***just starting*** to work towards getting my life back on track	0	1	2	3	4	5
49.	I am ***beginning*** to feel responsible for my own life	0	1	2	3	4	5
50.	I am in control of my own life	0	1	2	3	4	5

Appendix 6: Recovery Process Inventory (RPI)

Gender

☐ Male

☐ Female

Ethnicity

☐ Caucasian/White

☐ African American/Black

☐ Asian

☐ Native American/Indian

☐ Hispanic/Latino

☐ Other _____

Age

☐ 18-25 ☐ 26-35

☐ 36-55 ☐ 56-75

☐ 75+

What diagnosis have you received?

☐ Schizophrenia

☐ Bipolar disorder

☐ Schizoaffective disorder

☐ Dually diagnosed (substance use and mental illness)

☐ Major depression

☐ Anxiety disorder

☐ Other _____

Housing

☐ Private residence/household (lives alone, lives with family, supervised living)

☐ Homeless shelter ☐ On the street ☐ Jail or correctional facility

☐ Other residential or institutional setting (community care home, inpatient facility, nursing home)

Employment

☐ Employed (competitive full or part time or supportive full or part time)

☐ Unemployed but desiring work

☐ Not in workforce/not desiring to work (retired, volunteer unpaid family worker, adult student, home maker)

How long have you been receiving services from the South Carolina Department of Mental Health?

☐ <1 year ☐ 1-5 years ☐ 6-10 years ☐ 11-15 years ☐ 16-20 years ☐ 21-25 years ☐ 26+ years

Please indicate how much agreement or disagreement you have with the following statements. Your response is based on a 5 point scale with one (1) being I strongly disagree and five (5) being I strongly agree.		I strongly disagree 1	I disagree 2	I am neutral 3	I agree 4	I strongly agree 5
1.	I feel discriminated against or excluded from my community because of my mental illness.	1	2	3	4	5
2.	I feel lost and hopeless much of the time.	1	2	3	4	5
3.	I feel isolated and alone when I am with my family.	1	2	3	4	5
4.	I find places and situations where I can make friends.	1	2	3	4	5
5.	There is meaning and purpose to my life.	1	2	3	4	5
6.	I have a good, safe place to live.	1	2	3	4	5
7.	I ask for help from others when I need it.	1	2	3	4	5
8.	Fear doesn't stop me from living the way I want to.	1	2	3	4	5
9.	I feel isolated and alone much of the time.	1	2	3	4	5
10.	I am living in the kind of place I like.	1	2	3	4	5
11.	My family tries to control my treatment too much.	1	2	3	4	5
12.	I can be with people at church, temple, or a prayer meeting who understand my journey to recovery.	1	2	3	4	5
13.	I don't think that I will ever find the kind of place where I want to live.	1	2	3	4	5
14.	I have a positive outlook on life.	1	2	3	4	5
15.	No one would hire me to work for them.	1	2	3	4	5
16.	I trust myself to make good decisions and positive changes in my life.	1	2	3	4	5
17.	Even when I don't care about myself, other people do.	1	2	3	4	5
18.	I get on with my life when I have hope.	1	2	3	4	5
19.	I feel better when I know how to take care of myself.	1	2	3	4	5
20.	I feel more isolated when people around me pray for help.	1	2	3	4	5
21.	Other people are always making decisions about my life.	1	2	3	4	5
22.	I spend time with people to feel connected and better about myself.	1	2	3	4	5

Appendix 7: Recovery Oriented Systems Indicator Measure (ROSI) – Process form

Administering entity:

_____

Address:

_____

1. **ROSI measures completed**

a. ☐ Consumer self-report survey

b. ☐ Consumer self-report survey

2. **Date data collection began: (day/month/year)** ___/___/_____

   Date data collection ended: (day/month/year) ___/___/_____

3. **Type of process used to collect consumer self-report data (check all that apply and include the response rate, i.e., ___%, if applicable)**

a. ☐ Consumer self-administered (___%)

b. ☐ Mail administration (___%)

c. ☐ Phone administration (___%)

d. ☐ Face-to-face administration (___%)

e. ☐ Individual data collection (___%)

f. ☐ Group data collection (___%)

g. ☐ Program staff interviewers (___%)

h. ☐ Consumer interviewers (___%)

i. ☐ On-line data collection (___%)

j. ☐ Quality assurance interview (___%)

k. ☐ External evaluation interviewers (___%)

l. ☐ Other (___%)

4. **If a sample was used, what sample methodology was involved?**

a. ☐ Convenience sample

b. ☐ Random sample

c. ☐ Stratified sample

d. ☐ Other: _____

5. **Purpose for utilizing ROSI (check all that apply)**

a. ☐ Quality assurance activity

b. ☐ Program audit

c. ☐ Program evaluation

d. ☐ Research

e. ☐ Other: _____

6. **Provide any important feedback concerning the performance, usefulness, process, and findings based upon your use of the ROSI measures**

_____

7. **Contact information for a person knowledgeable about the survey process**

_____

Thank you!

Appendix 8: Recovery Oriented Systems Indicator Measure (ROSI) – Consumer survey

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

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

1.	There is at least one person who believes in me	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
2.	I have a place to live that feels like a comfortable home to me	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
3.	I am encouraged to use consumer-run programs (for example, support groups, drop-in centers, etc.)	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
4.	I **do not** have the support I need to function in the roles I want in my community	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
5.	I **do not** have enough good service options to choose from	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
6.	Mental health services helped me get housing in a place I feel safe	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
7.	Staff **do not** understand my experience as a person with mental health problems	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
8.	The mental health staff ignore my physical health	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
9.	Staff respect me as a whole person	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
10.	Mental health services have caused me emotional or physical harm	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
11.	I **cannot** get the services I need when I need them	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
12.	Mental health services helped me get medical benefits that meet my needs	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
13.	Mental health services led me to be more dependent, not independent	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
14.	I lack the information or resources I need to uphold my client rights and basic human rights	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
15.	I have enough income to live on	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me
16.	Services help me develop the skills I need	Strongly disagree	Disagree	Agree	Strongly agree	Does not apply to me

Section Two directions: Please read each statement and then circle the response that best represents your situation *during the past six months*. The responses range from 'Never/rarely' to 'Almost always/always.' If the statement was about something you did not experience, circle the last response 'Does Not Apply To Me.'

17.	I have housing that I can afford	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
18.	I have a chance to advance my education if I want to	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
19.	I have reliable transportation to get where I need to go	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
20.	Mental health services helped me get or keep employment	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
21.	Staff see me as an equal partner in my treatment program	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
22.	Mental health staff support my self-care or wellness	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
23.	I have a say in what happens to me when I am in crisis	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
24.	Staff believe that I can grow, change and recover	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
25.	Staff use pressure, threats, or force in my treatment	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
26.	There was a consumer peer advocate to turn to when I needed one	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
27.	There are consumers working as paid employees in the mental health agency where I receive services	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
28.	Staff give me complete information in words I understand before I consent to treatment or medication	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
29.	Staff encourage me to do things that are meaningful to me	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
30.	Staff stood up for me to get the services and resources I needed	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
31.	Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc)	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
32.	Staff listen carefully to what I say	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
33.	Staff lack up-to-date knowledge on the most effective treatments	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
34.	Mental health staff interfere with my personal relationships	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
35.	Mental health staff help me build on my strengths	Never/rarely	Sometimes	Often	Almost	Does not apply to me

36.	My right to refuse treatment is respected	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
37.	My treatment plan goals are stated in my own words	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
38.	The doctor worked with me to get on medications that were most helpful for me	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
39.	I am treated as a psychiatric label rather than as a person	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
40.	I can see a therapist when I need to	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
41.	My family gets the education or supports they need to be helpful to me	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me
42.	I have information or guidance to get the services and supports I need, both inside and outside my mental health agency	Never/rarely	Sometimes	Often	Almost always/always	Does not apply to me

Section Three directions: Are there other issues related to how services help or hinder your recovery? Please explain.

Section Four directions: We are asking you to provide the following information in order for us to be able to have a general description of participants taking this survey. Please check the answer that best fits your response to the question or write in the answer in the line provided. Only answer those items you wish to answer. Please do not write your name or address on this survey. This keeps your identity confidential.

1. What is your gender? a. ☐ Female b. ☐ Male

2. What is your age? _____

3. What is your racial or ethnic background? (Check the one that applies best)

a. ☐ American Indian / Alaska native
b. ☐ Asian
c. ☐ Black or African American
d. ☐ Native Hawaiian/ Other Pacific Islander
e. ☐ White / Caucasian
f. ☐ More than one race
g. ☐ Other _____

Do you consider yourself Hispanic or Latino/a? a. ☐ Yes b. ☐ No

4. Your level of education is: (Check the highest level your reached or are currently in)

a. ☐ Less than high school
b. ☐ High school/GED
c. ☐ College/Technical training
d. ☐ Graduate school
e. ☐ Other _____

5. How long have you been receiving mental health services?

a. ☐ Less than 1 year
b. ☐ 1 to 2 years
c. ☐ 3 to 5 years
d. ☐ More than 5 years

6. Which services have you used in the past six months? (Check all that apply)

a. ☐ Counselling/psychotherapy
b. ☐ Housing/residential services
c. ☐ Medication management
d. ☐ Self-help/consumer run service
e. ☐ Assertive Community Treatment (ACT)
f. ☐ Psychosocial rehabilitation
g. ☐ Employment/vocational services
h. ☐ Alcohol/drug abuse treatment
i. ☐ Case management
j. ☐ Clubhouse
k. ☐ Other _____

7. The town, city or community you live in is mostly:

a. ☐ Urban
c. ☐ Rural

b. ☐ Suburban
d. ☐ Remote/frontier

8. What type of place do you live in?

a. ☐ Living in my own home or apartment
d. ☐ Living in a boarding house

b. ☐ Living in supervised/supported apartment
e. ☐ Homeless or homeless shelter

c. ☐ Living in a residential facility
f. ☐ Other: _____

9. Are you a person who currently has both mental health and substance abuse (alcohol, drug addiction) problems?

a. ☐ Yes
b. ☐ No

Appendix 9: Recovery Oriented Systems Indicator Measure (ROSI) – Administrative data profile: Authority characteristics

Authority: **Date:** ___/___/_____

_____

1. What is your organization's legal structure?

a. ☐ Public

b. ☐ Private nonprofit

c. ☐ Private for profit

d. ☐ Other: _____

2. Geographic location:

Country: _____

State/province: _____

3. What geographic area do you cover?

_____

_____

4. Geographic setting (check all that apply):

a. ☐ Urban

b. ☐ Small city

c. ☐ Suburban

d. ☐ Rural

e. ☐ Remote/frontier

5. How many providers of mental health services are in your network (unduplicated)? _____

6. How many providers of mental health services in your network provided data for this ROSI Administrative data profile? _____

7. What population do you serve? (check all that apply)

a. ☐ Children general mental health

b. ☐ Adult general mental health

c. ☐ Elderly general mental health

d. ☐ Children serious emotional disorders

e. ☐ Adult serious mental illness

f. ☐ Elderly serious mental illness

g. ☐ Children substance abuse

h. ☐ Adult substance abuse

i. ☐ Other: _____

Appendix 10: Recovery Oriented Systems Indicator Measure (ROSI) – Administrative data profile: Mental health provider characteristics

Provider organization:_____ **Date:** ___/___/_____

1. What is your organization's legal structure?

a. ☐ Public
b. ☐ Private nonprofit
c. ☐ Private for profit
d. ☐ Other: _____

2. Geographic location:

Country: _____

State/province: _____

State/province: _____

3. Geographic setting (check all that apply):

a. ☐ Urban
b. ☐ Small city
c. ☐ Suburban
d. ☐ Rural
e. ☐ Remote/frontier

4. How many consumers does your organization serve in mental health services each year (unduplicated)? _____

5. How many full time equivalents (FTEs) do you have on staff who directly provide mental health services at this time? _____

6. Which mental health services do you provide at this time? (check all that apply)

a. ☐ Counseling/psychotherapy
b. ☐ Case management
c. ☐ Housing/residential services
d. ☐ Medication management
e. ☐ Self-help/Consumer run services
f. ☐ Psychosocial rehabilitation
g. ☐ Assertive Community Treatment (ACT)
h. ☐ Clubhouse
i. ☐ Alcohol/drug abuse treatment
j. ☐ Employment/vocational services
k. ☐ Other: _____

Appendix 11: Recovery Oriented Systems Indicator Measure (ROSI) – Administrative data profile

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

Performance Indicator: Free Standing Peer/Consumer Operated Programs

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

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

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

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

Performance Indicator: Peer/Consumer Operated Services Funding

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

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

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

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

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

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

Performance Indicator: Consumer Employment in Mental Health Systems

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

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

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

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

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

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

Performance Indicator: Advance Directives

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

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

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

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

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

Performance Indicator: Direct Care Staff to Client Ratio

Authority Measure 7: The ratio of direct care staff to clients in each local mental health provider agency.

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

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

Provider Version of Measure 7: The ratio of direct care staff to clients in the provider agency.

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

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

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

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

Performance Indicator: Recovery Oriented Mission Statement

Authority Measure 8: The state mental health authority's mission statement explicitly includes a recovery orientation. (Yes/No).

Authority Measure 9: The percentage of local mental health provider agencies whose mission statements explicitly include a recovery orientation.

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

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

Provider Version of Measure 9: Our agency's mission statement explicitly includes a recovery orientation. (Yes/No)

Performance Indicator: Consumer Involvement in Provider Contract Development

Authority Measure 10: The percentage of provider agency performance contracts that have primary consumer involvement in their development/yearly review (specifying services, outcomes, target numbers, etc).

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

Denominator: The total number of provider agency performance contracts.

Performance Indicator: Office of Consumer Affairs

Authority Measure 11: The percentage of staff in the state office of consumer affairs who are former or current consumers.

Numerator: The number state office of consumer affairs staff (unduplicated) who are disclosed consumers (former or current) during the reporting period.

Denominator: The total number of state office of consumer affairs staff (unduplicated) during the reporting period.

Authority Measure 12: The percentage of regional mental health offices/local mental health authorities (or equivalent) that have an office of consumer affairs.

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

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

Performance Indicator: Consumer Inclusion in Governance and Policy

Authority Measure 13: The percentage of state mental health authority planning council members who are primary consumers.

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

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

Authority Measure 14: The percentage of local mental health provider agency board membership that are primary consumers.

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

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

Provider Version of Measure 14: The percentage of our agency's board membership that are primary consumers.

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

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

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

Performance Indicator: Involuntary Inpatient Commitments

Authority Measure 15: The percentage of clients under involuntary commitments in public and private inpatient units.

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

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

Provider Version of Measure 15: The percentage of clients under involuntary commitments in inpatient units.

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

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

Performance Indicator: Involuntary Outpatient Commitments

Authority and Provider Measure 16: The percentage of clients under involuntary outpatient commitments.

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

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

MHSIP's Indicators on Seclusion

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

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

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

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

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

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

MHSIP's Indicators on Restraints

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

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

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

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

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

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

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

MHSIP's Proposed Indicator on Involvement in the Criminal/Juvenile Justice System

Add Authority Measure 21: The percentage of mental health catchment or service areas that have jail diversion services.

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

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

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

MHSIP's Proposed Indicator on Reduced Substance Abuse Impairment

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

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

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

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

Performance Indicator: Trauma Service Provision

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

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

Provider Version of Measure 23: Trauma services are available in our community for mental health consumers. (Yes/No)

Appendix 12: Recovery Self Assessment (RSA) – Person in recovery version

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of your agency.

		1 Strongly disagree	2	3	4	5 Strongly agree	
1.	Staff focus on helping me to build connections in my neighborhood and community	1	2	3	4	5	N/A
2.	This agency offers specific services and programs to address my unique culture, life experiences, interests, and needs	1	2	3	4	5	N/A
3.	I have access to all my treatment records	1	2	3	4	5	N/A
4.	This agency provides education to community employers about employing people with mental illness and/or addictions	1	2	3	4	5	N/A
5.	My service provider makes every effort to involve my significant others (spouses, friends, family members) and other sources of natural support (i.e., clergy, neighbors, landlords) in the planning of my services, if this is my preference	1	2	3	4	5	N/A
6.	I can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom I work	1	2	3	4	5	N/A
7.	Most of my services are provided in my natural environment (i.e., home, community, workplace)	1	2	3	4	5	N/A
8.	I am given the opportunity to discuss my sexual and spiritual needs and interests	1	2	3	4	5	N/A
9.	Staff of this agency regularly attend trainings on cultural competency	1	2	3	4	5	N/A
10.	Staff at this agency listen to and follow my choices and preferences	1	2	3	4	5	N/A
11.	Staff at this agency help to monitor the progress I am making towards my personal goals on a regular basis	1	2	3	4	5	N/A
12.	This agency provides structured educational activities to the community about mental illness and addictions	1	2	3	4	5	N/A
13.	Agency staff do not use threats, bribes, or other forms of coercion to influence my behavior or choices	1	2	3	4	5	N/A
14.	Staff at this agency encourage me to take risks and try new things	1	2	3	4	5	N/A
15.	I am/can be involved with facilitating staff trainings and education programs at this agency	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
17.	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school	1	2	3	4	5	N/A
18.	This agency actively attempts to link me with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
19.	I am able to choose from a variety of treatment options at this agency (i.e., individual, group, peer support, holistic healing, alternative treatments, medical)	1	2	3	4	5	N/A
20.	The achievement of my goals is formally acknowledged and celebrated by the agency	1	2	3	4	5	N/A
21.	I am/can be routinely involved in the evaluation of the agency's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A
23.	Staff play a primary role in helping me to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education	1	2	3	4	5	N/A

24.	If the agency can not meet my needs, procedures are in place to refer me to other programs and services	1	2	3	4	5	N/A
25.	Staff actively assist me with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
26.	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests	1	2	3	4	5	N/A
27.	I am/can be a regular member of agency advisory boards and management meetings	1	2	3	4	5	N/A
28.	At this agency, participants who are doing well get as much attention as those who are having difficulties	1	2	3	4	5	N/A
29.	Staff routinely assist me in the pursuit of my educational and/or employment goals	1	2	3	4	5	N/A
30.	I am/can be involved with agency staff on the development and provision of new programs and services	1	2	3	4	5	N/A
31.	Agency staff actively help me become involved with activities that give back to my community (i.e., volunteering, community services, neighborhood watch/cleanup)	1	2	3	4	5	N/A
32.	This agency provides formal opportunities for me, my family, service providers, and administrators to learn about recovery	1	2	3	4	5	N/A
33.	The role of agency staff is to assist me, and other people in recovery with fulfilling my individually-defined goals and aspirations	1	2	3	4	5	N/A
34.	Criteria for exiting or completing the agency were clearly defined and discussed with me upon entry to the agency	1	2	3	4	5	N/A
35.	The development of my leisure interests and hobbies is a primary focus of my services	1	2	3	4	5	N/A
36.	Agency staff believe that I can recover and make my own treatment and life choices	1	2	3	4	5	N/A

Appendix 13: Recovery Self Assessment (RSA) – Family / significant other / advocate version

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of the agency from which you received this assessment.

		1 Strongly disagree	2	3	4	5 Strongly agree	
1.	Staff focus on helping people in recovery to build connections in their neighborhood and community	1	2	3	4	5	N/A
2.	This agency offers specific services and programs to address the unique culture, life experiences, interests, and needs of people in recovery	1	2	3	4	5	N/A
3.	People in recovery have access to all of their treatment records	1	2	3	4	5	N/A
4.	This agency provides education to community employers about employing people with mental illness and/or addictions	1	2	3	4	5	N/A
5.	Service providers at this agency makes every effort to involve significant others (spouses, friends, family members) and other sources of natural support (i.e., clergy, neighbors, landlords) in the planning of a person's services, if this is his/her preference	1	2	3	4	5	N/A
6.	People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work	1	2	3	4	5	N/A
7.	Most services are provided in a person in recovery's natural environment (i.e., home, community, workplace)	1	2	3	4	5	N/A
8.	People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests	1	2	3	4	5	N/A
9.	The staff of this agency regularly attend trainings on cultural competency	1	2	3	4	5	N/A
10.	Staff at this agency listen to and follow the choices and preferences expressed by people in recovery	1	2	3	4	5	N/A
11.	Staff at this agency help to monitor the progress towards a person in recovery's personal goals on a regular basis	1	2	3	4	5	N/A
12.	This agency provides structured educational activities to the community about mental illness and addictions	1	2	3	4	5	N/A
13.	Agency staff do not use threats, bribes, or other forms of coercion to influence the behavior or choices of people in recovery	1	2	3	4	5	N/A
14.	Staff at this agency encourage people in recovery to take risks and try new things	1	2	3	4	5	N/A
15.	People in recovery are/can be involved with facilitating staff trainings and education programs at this agency	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
17.	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school	1	2	3	4	5	N/A
18.	This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
19.	People in recovery can choose from a variety of treatment options at this agency (i.e., individual, group, peer support, holistic healing, alternative treatments, medical)	1	2	3	4	5	N/A
20.	The achievement of a person in recovery's goals is formally acknowledged and celebrated by the agency	1	2	3	4	5	N/A
21.	People in recovery are/can be routinely involved in the evaluation of the agency's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A

23.	Staff play a primary role in helping people in recovery to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education	1	2	3	4	5	N/A
24.	If the agency can not meet a person in recovery's needs, procedures are in place to refer him/her to other programs and services	1	2	3	4	5	N/A
25.	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
26.	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests	1	2	3	4	5	N/A
27.	People in recovery are/can be a regular member of agency advisory boards and management meetings	1	2	3	4	5	N/A
28.	At this agency, participants who are doing well get as much attention as those who are having difficulties	1	2	3	4	5	N/A
29.	Staff routinely assist people in recovery in the pursuit of their educational and/or employment goals	1	2	3	4	5	N/A
30.	People in recovery are/can be involved with agency staff on the development and provision of new programs and services	1	2	3	4	5	N/A
31.	Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup)	1	2	3	4	5	N/A
32.	This agency provides formal opportunities for people in recovery, family and significant others, service providers, and administrators to learn about recovery	1	2	3	4	5	N/A
33.	The role of agency staff is to assist people in recovery with fulfilling their individually-defined goals and aspirations	1	2	3	4	5	N/A
34.	Criteria for exiting or completing the agency are clearly defined and discussed with people in recovery upon entry to the agency	1	2	3	4	5	N/A
35.	The development of a person in recovery's leisure interests and hobbies is a primary focus of services	1	2	3	4	5	N/A
36.	Agency staff believe that people can recover and make their own treatment and life choices	1	2	3	4	5	N/A

Appendix 14: Recovery Self Assessment (RSA) – Provider version

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of your agency.

		1 Strongly disagree	2	3	4	5 Strongly agree	
1.	Helping people build connections in their neighborhoods and communities is one of the primary activities in which staff at this agency are involved	1	2	3	4	5	N/A
2.	This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs	1	2	3	4	5	N/A
3.	People in recovery have access to all of their treatment records	1	2	3	4	5	N/A
4.	This agency provides education to community employers about employing people with mental illness and/or addictions	1	2	3	4	5	N/A
5.	Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbors, landlords) in the planning of a person's services, if so desired	1	2	3	4	5	N/A
6.	People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work	1	2	3	4	5	N/A
7.	Most services are provided in a person's natural environment (i.e., home, community, workplace)	1	2	3	4	5	N/A
8.	People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests	1	2	3	4	5	N/A
9.	All staff at this agency regularly attend trainings on cultural competency	1	2	3	4	5	N/A
10.	Staff at this agency listen to and follow the choices and preferences of participants	1	2	3	4	5	N/A
11.	Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis	1	2	3	4	5	N/A
12.	This agency provides structured educational activities to the community about mental illness and addictions	1	2	3	4	5	N/A
13.	Agency staff do not use threats, bribes, or other forms of coercion to influence the behavior or choices	1	2	3	4	5	N/A
14.	Staff and agency participants are encouraged to take risks and try new things	1	2	3	4	5	N/A
15.	Persons in recovery are involved with facilitating staff trainings and education programs at this agency	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
17.	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school	1	2	3	4	5	N/A
18.	This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
19.	This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose	1	2	3	4	5	N/A
20.	The achievement of goals by people in recovery is formally acknowledged and celebrated by the agency	1	2	3	4	5	N/A
21.	People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A
23.	Staff play a primary role in helping people in recovery to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education	1	2	3	4	5	N/A

24.	Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs	1	2	3	4	5	N/A
25.	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
26.	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests	1	2	3	4	5	N/A
27.	People in recovery are regular members of agency advisory boards and management meetings	1	2	3	4	5	N/A
28.	At this agency, participants who are doing well get as much attention as those who are having difficulties	1	2	3	4	5	N/A
29.	Staff routinely assist individuals in the pursuit of their educational and/or employment goals	1	2	3	4	5	N/A
30.	People in recovery work along side agency staff on the development and provision of new programs and services	1	2	3	4	5	N/A
31.	Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup)	1	2	3	4	5	N/A
32.	This agency provides formal opportunities for people in recovery, family and significant others, service providers, and administrators to learn about recovery	1	2	3	4	5	N/A
33.	The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations	1	2	3	4	5	N/A
34.	Criteria for exiting or completing the agency are clearly defined and discussed with participants upon entry to the agency	1	2	3	4	5	N/A
35.	The development of a person's leisure interests and hobbies is a primary focus of services	1	2	3	4	5	N/A
36.	Agency staff believe that people can recover and make their own treatment and life choices	1	2	3	4	5	N/A

Appendix 15: Recovery Self Assessment (RSA) – CEO/Agency director version

Please indicate the degree to which you feel the following items reflect the activities, values, and practices of your agency.

		1 Strongly disagree	2	3	4	5 Strongly agree	
1.	Helping people build connections in their neighborhoods and communities is one of the primary activities in which staff at this agency are involved	1	2	3	4	5	N/A
2.	This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs	1	2	3	4	5	N/A
3.	People in recovery have access to all of their treatment records	1	2	3	4	5	N/A
4.	This agency provides education to community employers about employing people with mental illness and/or addictions	1	2	3	4	5	N/A
5.	Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbors, landlords) in the planning of a person's services, if so desired	1	2	3	4	5	N/A
6.	People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work	1	2	3	4	5	N/A
7.	Most services are provided in a person's natural environment (i.e., home, community, workplace)	1	2	3	4	5	N/A
8.	People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests	1	2	3	4	5	N/A
9.	All staff at this agency regularly attend trainings on cultural competency	1	2	3	4	5	N/A
10.	Staff at this agency listen to and follow the choices and preferences of participants	1	2	3	4	5	N/A
11.	Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis	1	2	3	4	5	N/A
12.	This agency provides structured educational activities to the community about mental illness and addictions	1	2	3	4	5	N/A
13.	Agency staff do not use threats, bribes, or other forms of coercion to influence the behavior or choices	1	2	3	4	5	N/A
14.	Staff and agency participants are encouraged to take risks and try new things	1	2	3	4	5	N/A
15.	Persons in recovery are involved with facilitating staff trainings and education programs at this agency	1	2	3	4	5	N/A
16.	Staff are knowledgeable about special interest groups and activities in the community	1	2	3	4	5	N/A
17.	Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school	1	2	3	4	5	N/A
18.	This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs	1	2	3	4	5	N/A
19.	This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose	1	2	3	4	5	N/A
20.	The achievement of goals by people in recovery is formally acknowledged and celebrated by the agency	1	2	3	4	5	N/A
21.	People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers	1	2	3	4	5	N/A
22.	Staff use a language of recovery (i.e., hope, high expectations, respect) in everyday conversations	1	2	3	4	5	N/A
23.	Staff play a primary role in helping people in recovery to become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education	1	2	3	4	5	N/A

24.	Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs	1	2	3	4	5	N/A
25.	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization	1	2	3	4	5	N/A
26.	Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests	1	2	3	4	5	N/A
27.	People in recovery are regular members of agency advisory boards and management meetings	1	2	3	4	5	N/A
28.	At this agency, participants who are doing well get as much attention as those who are having difficulties	1	2	3	4	5	N/A
29.	Staff routinely assist individuals in the pursuit of their educational and/or employment goals	1	2	3	4	5	N/A
30.	People in recovery work along side agency staff on the development and provision of new programs and services	1	2	3	4	5	N/A
31.	Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup)	1	2	3	4	5	N/A
32.	This agency provides formal opportunities for people in recovery, family and significant others, service providers, and administrators to learn about recovery	1	2	3	4	5	N/A
33.	The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations	1	2	3	4	5	N/A
34.	Criteria for exiting or completing the agency are clearly defined and discussed with participants upon entry to the agency	1	2	3	4	5	N/A
35.	The development of a person's leisure interests and hobbies is a primary focus of services	1	2	3	4	5	N/A
36.	Agency staff believe that people can recover and make their own treatment and life choices	1	2	3	4	5	N/A

Appendix 16: Recovery Oriented Practices Index (ROPI)

The item narrative and 5 behaviorally anchored scale points are meant to serve as a guide for scoring a program on the principle represented in each item. However, it is impossible to anticipate all circumstances and characteristics that may be displayed by a program. For those cases in which a particular program does not fit into any of the scale points provided, use the following general instructions for scoring the item (adapted from the Quality of Supported Employment Implementation Scale):

5 = Full and complete adherence to all components of the principle stated in the item narrative
4 = A close approximation to the principle, but falls short on 1 or more of the necessary components
3 = A significant departure from the principle, but nonetheless partially embodies the necessary components
2 = Very little presence of the principle
1 = Absence of the principle

1. *Meeting Basic Needs* – Indicating that the assessment, planning and delivery of all services should first address basic needs. Services should include assistance in these areas:

___1) *Shelter* – program has relationships with housing providers and has placed clients in housing through referrals; housing services are a basic component of care and not merely addressed in isolated situations. (Respondent should discuss role of housing in care.)
___2) *Food* – program routinely provides clients with help locating resources for food. (This is reflected in detailed knowledge of soup kitchens and food pantries and other resources in the community. Lack of such knowledge indicates the service isn't being provided and thus credit should not be given.)
___3) *Medical* – program assesses medical issues of clients, makes referrals to medical providers when necessary, and follows-up on clients with any medical difficulties. (Ask about two clients with significant medical issues and how program facilitated care.)
___4) *Entitlements* – program assists with entitlements for all clients that need them.
___5) *Clothing* – program provides clients with help locating resources for clothing, such as community organizations and thrift shops in the community. (Respondent must identify such resources or no credit is given.)

	1	2	3	4	5
1a. Assessments – assessment should cover basic needs in detail.	Assessments do not cover any basic needs, including shelter, food, medical care, entitlements, and clothing	Assessments typically (>60%) address basic needs in a cursory fashion (e.g., brief description of current housing or some assessment of medical issues)	Assessments typically (>60%) cover 1 or 2 basic needs in detail	Assessments typically (>60%) cover 3 or 4 basic needs in detail	Assessments typically (>60%) cover all 5 areas in detail
1b. Services – services related to basic needs should be provided routinely.	Program routinely provides 1 or no services related to basic needs	Program routinely provides 2 services related to basic needs	Program routinely provides 3 services related to basic needs	Program routinely provides 4 services related to basic needs	Program routinely provides all 5 services related to basic needs

2. Comprehensive services – Indicating that a range of treatment services (medication, vocational, family-based, substance abuse, wellness, counseling, trauma) using different modalities (individual, group, peer) should be provided by the team, including the following:

___1) *Medication* – program provides prescriptions, medications, and delivery of medications.

___2) *Vocational* – program provides a range of proactive employment services, including job assessment, development, placement, coaching, and ongoing supports. (If program only assesses job needs and provides some coaching, then it doesn't pass for this indicator; there should be evidence of active job assistance that has resulted in at least 1 job placement.)

___3) *Substance abuse* – program provides both individual and group substance abuse counseling for clients. (No credit given if there is no group treatment.)

___4) *Counseling* – program provides individual counseling and symptom management. (Respondent should identify an instance in which counseling or psychotherapeutic intervention was provided to address a specific client difficulty. For example, helping a client suffering from panic symptoms overcome fears related to leaving the house.)

___5) *Family-based treatment* – program provides services to families designed to engage them in clients' treatment as demonstrated by frequent collateral visits with clients' families. (This should include frequent visits with collaterals and family-based groups run by the team. If one or the other is not present, no credit is given.)

___6) *Trauma services* – program assesses and provides services related to trauma for clients in need of such services. (This should include proactive efforts to identify clients suffering from trauma and targeted interventions to address it. Respondent should be able to identify at least two instances in which the team addressed an issue related to trauma.)

___7) *Wellness management* – program provides services designed to help clients manage their own symptoms and achieve valued personal goals. (This should include a group or use of a curriculum designed to promote clients ability to manage their symptoms. In the absence of a group or curriculum, no credit is given.)

	1	**2**	**3**	**4**	**5**
2a. Services– program should provide services in each of the above areas.	Program provides at least 2 of the services as part of routine care	Program provides 3 of the services as part of routine care	Program provides 4-5 of the services as part of routine care	Program provides 6 of the services as part of routine care	Program provides all 7of the services as part of routine care

3. Customization and choice – Indicating that the planning and delivery of all services should be designed to address the unique circumstances, history, needs, expressed preferences, and capabilities of each consumer

	1	2	3	4	5
3a. Program documentation – program documentation should identify consumer choice as a fundamental principle of program philosophy.	Program documentation and brochures contain no mention of consumer choice		Program brochures and documentation refer to consumer choice but do not make it cornerstone of expressed program philosophy		Program brochures and documentation make clear that consumer choice is a fundamental principle guiding policies, procedures, and services
3b. Service planning – service planning should reflect individualized client goals, with substantial variation across charts.	Treatment plans are boilerplate, with minimal to no variation across charts	Treatment plans show minimal variation in treatment goals, with 90% of charts having at least 1 similar or identical goal (for example, psychiatric stabilization, med adherence)	Treatment plans show moderate degree of variation in treatment goals, with 50-80% of charts having at least 1 similar or identical goal	Treatment plans show high degree of variation in treatment goals, with 20-49% of charts having at least one similar or identical goal	Treatment plans show substantial variation in treatment goals, with <20% of charts having at least 1 similar or identical goal in most recent treatment plan
3c. Services – services should show considerable variation across clients, reflecting efforts to address individual client needs.	Services show minimal to no variation across clients	Services show some variation (for example, some clients have an outside psychiatrist) but treatment is substantially the same across clients	Services show a moderate level of variation (e.g., substance abuse; some employment services)	Services show substantial variation (e.g., clients participate in a range of groups) but efforts to address unique needs of individual consumers are minimal	Services show substantial variation and active efforts are made to address unique client needs (*respondent should be able to identify at least 3 clients with services that are unique to them*)

4. Consumer involvement/participation – Indicating consumer involvement should be integral to the planning and delivery of all services and to the determination of policies and procedures for program operations. Program should also actively recruit consumers who are hired with equality in pay, benefits, and responsibilities.

	1	2	3	4	5
4a. Policies and formal mechanisms for consumer input – program has policy and formal mechanism for soliciting consumer input that has resulted in demonstrable changes in program policies, procedures, or services.	Program policies do not specifically address consumer involvement in program activities or operations and there is no formal mechanism for promoting consumer involvement	Program has policies regarding consumer involvement but no formal mechanism for promoting consumer involvement	Program has policy and formal mechanism for promoting consumer involvement but mechanism is cursory (e.g., yearly satisfaction survey) and has not significantly informed program development	Program has policy and formal mechanism for promoting consumer involvement that has resulted in at least one significant change to program services (*respondent must identify this change*)	In addition to 4, program has consumer advisory board or consumer on program's governing body
4b. Policies for consumer-directed service planning – program has policy and protocol for promoting consumer involvement and control over service planning processes.	Program has no policy or protocol regarding consumers' role in treatment planning		Program has policy but no protocol for consumer-directed service planning		Program has policy and protocol for consumer-directed service planning
4c. Staffing – program employs consumers in administrative and/or clinical staff positions at equal pay and with equal responsibility.	Program employs no consumers or consumers who are not equally paid		Program employs consumers in part-time positions or with limited responsibilities		Program employs consumers in full-time positions with equal pay and responsibilities

5. Network supports/community integration – Indicating there should be active efforts in the planning and delivery of services to involve environmental supports in the consumer's recovery and to promote community integration.

	1	2	3	4	5
5a. Services – Network supports – program makes active efforts to involve client's support system in client's treatment[1].	Fewer than 10% of clients have some member of their support network involved in treatment	11-20% of clients have some member of their support network involved in treatment	21-30% of clients have some member of their support network involved in treatment	31-40% of clients have some member of their support network involved in treatment	>41% of clients have some member of their support network involved in treatment

5b. Services to promote community integration include:

___1) Self-Help – program makes routine referral to self-help groups. (A list or detailed knowledge of self-help groups in team's immediate area should be readily available.)

___2) Non-mental Health Activities – program routinely facilitates clients' participation in non-mental health activities. (Respondent should be able to identify at least 3 instances in which clients were given assistance to participate in a desired activity, which may include educational, recreational or other pursuits. Group outings should not be counted toward this indicator)

___3) Vocational Services - program provides a range of proactive employment services, including job assessment, development, placement, coaching, and ongoing supports. (If program only assesses job needs and provides some coaching, then it doesn't pass for this indicator; there should be evidence of active job assistance that has resulted in at least 1 job placement.)

	1	2	3	4	5
5b. Services – Community integration – program provides a range of services designed to promote consumer's integration into community.	Program provides no services related to community integration		Program provides 1 service related to community integration	Program provides 2 services related to community integration	Program provides all 3 services related to community integration

[1] Involved is defined as having at least 1 visit or contact (by phone is okay) in last 2 months.

6. Strengths-based approach – Indicating that service delivery and planning should be fundamentally oriented toward consumer's strengths rather than deficits.

	1	2	3	4	5
6a. Assessment – program assessment form addresses consumer strengths in multiple areas.	Assessment form does not address consumer strengths		Assessment form includes one generic section on strengths		Assessment form addresses strengths in multiple areas of functioning
6b. Service planning – program service planning form integrates strengths into treatment goals.	Service planning form does not address role of consumer strengths		Service planning form includes one generic section on strengths		Service planning form promotes integration of strengths into the achievement of treatment goals
6c. Program documentation – program policies or brochures include documented goal of promoting consumer strengths.	Program has no documented goal of promoting a strengths-based approach		Program documentation includes mention of promoting consumer strengths but it is not basic to program philosophy		Program documentation evinces clear emphasis on consumer strengths as a basic principle of care

7. Client as source of control/self-determination – Indicating that the development of autonomous motivation and feelings of self-agency should be integral to the planning and delivery of all services, with minimal reliance on coercive treatment alternatives (e.g., rep payee, outpatient commitment orders, and involuntary hospitalization).

	1	2	3	4	5
7a. Representative payee – program should use rep payee to a minimal extent.	>41% of clients have the program as its rep payee	31-40% of clients have the program as its rep payee	21-30% of clients have the program as its rep payee	6-20% of clients have the program as its rep payee	<6% of clients have the program as its rep payee
7b. Outpatient commitment – program should minimally employ outpatient commitment.	Program has sought to *renew* the outpatient commitment orders of >80% of clients who have had AOT status in past 12 months	Program has sought to *renew* the outpatient commitment orders of 61-79% of clients who have had AOT status in past 12 months	Program has sought to *renew* the outpatient commitment orders of 50-60% of clients who have had AOT status in past 12 months	Program has sought to *renew* the outpatient commitment orders of 30-49% of clients who have had AOT status in past 12 months	Program has sought to *renew* the outpatient commitment orders of <30% of clients who have had AOT status in past 12 months
7c. Involuntary hospitalisation – program should minimally employ involuntary hospitalisation.	Involuntary hospitalizations are >21% of total # of hospitalizations in last 12 months	Involuntary hospitalizations are 16-20% of total # of hospitalizations in last 12 months	Involuntary hospitalizations are 11-15% of total # of hospitalizations in last 12 months	Involuntary hospitalizations are 5-10% of total # of hospitalizations in last 12 months	Involuntary hospitalizations are <5% of total # of hospitalizations in last 12 months

8. Recovery focus – indicating that services should be oriented toward life roles, client aspirations, and independence from services, including techniques for self-management of mental health symptoms, development of meaningful activities, and assistance with employment, parenthood, and romantic relationships.

	1	2	3	4	5
8a. Service plan – service plan should address individual goals related to life roles, client aspirations, and relationships.	<20% of service plans include one goal related to life roles, client aspirations, or relationships	21-40% of service plans include one goal related to life roles, client aspirations, or relationships	41-60% of service plans include one goal related to life roles, client aspirations, or relationships	61-80% of service plans include one goal related to life roles, client aspirations, or relationships	>80% of service plans include one goal related to life roles, client aspirations, or relationships
8b. Services – program provides services designed specifically to promote participation in life roles, to achieve valued goals and aspirations, to self-manage illness, and to enhance relationships with others.	Approximately <10% of total service provided is designed to address life roles, client aspirations, self-management of illness, or improving relationships (e.g., one group on goals or illness management)	10-20% of total service provided is designed to address life roles, client aspirations, self-management of illness, or improving relationships	21-30% of total service provided is designed to address life roles, client aspirations, self-management of illness, or improving relationships	31-40% of total service provided is designed to address life roles, client aspirations, self-management of illness, or improving relationships	>50% of total service provided is designed to address life roles, client aspirations, self-management of illness, or improving relationships
8c. Training – program provides routine training to all staff in topics relevant to recovery-oriented practice (e.g., recovery philosophy or person-centered treatment planning.	Program has provided no training in the last year on a topic related to recovery		Program has provided training on recovery, empowerment, or person-centered treatment planning within the last year		Program provides training on a topic related to recovery, empowerment, or person-centered treatment planning as a part of orientation for each staff person

Appendix 17: Recovery Promotion Fidelity Scale (RPFS)

Items by Recovery Domain	0	1	2	3	4	Bonus
Collaboration 1. Satisfaction Survey	Agency has never distributed a survey to persons in recovery	Agency has distributed survey to all persons in recovery at least once in past 5 years	Agency distributes survey to all persons in recovery at least bi-annually	Agency distributes survey to persons in recovery at least annually	Agency distributes survey to all persons in recovery at least semi-annually	1 point if an annual report based on survey results has been issued and acted upon
Collaboration 2. Integration of suggestions from persons in recovery into service improvement efforts[a]	Agency has a mechanism for persons in recovery to provide anonymous suggestions	Agency has 2 service improvement mechanisms in place	Agency has 3 service mechanisms in place	Agency has 4 service improvement mechanisms in place	Agency has 5 or more service improvement mechanisms in place	N/A
Participation and acceptance 3. Involvement of persons in recovery on agency committees	Persons in recovery are not members on any (0%) committees	Persons in recovery are members on 1-25% of committees	Persons in recovery are members on 26-50% of committees	Persons in recovery are members on 51-75% of committees	Persons in recovery are members on at least 76% of committees	1 point if >2 persons in recovery on each committee; 1 point if person in recovery chairs or co-chairs ≥1 committee
Participation and acceptance 4. Employment of persons in recovery within agency[a]	None of the criteria are met	Agency meets both criteria	Agency meets all 3 criteria	Agency meets all 4 criteria	Agency meets all 5 criteria	N/A
Self-determination and peer support 5. Advocate for persons in recovery on agency staff	No paid or volunteer advocate on staff	Part-time, paid or volunteer person who is not in recovery serves as an advocate	Full- or part-time, volunteer, identified person in recovery serves as an advocate	Part-time, paid, identified person in recovery serves as an advocate	Full-time, paid, identified person in recovery serves as an advocate	N/A
Self-determination and peer support 6. Individualized recovery plans[a]	≤20% of recovery plans are individualized	21-40% of recovery plans are individualized	41-60% of recovery plans are individualized	61-80% of recovery plans are individualized	81-100% or recovery plans are individualized	N/A
Self determination and peer support 7. Consumer-Provider (C-P) representation on recovery teams	No C-P members on any recovery teams	At least 1 C-P member on at least 1 recovery team	≥2 C-P members on at least 1 recovery team	≥50% of recovery teams have ≥2 C-P members; or ≥80% have ≥1 C-P member	100% of recovery teams have ≥2 C-P members	N/A

Items by Recovery Domain	0	1	2	3	4	Bonus
Quality improvement 8. Promotion of recovery philosophy[a]	No recovery-driven vision/mission statement, posted or otherwise	Agency has a recovery-driven vision/mission statement, but it is not posted	Agency has a recovery-driven vision/mission statement that is posted	Agency meets 3 criteria	Agency meets 4 criteria	N/A
Quality improvement 9. Recovery-driven quality improvement (QI) goals/processes	No recovery-driven QI goals/processes in place	Recovery-driven goals/processes in place that were developed without input from persons in recovery	Recovery-driven QI goals/processes in place that were developed with input from persons in recovery, but have not been distributed to stakeholders	Recovery-driven QI goals/processes in place that were developed with input from persons in recovery and distributed only to stakeholders who are not in recovery	Recovery-driven QI goals/processes in place that were developed with input from persons in recovery and distributed to all stakeholders	N/A
Development 10. Recovery training of staff	No formal recovery training offered to staff	Recovery training has been made available to all staff, but it is not required	Recovery training required of only new staff at some point during employment	Recovery training required of all new and existing staff at some point during employment	All new staff are trained on recovery within 30 days from hire and all staff receive continuing education at least bi-annually	N/A
Development 11. Recovery knowledge of agency leaders and staff	No staff can explain recovery concept and why it is a guiding principle	1 staff can explain recovery concept and why it is a guiding principle	2 staff can explain recovery concept and why it is a guiding principle	3 staff can explain recovery concept and why it is a guiding principle	≥4 staff can explain recovery concept and why it is a guiding principle	N/A
Development 12. Recovery training for persons in recovery	≤20% of persons in recovery receive recovery education at least annually	21-40% of persons in recovery receive recovery education at least annually	41-60% of persons in recovery receive recovery education at least annually	61-80% of persons in recovery receive recovery education at least annually	81-100% of persons in recovery receive education at least annually	1 point if recovery education is conducted by peer specialist(s)

a. Details pertaining to scoring criteria are delineated in the RPFS Administration Manual, available from the authors