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**Improving Outcomes by Enhancing  
Caseworker - Consumer Interactions**

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## ABOUT THE OUTCOMES INSTRUMENTS

### **Overview**

*“The Ohio Mental Health Consumer Outcomes System is an ongoing endeavor to obtain outcome measures for consumers served by Ohio’s public mental health system.”*

Recognizing the lack of a statewide system of data for consumer outcomes as an indicator of quality, Michael F. Hogan, Ph.D., Director of the Ohio Department of Mental Health convened the Ohio Mental Health Outcomes Task Force (OTF) on September 12, 1996. The OTF, consisting of consumers, family members, providers, boards, researchers, evaluators, and staff from the Department of Mental Health and the Department of Alcohol and Drug Abuse, was asked to recommend to ODMH “a standard, statewide, ongoing approach to measuring outcomes for consumers served by Ohio’s public mental health system” (The Ohio Mental Health Consumer Outcomes System Procedure Manual, 1-2).

The OTF submitted its final report, *Vital Signs*, to Director Hogan on March 31, 1998. These efforts were followed by the development of the Outcomes Implementation Pilot Coordinating Group (OIPCG) that planned and conducted a consumer outcomes implementation pilot. Lake County, Stark County and an adult provider in Columbiana County volunteered to be the sites for the consumer outcomes pilot. The pilot sites collected data from November 1998 through the spring of 1999. Based on the experiences of the pilot sites, the OIPCG made final recommendations to Director Hogan in December 1999.

### **Defining Outcomes**

The OTF defines consumer outcomes as “indicators of health or well-being for an individual or family, as measured by statements or characteristics of the consumer/family, not the service system” (procedure manual 1-2). The Adult Consumer Form A (used by severely mentally disabled consumers) consists of four parts: Quality of Life, Safety and Health, Symptom Distress, and Function Status. These domains will be discussed in greater detail in Section D. The Adult Consumer Form B, a shorter version of the Adult A form is used for consumers with less severe illness, typically referred to as the “general mental health population.” Likewise, the Ohio Scales and/or CAFAS are used for children and their parents/guardians.

## ABOUT THE OUTCOMES INSTRUMENTS *continued...*

The Provider Adult Form A measures two OTF Domains—Functional Status and Safety and Health. This form gathers the provider’s observations and clinical judgments about a severely mentally disabled adult consumer’s level of social and role functioning, housing status, activities of daily living, criminal justice involvement, harmful behavior, and victimization.

### **Purpose**

The three main purposes for using consumer outcomes are (a) to manage consumer care, (b) to improve the service delivery system, and (c) to account for public resources. The primary focus of this manual is the management of consumer care. As stated in the Ohio Mental Health Consumer Outcomes System Procedure Manual, “consumer outcomes data provide additional information for individual consumers and clinicians to use in assessment and treatment planning. Baseline outcomes data help the consumer and clinician to identify a consumer’s strengths, needs, goals, and to show areas in which the clinician needs to advocate on behalf of the consumer. The comparison of a consumer’s baseline outcomes data with his/her outcomes and subsequent intervals indicates where changes have occurred in the consumer’s life and identifies aspects of the treatment plan that the consumer and clinician may need to revise (1-7).”

For many clinicians, this requires a shift in the manner in which treatment is provided. In order for the Outcomes System to be used effectively, the consumer must be involved in treatment decisions and the treatment planning process. The consumer, to the extent possible, will become more involved in his or her treatment and take ownership of his or her progress. The Outcomes System will provide consumers and clinicians with a tool to enhance the consumer’s recovery.

## UNDERSTANDING THE BASICS OF RECOVERY

### Psychiatric Rehabilitation Model

During the 1990s, a great deal of discussion occurred comparing the value of the Medical Model versus the Recovery Model of treatment. There has been a great deal written about the fact that people can get well after experiencing serious mental illness. One of the first people that effectively challenged this terminal goal of stabilization in the community was Dr. William Anthony who proposed the Rehabilitation View of Recovery.

Dr. Anthony contends that “people can regain some social functioning, despite having symptoms, limitations, medications, and remaining mentally ill.” Dr. Anthony believes that people should be absorbed in their personal recovery, which he defines as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limits caused by the illness (Anthony, 1993).

Dr. Anthony has identified eight basic assumptions for a recovery-focused mental health system:

- Recovery can occur with or without professional intervention.
- People can recover with the help of self-help groups, families and/or friends.
- Critical to one’s recovery is a person or persons in whom one can trust to be available in times of need.
- Recovering is a deeply human experience, built on trust and understanding, and can be everybody’s business.
- Recovery can occur even with individuals who experience intense psychiatric symptoms from time to time (episodically). The fact that a person has a “setback” does not mean that previous growth had no value. Setbacks, although frustrating, may provide the basis for the process of recovering.
- Being in the process of recovering helps to reduce the frequency and duration of symptoms.
- People can get better.
- Recovering from the consequences of the illness is sometimes more difficult than recovering from the illness itself. This is to say that the stigma of “being mentally ill” is real and sometimes overwhelming (1993).

## UNDERSTANDING THE BASICS OF RECOVERY *continued...*

### **Empowerment Model**

While Dr. Anthony views recovery as a process, Dr. Daniel Fisher, co-founder of the National Empowerment Center, believes that full recovery is possible for everyone. He states that, “recovery is possible through a combination of supports needed to (re) establish a major social role and the self-management skills needed to take control of the major decisions affecting oneself” (Fisher, 1998). Dr. Fisher calls this viewpoint the Empowerment Vision. He proposes that people are labeled with mental illness through a combination of severe emotional distress and insufficient social supports/resources/coping skills to maintain the major social roles expected of them during a particular phase in their life.

Dr. Fisher says that the degree of interruption in a person’s social role is more important in affixing the label of mental illness to someone than his or her diagnosis. As such, the goal of treatment is to assist people in gaining greater control of their lives and regaining a valued role in society.

The combination of social supports and self-management help the person regain a meaningful role in society and the sense of being a whole person. He further points out that self-help and peer support are fundamental elements in the journey of recovery since the only people who truly understand the feeling of exclusion are those who have been labeled themselves.

### **The Emerging Best Practices in Mental Health Recovery Process**

In 1994, the ODMH Office of Consumer Services began working with consumers, family members, providers, and Board staff to develop a tool for caseworkers/clinicians and consumers to use to help guide the recovery process. In 1999, the *Emerging Best Practices in Mental Health Recovery* Book and training materials were developed. Furthermore, ODMH developed its guiding definition of recovery as “the process of overcoming the negative impact of a psychiatric disorder despite its continued presence.”

# DIRECT SERVICE STAFF



More about mental health recovery can be found at the following web sites:

- Boston Center for Psychiatric Rehabilitation  
<http://www.bu.edu/sarpsych/>
- National Empowerment Center  
<http://www.power2u.org/>
- National Mental Health Consumers' Self Help Clearinghouse  
<http://www.mhselfhelp.org/>
- Mental Health Recovery  
<http://www.mentalhealthrecovery.com/>
- ODMH Emerging Best Practices in Recovery  
<http://www.mh.state.oh.us>

# USING OUTCOMES TO FOCUS ON RECOVERY

## **Introduction**

Regardless of whether one believes that recovery is an ongoing process or that one can fully recover from mental illness, it's important to note that recovery-focused treatment produces more positive outcomes for the consumer. In particular, the more that consumers feel their needs are being met and that they are empowered in their treatment setting, the more positive their treatment outcomes (Ohio Department of Mental Health Longitudinal Consumer Outcomes Study, 1999).

There are a number of ways, both formal and informal, that the Ohio Outcomes process can be used to focus on recovery in the treatment environment. Some of these are discussed below.

## **Recognizing the Consumer as a Member of the Treatment Team**

As a clinician, there are a number of things that you can do with consumers to use their outcomes to focus on recovery. First, involve consumers in the entire outcomes and treatment planning process. Engage in conversations with the consumer in which you can seek their input and provide your own. In order for recovery to occur, consumers have to believe that their thoughts and opinions about their outcomes results and goals are just as important as yours. The more a consumer is involved, the more ownership he/she will take and the more empowerment he/she will experience.

Second, acknowledge that consumers can contribute to their treatment. Focus on what consumers are capable of doing rather than what they are not capable of doing. Recognize that, as the clinician, you can learn from consumers just as the consumers can learn from you.

Third, trust is a two-way street. In order for consumers to trust you, they must believe that you trust them. If consumers view their relationship with you as one where you have more power, it is less likely that they will place their trust in you. If this occurs, consumers will continue to rely on you to complete tasks that they would otherwise complete and their recovery will be hindered.

Finally, in order to effectively facilitate recovery, the clinician must enter into a partnership with the consumer. As with any valued partnership, the workload in which one takes responsibility depends upon the circumstances in one's life. As such, consumers who are new to treatment may need more assistance from their clinicians than consumers who have moved further along their recovery journey.

### **The Outcomes Results Reports**

To date, there are three standardized Outcomes Results Reports that the clinician can use to promote consumer recovery: (1) Summary of Client's Responses, (2) Red Flag Report, and (3) Client Trajectory Report. Also, item and subscale scores can be used as a barometer of the recovery process.

- **Summary of Client's Responses:** The Summary of Client's Responses report is a series of charts that produce an outcomes profile for an individual consumer. This report shows a consumer's response to each item of the outcomes instrument for the two most recent administrations. The report organizes the presentation of the items by domain. The report can help the consumer and clinician to visually compare a consumer's responses to identify the consumer's current strengths, needs and areas of improvement or lack of improvement. The consumer and clinician can use this information to collaborate on developing or revising the treatment plan as needed.
- **Red Flag Report:** This report is a list of all of the items on the Summary of Client's Responses Report that had a double negative or negative response rating. The consumer and clinician can use this information for treatment planning, if they are mutually deciding on the areas in need of attention and if the consumer is setting self-determined goals.
- **Client Trajectory Report** (known as the Multiple Report in the Data Entry Template): This is a set of graphs with trend lines that plot an individual consumer's responses across time for each administration of the outcomes instrument. These graphs help the consumer and clinician to see change in the consumer's outcomes over time. This information can help the consumer and clinician revise the treatment plan as needed (procedure manual, 3-14,15).

## USING OUTCOMES TO FOCUS ON RECOVERY *continued...*

### **Helping the Consumer Move Along the Continuum of Recovery**

In order to ensure the system and the individual caseworker/clinician have a way of planning for recovery that supports making progress in each of the areas defined in the outcomes survey, it's important to have an organized construct to use. One such construct is Emerging Best Practices in Mental Health Recovery (ODMH 1999), a tool developed by ODMH with the assistance of consumers, family members, agency, and Board staff.

The Emerging Best Practices in Mental Health Recovery approach proposes that individuals recovering from mental illness move from a state of dependence to interdependence and that they are either aware or unaware of their illness. The Best Practices approach accounts for a consumer's movement and degree of awareness within and across the following four stages:

- Dependent/Unaware
- Dependent/Aware
- Independent/Aware
- Interdependent/Aware

The Best Practices approach also identifies the following nine essential components that are needed in order for a community to provide effective services and support.

- Clinical Care
- Family Support
- Peer Support & Relationships
- Work/Meaningful Activity
- Power & Control
- Stigma
- Community Involvement
- Access to Resources
- Education

These nine components match up well with the four domains of the Ohio Outcomes. The table on the following page illustrates how the domains match up with the nine essential components of effective community services.



**Consumer Form A: Domains Matched to Emerging Best Practices Components**

<b>Consumer Form A Domains:</b>	<b>Related Adult Form A Survey Question(s)*:</b>	<b>Related Provider Form A Survey Question(s)*:</b>	<b>Emerging Best Practices in Mental Health Recovery Components:</b>
Symptom Distress	17-31		Clinical Care
Quality of Life	1-12; 34-61		Family Support, Peer Support & Relationships, Power & Control, Stigma, and Community Involvement
Functional Status	5	1-5; 6A-6H; 7A-7F; 8-11	Work & Meaningful Activity
Safety & Health	8, 9, 11,13-16	9, 11, 12	Access to Resources, Stigma

*\* As identified in the Ohio Mental Health Consumer Outcomes System Procedure Manual (4th edition, September 2000)*

The clinician and the consumer can use the results of the consumer outcomes to identify strengths, weaknesses and to determine what aspect of life the consumer wants to work on. They can then go to the appropriate component in the Emerging Best Practices in Mental Health Recovery book (based on the table above) to identify the consumer’s current status and to identify the consumer’s corresponding goals. It is important to note that consumer goals should be measurable and observable. This information can then be used when developing the consumer’s treatment plan.

# USING OUTCOMES IN TREATMENT PLANNING

## Introduction

The consumer and clinician will use the outcomes results with differing goals. For the consumer, outcomes information can be used to empower himself/herself in the recovery process. By using the results of the self-assessment in the development of his or her treatment plan, the consumer takes ownership of the recovery process.

The clinician, on the other hand, will use the outcomes results to facilitate the consumer's recovery process. The consumer and clinician would typically use the responses to individual items, subscale scores and total scores in each instrument to develop and/or revise individual treatment plans. The outcomes results can also be used to discuss specific or immediate strengths or concerns.

## Asking the Consumer to Complete the Outcomes Instrument

When you ask the consumer to participate in the survey, use the following script. This does not have to be a word-for-word recitation of the script, but it should be close.

*The form I am asking you to complete is called the (insert name of particular instrument, as appropriate).*

*You and I (substitute the Provider of Record's name if it is not you) will use these ratings to plan your (or your child's) treatment, and to monitor your progress.*

*It will take you about (substitute appropriate amount) minutes to complete.*

The survey has questions about a number of areas that consumers (or, families of children in treatment) are concerned about. (You should then give a very brief overview of what is in the specific questionnaire.) The following paragraph is an example for the Adult surveys: The questionnaire will ask about how satisfied you are with various aspects of your life, your health and medications, how much you are distressed or bothered by symptoms, (for the Consumer Form A add: and your views on life and having to make decisions). Next, I will tell you about your rights as a participant in this survey.

*Do you have any questions at this point?*

*If you don't want to do this, or you don't feel well enough or alert enough to do it today, that's okay. If you're not sure, I'd like you to try answering a few items on the survey before making up your mind.*

### **Focusing on Specific Subsets of Outcomes for Treatment Planning**

The Adult Consumer Form A gathers perceptions of quality of life, effects of health on functioning, medication concerns, symptom distress, and recovery/empowerment from adults experiencing serious and persistent mental illness. These elements are collapsed into the following four domains:

- **Symptom Distress:** This domain looks at the symptoms that a person may experience from their illness and how much they interfere with his or her daily living.
- **Quality of Life:** This domain addresses questions such as: "how 'good' a person's life is?" and "if their needs are being met?". An important piece of this domain is to determine how much control a person has over the events in his or her life (empowerment).
- **Functional Status:** This domain identifies how well a person is doing in the community including areas such as work, school and social relationships.
- **Safety and Health:** This domain addresses how well a person is doing physically and the amount of freedom a person has from psychological harm from self and others.

## **USING OUTCOMES IN TREATMENT PLANNING** continued...

### **Assuring Consumer Input in the Treatment Plan**

In order for the outcomes results to be used effectively, the consumer and clinician must have a discussion based on both the consumer and provider reported outcomes. The LOC results suggest that consumers and providers don't always share the same opinion in terms of what the consumer most wants or needs. This being the case, effective treatment planning can only occur when the consumer and clinician discuss the outcomes results and develop a mutually agreed upon treatment plan. If consumers do not participate in the treatment plan, they have no stake in their treatment outcome. The outcomes results provide consumers with a structured tool that allows them to be more involved.

### **Using Specific Items in Treatment Planning**

The consumer and clinician can use the results of the three standardized reports (Summary of Client's Responses, Red Flag Reports, and when appropriate, Client Trajectory Report) to identify strengths and weaknesses. The treatment plan goals should focus on one or several of the items identified. Consumers, with the assistance of the clinician, can then identify specific and measurable goals for their recovery. A projected timeline for achieving these goals should be developed. Furthermore, consumers and clinicians should also identify what roles each is going to fulfill in the attempt to reach these goals. When appropriate, activities conducted by community supports should also be identified.

After obtaining the outcomes results, it may be beneficial to review the nine recovery components of the Emerging Best Practices in Mental Health Recovery to guide the process of developing a treatment plan. For example, if the outcomes results indicate social isolation, the clinician may use the "Community Involvement" component of the Best Practices book to help consumers identify reasonable goals for them to strengthen this area of life. This Best Practices book can also be used to identify necessary supports from the clinician or the community.



**Example of Treatment Plan Using Outcomes Data**

**Individualized Service Plan**

**Strengths/assets related to achieving treatment goals:**

Optimism about the future, positive feelings about self, computer skills, insight regarding illness

**Needs related to achieving treatment goals:**

Managing anxiety symptoms so they do not interfere with social or vocational goals

Date	No.	Goal	Steps/Methods	Services/Frequency	Responsible Staff
2/16/01	1	Find a job, while maintaining my benefits and managing my anxiety	Get benefits analysis to determine earnings/hours limits, as related to benefits	Benefits Counseling- 1-3 sessions	Vocational CSP Staff
			Determine work options, based on results of benefits analysis and vocational strengths and preferences	Vocational Assessment and Placement (2x's a week)	Vocational CSP Staff
			Continue to develop understanding and coping skills related to anxiety	Psychotherapy (2x's per month)	Counselor
Target Date 7/01			Continue to follow medication plan, and co-monitor with staff re: effectiveness	Medical/Somatic (1x every other month)	Psychiatrist

# USING OUTCOMES TO MONITOR THE COURSE OF TREATMENT

## **Introduction: Jointly Monitoring Recovery**

Monitoring a consumer's recovery is the responsibility of both the consumer and clinician. To the extent possible, depending upon the consumer's progress within his or her recovery, the consumer is responsible for taking actions that will help him/her obtain his or her goals. Likewise, the clinician must, with feedback from the consumer, identify where a consumer is within recovery and facilitate the monitoring process. For consumers who are new to the recovery process, the clinician may need to be more assertive and take the lead in the decision-making process. At some point, however, the emphasis on decision-making should be shifted to the consumer.

## **Techniques for Monitoring Recovery**

Presented below are a number of techniques that clinicians and consumers can use to monitor the consumer's progress in recovery.

- **Assessing progress toward goals:** A clinician can use information from the Client's Response Report for an individual consumer to show a consumer's response to each item of the outcomes instrument for the two most recent administrations. By graphing the results for each administration of the consumer outcomes measures, the consumer and clinician can see change or the lack of change. Also, the Summary of Client's Responses Report provides information for a consumer and clinician to make point-in-time comparisons of a consumer's outcomes with the outcomes for a group of similar consumers, or with established benchmarks. These point-in-time analyses provide information that the consumer and clinician can use to check the consumer's outcomes in relation to those of a similar group of consumers, and then to discuss revision of the treatment plan as needed (procedure manual, 3-14, 15).

This assessment should be based on the steps outlined to achieve the goals in the treatment plan. If progress isn't occurring as desired, the clinician and consumer may need to modify goals and/or add additional supports.



- **Use of change graphs:** The Client Trajectory Multiple Report displays scale and subscale scores by domain in a graphical format. These graphs help the consumer and clinician to see change in the consumer’s outcomes over time. This information can help the consumer and clinician revise the treatment plan as needed.
- **Monitoring for level of care changes:** With time, norms and benchmarking, adjusting for case mix will be available and agency administrators will be able to use outcomes data to retrospectively monitor and manage service utilization. As such, utilization review by boards and provider organizations could facilitate consumers’ use of mental health services in a cost efficient manner. Ultimately, consumer outcomes (especially functional status outcomes) can play a role in determining the level of care a consumer needs (procedure manual, 3-6.8).
- **Identifying deterioration:** Using statistical analysis to identify consumers whose outcomes scores are outliers, administrators can compare the consumer’s actual scores with the expected scores and review their current level of care and service utilization pattern. If there is a marked discrepancy between the actual and expected outcomes scores for a consumer, the administrator may recommend a change in the treatment plan to improve the consumer’s outcomes (procedure manual, 3-7).
- **Recognizing when treatment should end (or change):** While outcomes results can be used to identify deterioration for a consumer, they can also be used to determine when a consumer is ready to terminate a service or move to a less intense service environment. It’s important to note, however, that the decision to terminate or modify intensity of services has to be a joint decision between the clinician and the consumer. For example, a consumer who has been receiving case management may progress to the point of no longer needing case management, but would benefit from ongoing therapy.

## **LIMITATIONS AND CAUTIONS WITH THE USE OF THE OUTCOMES MEASURES**

### **Not a Diagnostic Tool**

The Outcomes Survey Data Report should not be used as a diagnostic tool. To provide adequate services, clinicians need to assess level of functioning and clinical symptomology more often and in more depth. In other words, outcomes scores alone are not sufficient for determining treatment needs. Instead, outcomes scores should be considered in context with other variables when making treatment decisions or comparisons.

### **Survey Conducted Less Frequently than Treatment Plans**

The Outcomes Survey is conducted at intake, after six months and then annually but the treatment plan is developed quarterly. Although the outcomes results should drive the treatment planning process, it's important to realize that significant changes may occur that need more immediate attention.

Because treatment plans are developed more frequently than the Outcomes Survey, it may be helpful to prioritize the results of the Outcomes Survey so that more immediate needs are addressed first. Less serious facets of the outcomes results can be addressed in subsequent treatment plans. Providers also have the option of administering the outcomes instruments more frequently than annually and may administer the outcomes instrument at 3-month intervals to occur with the treatment plan.

## **GLOSSARY**

This Glossary is based on the operational definition of terms used in the Outcomes Task Force Final Report (Vital Signs). These terms may be used differently in different settings and some of the terms are still emerging (i.e., recovery, empowerment). This Glossary is not intended to be used as a way to redefine an area of practice or to provide meanings with universal acceptance. When in doubt about whether a term is being used in the sense described here, you should ask the individual(s) to clarify their meaning. This Glossary is included as a reference for Trainers.

### **Access**

The ability to obtain needed services.

### **Aggregate Data**

A combined whole or collective set of data at a level above the individual consumer, e.g., a combined set of data from one agency, from multiple agencies in a board area, or from many boards at the state level.

### **Benchmarking**

The process of comparing local data at different points in time or comparing it to a larger database at the local, regional, state or national level for the purpose of identifying areas for improvement.

### **Best Practices**

Clinical services and supports recommended to consumers and families via individualized planning that are based on the most recent validated research and expert consensus about clinical evidence and outcomes.

### **Board**

County or multi-county authority responsible for managing local mental health service system; most boards also manage substance abuse services and are referred to as Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards or Community Mental Health and Recovery Services (CMHRS) Boards, although seven of the ten largest boards manage mental health systems only, and are referred to as Community Mental Health (CMH) Boards.

### **Care Management**

A collection of information driven methods for facilitating the best consumer outcomes in the most cost-effective manner.

## **GLOSSARY** continued...

### **Client Satisfaction**

One indication of the extent to which the mental health system meets the needs and expectations of consumers and families, usually including such items as responsiveness and respect shown by personnel, cleanliness and accessibility of the facility and overall sense of the program's value.

### **Consumer**

Person receiving mental health services and/or supports, including adults, children and adolescents and their families. Sometimes used to include families of adults (as in "secondary consumer"). Also referred to as client or patient. A term sometimes, but not always, preferred by persons with serious mental illness and their advocates.

### **Consumer Quality Review Terms (CQRT)**

Service satisfaction teams composed of consumers, family members and providers, currently operating in two areas of the state. These teams interview consumers, family members and providers using a standard set of instruments that capture both satisfaction with services and system performance.

### **Continuous Quality Improvement (CQI)**

Ongoing and incremental system improvement through problem identification, solution development and evaluation.

### **Cultural Sensitivity**

An awareness, understanding and appreciation of the beliefs (family, religious, etc.) and ethnic heritage of a group of people, particularly those of race, ethnic group or life-style different from one's own.

### **Cultural Competence**

The extent to which a person, organization or system is characterized by recognition and respect for cultural differences and similarities, attention to the dynamics of difference, expansion of cultural knowledge and resources, commitment to hiring minority staff, consultation with the community regarding service provision and delivery, provision of cross cultural training, and development of policies and practices that enhance programs for diverse populations.

**Data**

Factual information, such as measurements or statistics, used as a basis for reasoning, discussion, calculation, and decision making.

**Domains**

In outcomes, a part or area of a person’s life which should be considered in designing treatment or services.

**Empowerment**

The experience of feeling in control of or being able to affect the important decisions in one’s life.

**LCO**

The Longitudinal Consumer Outcomes research project conducted by ODMH to study outcomes for a group of consumers over time. This project was originally conceived by ODMH and funded by the National Institute of Mental Health as the “Services in Systems” or SIS research grant.

**MACSIS**

The Multi-Agency Community Services Information System, an encounter-level information system being developed to manage mental health substance abuse system information for use at multiple levels.

**ODMH**

Ohio Department of Mental Health

**ORYX** (not an acronym)

Community mental health outcomes reporting system in development by the Joint Commission on Accreditation of Healthcare Organizations.

**Outcomes** (as used by the Ohio Mental Health Consumer Outcomes System) Indicators of health or well-being for an individual or family as measured by statements or observed characteristics of the consumer/family, not characteristics of the service system. These measures provide an overall consumer status measure with which to better understand the life situation of a consumer or family. Outcomes evaluation is conducted with methods similar to research, but its primary purpose is improvement of the effectiveness or impact of services being delivered.

## **GLOSSARY** continued...

### **Outlier**

A piece or trend of data that stands out as significantly different from average, usually defined as a percentage, e.g., 25% higher or lower than the average.

### **Performance**

A measure of how well a system does in providing mental health services to consumers, often including rates of treatment, cost per consumer, degree of satisfaction with services, and extent of consumer access.

### **Provider**

An organization that provides services and supports for consumers of mental health services.

### **Psychometric Properties**

The technical and scientific characteristics of a research or evaluation instrument that demonstrate its appropriateness for the topic and population surveyed. Primary elements include validity, or the likelihood that the instrument measures what it is intended to measure; reliability, or the likelihood that it will continue to measure the topic accurately over time and that similar items measure the same aspects of the topic; and norming, or the likelihood that the instrument is appropriate for the population it is intended to survey.

### **Publicly Funded System**

The system of services and supports that is funded in whole or in part by federal, state and/or local monies. This system exists in order to compensate for the lack of adequate insurance coverage (public or private) for persons who experience mental illness. In Ohio the publicly funded mental health system includes ODMH, local ADAMHS/CMH Boards and a set of providers that contract with these boards.

### **Quality**

The degree of excellence characteristic of a practitioner, service, program, provider, or system.

**Quality Assurance**

Activities conducted by providers or payers and reviewed internally to improve services and supports and to ensure that they meet established standards, are appropriate to the person's need and contribute to a person's recovery.

**Recovery**

Defined by the Ohio Outcomes System as a highly personal process of adaptation to severe mental illness that allows a person's life to go forward in a satisfying and meaningful way. Various authors believe recovery involves a personal transformation that includes (according to some) acceptance of the illness, a sense of responsibility or control over one's life, hope, the support of others, and treatment and rehabilitation in collaboration with providers. The ODMH publication, "Emerging Best Practices in Mental Health Recovery," defines recovery as: "a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."

**Recovery Management Plan**

A plan developed collaboratively by the consumer and clinician, with the focuses on the interventions that will facilitate recovery and the resources (not necessarily within the mental health system) that will support the recovery process.

**Risk Adjustment**

A research method used to understand baseline differences between groups that may account for differences in outcomes or other aspects of care.

**Service Utilization**

The extent and pattern in which individuals or groups of consumers use particular services or clusters of services.

**Stakeholder**

A person or group of persons, who are entrusted with representing a specific group of people.

## **APPENDIX**

### **Wilma Lee Townsend**

1425 East Dublin-Granville Road, Suite 216  
Columbus, Ohio 43229  
(614) 848-8302

### **Wilma Townsend, M.S.W.**

Wilma Townsend is founder of Office Support Agency (OSA) and is the principle consultant. Most recently she was the Chief of the Office of Consumer Services at the Ohio Department of Mental Health for 17 years. Ms. Townsend has significant experience in mental health policy development, cultural competence systems development and consumer and family involvement. She specializes in the development of consumer and family involvement in managed care initiatives and assisting systems in developing a recovery-oriented system. Ms. Townsend also brings to OSA considerable experience in the areas of community support, human resource development and training. Ms. Townsend is a Certified Trainer by the Ohio Department of Mental Health for the Emerging Best Practices Clinician Module. She developed the Emerging Best Practices Consumers Module. She holds a BSW from Capital University in Columbus, Ohio, and a MSW from Rutgers University, New Brunswick, New Jersey.

### **Synopsis of Professional Skills, Training and Experience**

- Currently co-owner of Office Support Agency, Mental Health Consulting Firm, consulting and training in the areas of consumer issues of consumer operated services, consumer-run organizational development and strategic planning; recovery; managed care; and cultural diversity.
- Over 10 years of experience in conducting training in the areas of cultural diversity, board training, developing consumer operated services, etc.
- 25 years of comprehensive experience in social services, progressing from Case Worker to Chief of the Office of Consumer Services (OCS), Ohio Department of Mental Health (ODMH).

## DIRECT SERVICE STAFF



- Developed the Office of Consumer Services, now responsible for support of 51 County Mental Health Boards and 353 Community Mental Health Agencies.
- Possessing an MSW from Rutgers University in addition to a BSW from Capital University, Columbus, Ohio.
- Direct liaison between ODMH, OCS, County Boards, Local Agencies, Ohio education, civic business and private associations/foundations and federal agencies including NIMH, National Alliance for the Mentally Ill, etc.
- Direct responsibility for the \$550,000 Office of Consumer Services operating budget; assistance with research/forecasting, development, dispersal, and monitoring of the \$6.6 million ODMH Case Management Budget.
- Total personnel management on the Office of Consumer Services Professional and Clerical staff; development and implementation of extensive training programs statewide, and at all levels.
- Development and successful funding of federal grant as large as \$940,000 (5 years).
- Speaker Designee for the Director of ODMH, presenting approximately 50 public relations presentations every year to federal, state and local agencies and associations; statewide conference development.
- Editing and publication of policy and procedure manuals utilized at federal, state, and local levels; preparation of several articles submitted for national journal publication.
- Development, execution direction or membership in a number of consortiums, coalitions and associations lobbying for increased funding of mental health programs; public relations spokesperson utilizing television, radio and newspaper media.

## APPENDIX continued...

### **Summary**

Professional career highlights the ability to recognize community needs, development/direct appropriate agencies, procure government and private funding, develop and implement operating policies and procedures statewide and direct training to continually upgrade the quality of professional services.

### **Education**

Masters of Social Work, Specializing in Administration, 1977 Rutgers University, New Brunswick, New Jersey

Bachelor of Social Work, 1976, Capital University, Columbus, Ohio

Completion of numerous seminars, workshops, etc.; Topics include; personnel management, training the trainer, financial management, internal controls, mental health and social services updates, etc.

### **Chronology of Professional Experience**

#### **Chief Executive Officer**

Office Support Agency, Inc.  
1425 East Dublin-Granville Road,  
Suite 216  
Columbus, Ohio 43229  
*January 1999 to Present*

Office Support Agency, Inc. provides Mental Health Consultation to States, Local Boards, Local M.H. Agencies, and National Agencies. Services offered include recovery training and implementation: consumer related issues such as consumer operated services and consumer organizational planning; strategic planning; cultural diversity training and assessment; keynote speaking; workshops and seminars.

# DIRECT SERVICE STAFF



## **Adjunct Professor**

Capital University  
Adult Degree Program,  
Social Work Department  
2199 E. Main Street  
Columbus, Ohio  
*1998 to Present*

Teach undergraduate level course work in social welfare, social welfare policy and cultural diversity.

## **Chief**

Office of Consumer Services,  
Community Support Program  
Ohio Department of Mental Health  
30 East Broad Street  
Columbus, Ohio  
March 1984 to July 1999

Development of the Office of Consumer Services and the Community Support Program. Development, implementation, evaluation, and administration of department policies and procedures, related to the support of 53 County Mental Health Boards and 353 Community Health Agencies. Management of Professional Staff, assigned to technical assistance statewide for Consumer Services and Community Support Programs. Preparation of the offices annual revenue legislation and federal budgets and development of grant proposals for acquisition of additional program funding. Development of statewide training programs including preparation of extensive policy and

## APPENDIX continued...

procedure manuals. Representation of the ODMH and OCS statewide and at the federal level; involvement in a wide variety of associations related to the Mental Health public relations, programs, marketing and general advocacy. Speaker Designee for the ODMH Director seminars.

### **District Coordinator**

Ohio Department of Mental Health  
30 East Broad Street  
Columbus, Ohio 43215  
*February 1982 to March 1984*

Responsible for the coordination and monitoring of the 53 County Mental Health Boards in Ohio. Developed and monitored the multi-million dollar operating budgets of the Boards. Oversaw mental health contract agencies and boards, and implemented State and District planning and program development.

### **Executive Director**

Michigan Indian Child Welfare Agency  
P.O. Box 537  
Sault Ste. Marie, Michigan 49783  
*December 1977 to January 1982*

Established, implemented and administered the Michigan Indian Child Welfare Agency, a foster care, adoption, and family service agency. Coordinated local state and federal services, and composed grant proposals for program development and funding. Maintained small caseloads, and trained and supervised staff.

# DIRECT SERVICE STAFF



**Social Worker Administrator**

New Jersey Association of Corrections  
New Brunswick, New Jersey  
*January 1977 to December 1977*

Responsible for research and evaluation of social service programs, and the development and implementation of these programs. Sponsored inter-agency contracts and conferences and wrote grant proposals. Supervised and trained staff.

**Case Manager**

Vita Treatment Center  
Columbus, Ohio  
*June 1976 to January 1977*

Responsible for counseling drug dependent persons, securing case histories, maintaining social rehabilitation records, and consulting with physicians.

**Case Worker**

Franklin County Children Services  
Grove City, Ohio  
*September 1975 to May 1976*

## **APPENDIX** continued...

### **Professional Affiliations And Responsibilities**

- Staff member CSP Advisory Board
- Member, State of Ohio Housing Task Force
- Member, 4-State Advisory Committee; Federal Funding Directions and involvement of Private industry and Foundations
- Former Chair Person, NIMH Committee on Case Management Services for the Long-Term Mentally Ill Patient
- Member, NIMH Committee for Development of a National Minority Community Support Program
- National Minority Illness Coalition; CSP Division of the National State Program Directors
- Organized Region V CSP Conference, Northwest and Southeast Rural CAO Conferences
- Commissioner, State of Ohio Minority Health Commission
- Project Manager, ODMH "Chums & Choices" Project (Elderly Care)
- Convened the Ohio Minority Concerns Committee; authored major statewide publication
- Member, National Association of Black Social Workers (Former)
- Member, Ohio Council for Children with Behavioral Disorders
- Phi Alpha Upsilon-Honorary Social Work Association
- Advisory Board of Directors, Midwest Consortium for Leadership Development

### **Major Funded Grant Proposals**

- "Chums & Choices: A Support Network for Severely Mentally Disabled" NIMH...Funded 1988, \$110,000 per year for three years
- "Development of Community Support Systems for the Mentally Disabled" NIMH...Funded 1983, \$188,000 per year for five years
- "Money \$ Mailboxes; Homeless Project." Funded 1985, \$115,000 per year for two years
- "Self-Directed Job Search" Center for Mental Health Services...Funded 1991, \$125,000 per year for three years



## Major Publications

- Townsend W, Boyd S, Griffen G, "Emerging Best Practices in Mental Health Recovery," Ohio Department of Mental Health, June 1999
- Co-Author, "Minorities Utilization of Public Mental Health Services in Ohio" and the Executive Summary, March 1988...State of Ohio and national distribution of this 284-page intensive analysis
- "An assessment of the Reliability and Validity of the Functional Scales Used in the 508 Certification Process" February 1988...NIMH and ODMH distribution
- "Partners in Recovery:1; Evaluation of a Consumer Operated Service", November 1988...ODMH report
- "Adult 508 Guidelines: County Procedures for the Severely Mentally Disabled Person...Guidelines for acquiring case management funding
- "Focused Analysis of the Community Support Services," 1986...Questionnaire Study distributed to the Ohio County Mental Health Boards
- Dareden-Arewa B, Townsend W: Training Session: The African American Male and the Public Mental Health System. Unpublished manuscript, 1993
- Townsend W, Griffen G, etal: Outreach to the African American and Hispanic Communities, Washington D.C.: Mental Health Law Project, 1990
- Townsend W, Griffen G: "Emerging Best Practices in Mental Health Recovery", June 1999
- Byrd J, Grisetta G, Jenkins E, Martin S, Townsend W: "The Ohio Department of Mental Health Culturally Competent Programs Funded Fys 94-95
- Townsend, W: "The Ohio Department of Mental Health Minority Concerns Committee and Diversity Action Team"
- Townsend, W: "Recovery: The New Force in Mental Health"

## Leadership Roles

- Led the development of ODMH policies and programs that impacted services and resulted in system change to Ohio's culturally diverse populations, consumer and family movements, and the development of community support.

## **APPENDIX** continued...

- Led the development of the statewide, Ohio cultural diversity conference for the past seven years that has grown from participation of 75 attendees to over 3,000 attendees and national acclaim.
- Led in my capacity on the executive committee with the Adult Comprehensive Community Support System, a division of the National Association of the State Mental Health Programs Directors. I have led the development of or been instrumental in planning strategies that fostered community support development and consumer empowerment.
- In my role as oversight staff for the four ODMH funded statewide organizations (Deaf Resources Center, Multiethnic Consortium, Ohio Advocates for Mental Health Services and Alliance for the Mentally Ill of Ohio), I have assisted these organizations to become more administratively and programmatically autonomous.

### **Major Conference Presentations**

- The University of Texas-Houston Health Science Center, Texas Department of Mental Health and Retardation and National Council of Juvenile and Family Court Judges, National Synopsis on Involuntary Interventions, the call for a national legal and medical response, "Special Needs of a Radically and Culturally Diverse Community", May 1994.
- International Association of Psychosocial Rehabilitation Services.