

Recovery Assessment Scale – Domains and Stages (RAS-DS)

Manual

Version 2. 2016



THE UNIVERSITY OF
SYDNEY

ACKNOWLEDGEMENTS

Reaching the point we are at today has involved a journey that started way back in 2005. There have been numerous cycles of data collection, feedback and analysis, collaborative reflection and development. Over 250 people living with mental illness, 50 mental health support workers and 3 non-government organisations (Richmond Fellowship Queensland, Schizophrenia Fellowship of NSW and Richmond PRA) have all generously volunteered their time and expertise. Thank you!

We would like to particularly acknowledge the expertise and generosity of so many people living with and recovering from mental illness who have engaged in various ways throughout the development of the RAS-DS; over 250 of you! The RAS-DS is a measure of consumer or service-user defined recovery (not clinician or researcher defined recovery). Without your honest and generous sharing of the expertise and knowledge each of you have gained through your own personal journeys, this would be a much poorer, less valid measure. You have played centre stage in the evaluation and refining of the RAS-DS. Thank you for your constructive criticisms as well as your positive feedback and suggestions!

Thank you to the organisations and support workers who have also, due to their commitment to advancing recovery-oriented practice in Australia, generously and passionately engaged in this study. Again, you provided invaluable insights into the usefulness of the RAS-DS as well as how to enhance its practical usefulness further.

We look forward to working with you and many others on the continued evaluation and development of the RAS-DS and this manual.

Note: In Australia the term 'consumer' is commonly used to refer to people living with a mental health diagnosis and using mental health services. It is therefore this term that we have chosen to use throughout this manual. We understand that this is not a term that everyone likes, and that other terms such as 'service-user' and 'survivor' are preferred by some and are more commonly used in other countries.

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SECTION 1: MEASURING RECOVERY – CAN WE DO IT AND WHY BOTHER TRYING?

There are three main reasons for mental health services to use a tool that enables consumers or service users to think about and measure their own recovery progress:

- 1) enhanced understandings (both personally for the consumer and between consumer and staff partnerships) that lead to
- 2) enhanced collaborative and recovery-oriented goal planning or personal recovery plans and
- 3) measuring individual and service outcomes with a focus on recovery rather than symptom reduction for example.

ENHANCED UNDERSTANDINGS

A self-report measure that enables exploration or enquiry into recovery related topics gives people living with mental illness (consumers) a structured opportunity to reflect upon their own recovery progress. The process of completing a self-report measure of recovery can facilitate consumers to develop greater recognition of the successes and achievement already made in their personal recovery journey as well as identifying the areas that they see as needing further work. When (and we suggest this is essential) consumers have the opportunity to talk about their self-ratings of recovery progress with their mental health support worker or clinician, there is the opportunity to enhance the shared understanding. Staff report having a better understanding of what consumers are feeling, experiencing and prioritising in relation to their recovery. Equally, consumers feel that the staff person who they are working with has a better understanding of them, their successes, feelings and needs.

ENHANCED COLLABORATIVE, RECOVERY-ORIENTED GOAL PLANNING OR PERSONAL RECOVERY PLANS

Conversations, in which the consumer and staff member explore the consumer's self-rating of recovery, lead naturally towards recovery planning that focuses upon the priorities of the consumer.

MEASURING RECOVERY OUTCOMES AT THE INDIVIDUAL AND SERVICE/PROGRAM LEVEL

In Australia, the outcome measures selected for routine use across State mental health sectors have a predominantly symptom/illness measurement focus. There is a repeated call internationally to include recovery-oriented outcome measurement in the suite of instruments used, particularly with the growing understanding and embracing of the need for systemic change that sees a shift from illness management approaches to recovery-oriented approaches.

There is an argument that perhaps only measures of recovery-oriented practice (i.e., measures of service quality in relation to their recovery-orientation) are needed. We would argue that 1) we need to know that if recovery-oriented practice is enhanced, it leads to

enhanced individual recovery, 2) consumers have the right to reflect and report on their personal perspectives of recovery progress (who other than the person themselves would know how hopeful they feel for example?) and 3) inclusion of a structure that enables consumers to actively participate in the 'assessment' process is a fundamental first step towards self-directed care (a cornerstone of recovery-oriented practice).

SECTION 2: INSTRUMENT DESCRIPTION

The RAS-DS has 38 items or statements for the consumer to rate. It is a Likert scale with 4 rating categories for consumers to select from: “untrue”; “a bit true”; “mostly true” and “completely true”. See Figures 1 and 2 on the following page for examples of what the RAS-DS looks like. The complete RAS-DS is provided in the appendices at the back.

The items have been divided into 4 recovery domains: Doing Things I Value; Looking Forward; Mastering My Illness and Connecting and Belonging.

As you will see in Section 4 where we describe how to score the RAS-DS, each domain can be used and scored separately as well as collectively for a more holistic exploration. See Table 1 below for descriptions of the 4 domains and their relationship to stages of recovery.

Table 1: Four Domains of Recovery covered by the RAS-DS

DOMAINS	STAGES		
	Very Early	Middle	Later
Doing Things I Value	Unengaged, inactive or poverty of activity or role engagement; sick or patient role dominates	→	Doing things that are personally valued and meaningful; sense of contributing to others
Looking Forward	Anguish; hopelessness; views self as “sick person”	Awareness; insight; action plan	In control of life; wellbeing; hopeful about the future; views self as external to experience of illness
Mastering My Illness	Dominated by symptoms	→	Control over, or management of, any residual symptoms; minimal interference with life
Connecting and Belonging	Few relationships; dependent; mostly family	→	Larger social network; greater diversity including peers, family and broader communities; reciprocal in nature; personally satisfying

Please note:

1. In the Doing Things I Value domain, there is an emphasis on doing things that are PERSONALLY valued /meaningful rather than a focus on socially valued activities/roles
2. The Mastering My Illness domain differs to the medically oriented definition of clinical recovery that focuses on the degree of symptom amelioration. In the RAS-DS the focus is on developing a sense of control over & management of symptoms, and reducing their impact on living.

Figure 1: Excerpt from the RAS-DS (part of page 1)

DOING THINGS I VALUE					
		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
1	It is important to have fun	1	2	3	4
2	It is important to have healthy habits	1	2	3	4
3	I do things that are meaningful to me	1	2	3	4
4	I continue to have new interests	1	2	3	4
5	I do things that are valuable and helpful to others	1	2	3	4
6	I do things that give me a feeling of great pleasure	1	2	3	4
LOOKING FORWARD					
		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
7	I can handle it if I get unwell again	1	2	3	4
8	I can help myself become better	1	2	3	4
9	I have the desire to succeed	1	2	3	4
10	I have goals in life that I want to reach	1	2	3	4

(see Appendix at the back of the manual for a complete copy of the RAS-DS)

Figure 2: Excerpt from the RAS-DS (part of page 2)

MASTERING MY ILLNESS					
		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
25	I can identify the early warning signs of becoming unwell	1	2	3	4
26	I have my own plan for how to stay or become well	1	2	3	4
27	There are things that I can do that help me deal with unwanted symptoms	1	2	3	4
28	I know that there are mental health services that help me	1	2	3	4
29	Although my symptoms may get worse, I know I can handle it	1	2	3	4
30	My symptoms interfere less and less with my life	1	2	3	4
31	My symptoms seem to be a problem for shorter periods of time each time they occur	1	2	3	4
CONNECTING AND BELONGING					
		UNTRUE	A bit TRUE	Mostly TRUE	Completely TRUE
32	I have people that I can count on	1	2	3	4
33	Even when I don't believe in myself, other people do	1	2	3	4
34	It is important to have a variety of friends	1	2	3	4
35	I have friends who have also experienced mental illness	1	2	3	4

SECTION 3: INSTRUMENT ADMINISTRATION & USE

COMPLETING THE FORM

This is a self-report measure. Therefore, it is critical that consumers who use the RAS-DS are providing their OWN self-assessment freely and that their ratings are not influenced by others.

However, this does not mean that some consumers might need or like to have assistance with reading the items. We have made a lot of effort to ensure that the language of the RAS-DS is as accessible and user-friendly as possible, but, for various reasons, some consumers might find it hard to read and concentrate on all 38 statements at the same time as thinking about the statements and rating their responses.

It is more than acceptable for staff or peers/peer workers to read the statements to the consumer completing the RAS-DS. In fact, administering self-report instruments via interview has been recommended by others (Corrigan et al, 1999). If each person has their own copy of the RAS-DS while this is being done, it will avoid the sense of “someone watching over me as I do it”. To avoid any sense of being judged or the risk that consumers rate in the way that they think others want them to, people present should not watch the scoring process or comment on the consumers ratings until the process is completed. Consumers might ask what a statement means, if this happens it would be best to say something like “The important thing is what it means to you. It might mean different things to different people”. Try to avoid rephrasing the statement if you can because that can change the meaning without you realising it.

Please note: In some of the stages of our research, trained consumer researchers read the instrument statements out to consumer participants as they completed the ratings. We received only positive feedback about peers facilitating this process. We anticipate and hope that much of the future work done using the RAS-DS will include the peer-workforce.

CONVERSATIONS LEADING TO SHARED UNDERSTANDING & PERSONAL RECOVERY PLANS

The magic in the use of the RAS-DS comes from its use as a conversation starter that leads to deeper personal and shared understandings. In our studies to-date, both consumers and staff feedback demonstrates that:

- Doing the RAS-DS helps almost all consumers to think about and reflect upon their recovery journey (both achievements to-date and areas to work on in the future)
- Staff frequently find that the process of talking over RAS-DS results with consumers is helpful in gaining a richer understanding of the perspectives, feelings and priorities of the consumers they support. Those who use it to identify and develop recovery goals also find it helpful in that process.

The most useful or meaningful way of using the RAS-DS in practice is for staff and

consumers to talk about the 'results' together; identifying the recovery areas that consumers feel positive about (rated 3 or 4) and celebrating these. Staff and consumers should also look at and talk about the areas of recovery that could be worked on (the ones they scored 1 or 2) and discuss which of these are most important to the consumer and could therefore be incorporated into recovery action plans and goals.

Examples of questions you might ask...

- Can you tell me more about why you rated this one this way?
- What would it take for us to get this one up to a 4?
- When you look at the RAS-DS which things do you think are most important to you/do you want us to work on?
- and Don't forget to celebrate the successes!!

REPEATED USE OF THE RAS-DS TO SEE CHANGES OVER TIME

Recovery is a non-linear process. Sometimes going backwards in a measure like this reflects that consumers have taken on or are facing new challenges/risks. We know that risks and challenges are essential components of the recovery journey. It is important not to assume that a 'backwards' change is necessarily a negative. Again, a conversation is needed!

Positive conversations about 'backwards' changes in recovery scores can also lead to opportunities to review and further develop relapse prevention plans and also to add to or refine advanced directives if the organisation/service is courageous enough to engage in that process.

SECTION 4: SCORING

Often, for measures to be useful, we are required to convert scores to statistically adjusted measures (using something called key forms). We are delighted to report that our data analysis shows an almost perfect correlation between raw scores and rankings. We are therefore able to say that using raw scores is acceptable (and obviously much simpler!).

TOTAL RECOVERY SCORE

It is OK to add the scores up for all 38 items to gain a total recovery score out of 152.

SCORING EACH RECOVERY DOMAIN

It is also OK to also have sub-score totals for each recovery domain so that you can see relative progress across domains. However, please remember that there are different numbers of items/statements in each domain so converting to a percentage (%) domain score might be most useful to consumers to see variance across domains).

To do this with the paper version of RAS-DS:

1. Add the item scores together for the domain
2. Divide the total for the domain by the number of items in that domain that have been completed by the person (this will give you an average score for each domain)
3. Divide the average score by 4 and multiply by 100

Calculations:

Total Recovery Score	Add all item scores.	This will be a total recovery score out of 152
Doing Things I Value Recovery Score	Add all items Divide by 6 (or less if any items are not rated) Divide by 4 Multiply by 100	This will give a percentage score for each domain
Looking Forward Recovery Score	Add all items Divide by 18 (or less if any items are not rated) Divide by 4 Multiply by 100	
Mastering My Illness Recovery Score	Add all items Divide by 7 (or less if any items are not rated) Divide by 4 Multiply by 100	
Connecting and Belonging Recovery Score	Add all items Divide by 7 (or less if any items are not rated) Divide by 4 Multiply by 100	

RAS-DS online: The on-line version will do the calculations for you. Consumers are required to score every item when they use the on-line version.

Important Note:

We understand that adding scores is useful when using the RAS-DS as an outcome measure. However, we want to re-emphasise that perhaps the most useful or meaningful way of using the RAS-DS in practice is for staff and consumers to talk about the 'results' together as described above. That is, to identify the recovery areas that consumers feel positive about and where successes have occurred (rated 3 or 4) and to celebrate these as well as looking at and talking about the areas of recovery that could be worked on (the ones they scored as a 1 or 2) and incorporated into new recovery action plans and goals. Sometimes the aspect that consumers most want to work further on is not the thing they scored most low.

The on-line version of the RAS-DS had a comments column. This is often the most useful part of the RAS-DS for discussion and making plans together. Additionally, the visual display of results provided by the on-line RAS-DS might also be helpful for some consumers in reviewing and 'interpreting' their results.

SECTION 5: INSTRUMENT DEVELOPMENT & RESULTS (USEFULNESS & PSYCHOMETRIC PROPERTIES)

THE JOURNEY OF RAS-DS DEVELOPMENT

The RAS-DS (Recovery Assessment Scale – Domains & Stages) has developed through numerous iterative study cycles over a more than 8 year period. Its development began with an analysis of the original 41-item Recovery Assessment Scale (RAS) developed in America (Gifford et al. 1995).

The RAS was selected originally because it had stronger psychometric properties than any other recovery-based instrument at that time. As you can see from our published work, after testing, we found three main problems with the original instrument:

- poor category structure (although there were five points on the original scale, when we did the analysis, there was only really meaningful differences between “Agree” / “Strongly agree” and the other points of the scale – consumers tended to use it as a two point “yes” / “no” scale.),
- a very significant ceiling effect (many consumers selected high scores on many items, which suggested that there may be too few items relating to the later stage of recovery), and
- a number of items did not seem to line up with the overall construct of “recovery” or were repetitive.

In a second stage study, we used focus groups with consumers who reported being further along their recovery journey in attempt to identify 'missing' items – that is, to identify key achievements or challenges associated with later stages of the recovery journey. From these 2 studies we developed the RAS-DS.

In the third stage of development, we trialled the RAS-DS with the support of 3 large non government services in two Australian states: The Richmond Fellowship Queensland, the Schizophrenia Fellowship of NSW and Richmond PRA (New South Wales). Over 120 staff/consumer paired data sets were obtained. Consumers completed the RAS-DS and both consumer and staff member were then asked to complete a questionnaire about its usefulness. Very preliminary analysis of the data looked good (good item fit, internal reliability etc.) However, there was a repeated theme in the qualitative data that we decided needed to be acted upon immediately. Staff and, more importantly, consumers said that they needed another point in the rating scale between “unsure” and “yes” - they needed a “partial” point. Also, we could see from the quantitative data that an additional point would enhance the sensitivity of the RAS-DS to capture change over time. We stopped the study, re-worked the scale descriptors, trialled our preferred descriptors with a small group of consumers and staff and recommenced the study.

Using preliminary data from this revised RAS-DS questionnaire, we were able to complete an analysis to examine if the RAS-DS could:

- a) Be a useful tool that facilitates enhanced understandings (both personally for the consumer and, through conversation, between consumer and staff partnerships), leading to more collaborative and recovery-oriented goal planning or personal recovery plans, and
- b) Measure individual and service outcomes with a focus on recovery

RESULTS:

A. ENHANCE UNDERSTANDINGS & FACILITATION OF RECOVERY-ORIENTED GOAL PLANNING

A taste of what consumers and MH workers said....

"My case manager understood me and I understood me" Consumer

"was useful with regard to forming the PRP" MH Worker

"Asked relevant questions to recovery journey" Consumer

"Very useful as a measure of positive progress, rather than identifying deficits" MH Worker

"Felt different to last survey. I have improved knowledge of symptoms. Happier with situation." Consumer

"Realisation of where my mental health is at. My family can not be my only support" Consumer

"it was a helpful tool to gain insight into clients feelings on recovery" MH Worker

"Did not realise how much things had improved until I did the second survey" Consumer

"notice big change in the way (I) think about recovery - positive change" Consumer

"it is so nice to see smiles on my clients face when they can relate to a statement and we can talk about it" MH Worker

"The 4 columns are much more useful in identifying where community members are at in their recovery and it helps us to see what we can work on to help improve mental health" MH Worker

"It was useful in terms of opening up discussion about specific issues the client deals with. Gave me some more insight." MH Worker

- Qualitative data shows clearly that doing the RAS-DS helps almost all consumers to think about and **reflect upon their recovery journey** (both achievements to-date and areas to work on in the future)
- Qualitative data also shows that staff almost always find the process of talking over RAS-DS results with consumers **helpful in gaining a richer understanding of the perspectives, feelings and priorities of those consumers with whom they work.**
- Consumers also recognised that **staff had a better understanding of them** after discussions following completion of the RAS-DS.
- Those who use it **to identify and develop recovery goals also find it helpful** in that process.

TIME - How long does it take?

It will take most consumers between 5 and 15 minutes to complete the RAS-DS (around 80%) without any support/reading.

If people want to reflect very deeply on items, or if they prefer/need assistance with reading statements and don't receive it, it may take longer than 15 minutes.

How EASY is it for consumers to use?

78% of consumers who used the RAS-DS rated it as "easy" or "very easy". 20% of consumers rated it as "hard". 2% rated it as "very hard".

Reasons given for easy/very easy ratings:

"questions were easy to read and answer"; "just had to circle my answer"

Reasons given for hard or very hard rating:

"having to give it a great deal of thought"; "deep decisions" and "trouble reading"

B. MEASURING INDIVIDUAL AND SERVICE LEVEL OUTCOMES (PSYCHOMETRIC PROPERTIES)

Through-out each stage of the development of the RAS-DS, raw data were subjected to Rasch analysis using Winsteps (<http://Winsteps.com>, Chicago; Smith & Smith, 2004; Linacre, 2005). Unlike classic forms of analysis, Rasch analysis converts ordinal level data into interval level data and this method of analysis is increasingly becoming the preferred method of analysis in instrument development (Wolfe & Smith, 2006). A further advantage of this method of analysis is that it is more robust with smaller data sets and where there are missing data (some participants did not complete every question). We will not go into further detail here, however, if readers would like more information about Rasch analyses we refer them to the references above and are very happy to provide further detail.

In this manual we will only report on the most recent analysis, based on the current form of the RAS-DS that contains 38 items and has a 4-point rating scale. Results from earlier stages can be access in the following published manuscripts (Hancock et al 2011, Hancock et al 2012).

We start with a user-friendly summary of our findings. A more detailed understanding of the psychometric testing of this measure can be found in the publication in Australian and New Zealand journal of Psychiatry which can be accessed at <http://anp.sagepub.com/content/49/7/624.short> .

PUT SIMPLY.....

- ❖ The RAS-DS is a reliable and useful measure of recovery.
- ❖ The statements/items are all useful to the overall measurement.
- ❖ The 4 point scale works well with almost all items. There are a couple that are unclear but we will need more data to see how they work.
- ❖ It is OK to add the scores up to gain a total recovery score out of 152.
- ❖ It is also OK to also have sub-score totals for each recovery domain so that you can see which domains people are doing better and less well in
- ❖ Either many of the people who used the RAS-DS in this study were at a 'high' stage of recovery or 'in recovery' (a term used by some people to refer to "fully recovered") OR we have not yet identified all of the recovery-oriented achievements that occur as people approach being in-recovery. We will be exploring this further.
- ❖ We now need to collect more data over time to see if changes in recovery show up when people use the RAS-DS repeatedly over time.

SECTION 6: OUR FUTURE PLANS/WHAT WE STILL NEED TO EXAMINE & DEVELOP

DOES THE RAS-DS MEASURE THE ENTIRE RECOVERY CONSTRUCT?

As we explained earlier, during the process of developing the RAS-DS, we added items/statements that consumers identified as missing and being important aspects of their later recovery journeys.

However, we have recently tested this and found that while those items are indeed part of the recovery construct and give a richer/fuller instrument, they do not seem to add a 'harder' set of items. This has led us to consider 2 possibilities:

1. The RAS-DS still does not 'capture' or ask about all of the achievements of the later stage of recovery, or
2. The RAS-DS does capture or ask about all of the recovery 'achievements, but many of the people who used the instrument were in recovery.

We are now engaging in further study to try and answer this question.

IS THE RAS-DS SENSITIVE TO CHANGE?

Due to the change in rating scale structure (from 3 points to 4), we have not yet been able to evaluate whether the RAS-DS is sensitive to change (i.e., when a consumer feels that their recovery has progressed or gone backwards, do RAS-DS scores reflect this change over time). This is the next step in our ongoing study and we look forward to sharing the results when we have them. This is an important aspect of instrument development/testing and to date no recovery measure has reported robust capacity to measure change over time.

EXAMINING THE CATEGORY STRUCTURE WITH LARGER SETS OF DATA

While we are happy with the findings to date, further data will enable us to be more confident about the order and separation of the category structure for all items.

EXAMINING TEST-RETEST RELIABILITY

We will be examining whether consumers use the RAS-DS the same way when they use it repeatedly. That is, would people completing the RAS-DS give the same ratings today as they would tomorrow if nothing had changed in terms of their recovery?

A VISUAL, USER-FRIENDLY DISPLAY OF INDIVIDUAL RAS-DS RESULTS

We have now developed the on-line RAS-DS. This enables consumers to track their own recovery over time, store their results, view their results as a bar graph and compare their results over time. This version is freely available at www.rasds.net.au

CONTACT INFORMATION

If you have any further questions about the RAS-DS, please contact Nicola Hancock

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REFERENCES

- Corrigan, P. W., Giffort, D., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community Mental Health Journal*, 35, 231–239. doi: 10.1023/A:1018741302682
- Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). *Recovery Assessment Scale*. Cambridge, MA: Human Services Research Institute.
- Hancock, N., Scanlan, J.N., Honey, A., Bundy, A.C. & O’Shea, K. (2015). Recovery Assessment Scale – Domains & Stages (RAS-DS): Feasibility and measurement. *Australian and New Zealand Journal of Psychiatry*. DOI: 10.1177/0004867414564084.
- Hancock, N., Bundy, A., Honey, A., Helich, S., & Tamsett, S. (2012). Measuring the later stages of the recovery journey: Insights gained from Clubhouse members. *Community Mental Health Journal*. Doi: 10.1007/s10597-012-9533-y
- Hancock, N., Bundy, A., Honey, A., James, G., & Tamsett, S. (2011). Improving measurement properties of the Recovery Assessment Scale (RAS) with Rasch analysis, *American Journal of Occupational Therapy*, 65, e77-e85. Doi: 10.5014/ajot.2011.001818.
- Hancock, N., Bundy, A., Tamsett, S., & McMahon, M. (2012). Participation of Mental Health Consumers in Research: Training addressed and reliability assessed. *Australian Occupational Therapy Journal*, 59(3), 218-224. Doi: 10.1111/j.1440-1630.2012.01011.x
- Linacre, J.M. (2005). A User’s Guide to Winsteps Ministep Rasch-Model Computer Programs. Retrieved February 20, 2010, from www.winsteps.com/winpass.htm
- Wolfe, E. W., & Smith, E. V. (2006). Instrument development tools and activities for measure validation using Rasch models: part II--validation activities. *Journal of Applied Measurement*, 8(2), 204-234.

APPENDIX 1:

RECOVERY ASSESSMENT SCALE – DOMAINS & STAGES (RAS-DS)

Name:

RAS-DS (Recovery Assessment Scale – Domains and Stages)

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 you at the moment. Circle only one number for each statement and do not skip any items.

DOING THINGS I VALUE					
		UNTRU	A bit TRU	Mostly TRUE	Completel y TRUE
1	It is important to have fun	1	2	3	4
2	It is important to have healthy habits	1	2	3	4
3	I do things that are meaningful to me	1	2	3	4
4	I continue to have new interests	1	2	3	4
5	I do things that are valuable and helpful to others	1	2	3	4
6	I do things that give me a feeling of great pleasure	1	2	3	4
LOOKING FORWARD					
		UNTRU	A bit TRU	Mostly TRUE	Completel y TRUE
7	I can handle it if I get unwell again	1	2	3	4
8	I can help myself become better	1	2	3	4
9	I have the desire to succeed	1	2	3	4
10	I have goals in life that I want to reach	1	2	3	4
11	I believe that I can reach my current personal goals	1	2	3	4
12	I can handle what happens in my life	1	2	3	4
13	I like myself	1	2	3	4
14	I have a purpose in life	1	2	3	4
15	If people really knew me they would like me	1	2	3	4
16	If I keep trying, I will continue to get better	1	2	3	4
17	I have an idea of who I want to become	1	2	3	4
18	Something good will eventually happen	1	2	3	4
19	I am the person most responsible for my own improvement	1	2	3	4
20	I am hopeful about my own future	1	2	3	4
21	I know when to ask for help	1	2	3	4

Recovery Assessment Scale – Domains and Stages (RAS-DS – Research Version 3).

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LOOKING FORWARD (continued)					
		UNTRU	A bit TRU	Mostly TRUE	Completel y TRUE
22	I ask for help, when I need it	1	2	3	4
23	I know what helps me get better	1	2	3	4
24	I can learn from my mistakes	1	2	3	4
MASTERING MY ILLNESS					
		UNTRU	A bit TRU	Mostly TRUE	Completel y TRUE
25	I can identify the early warning signs of becoming unwell	1	2	3	4
26	I have my own plan for how to stay or become well	1	2	3	4
27	There are things that I can do that help me deal with unwanted symptoms	1	2	3	4
28	I know that there are mental health services that help me	1	2	3	4
29	Although my symptoms may get worse, I know I can handle it	1	2	3	4
30	My symptoms interfere less and less with my life	1	2	3	4
31	My symptoms seem to be a problem for shorter periods of time each time they occur	1	2	3	4
CONNECTING AND BELONGING					
		UNTRU	A bit TRU	Mostly TRUE	Completel y TRUE
32	I have people that I can count on	1	2	3	4
33	Even when I don't believe in myself, other people do	1	2	3	4
34	It is important to have a variety of friends	1	2	3	4
35	I have friends who have also experienced mental illness	1	2	3	4
36	I have friends without mental illness	1	2	3	4
37	I have friends that can depend on me	1	2	3	4
38	I feel OK about my family situation	1	2	3	4

Recovery Assessment Scale – Domains and Stages (RAS-DS – Research Version 3).

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