Milestones of Recovery Scale (MORS)

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Background and Introduction

Over the last decade, the concept of recovery has become nearly universal in public mental health policy discussions. For example, the following statement appears in the recently enacted Mental Health Services Act (MHSA) in California:

> "Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers..."(Mental Health Services Act, Section 7)

This new focus on recovery has significant implications not only on the types of mental health services offered and the manner in which they are delivered, but also on the way in which we evaluate the effectiveness (outcomes) of our mental health programs and systems. For example, ten years ago, McGlynn (1996) described five major domains of outcome measurement for mental health programs:

> 1. *Clinical status* refers to how a disorder is defined, particularly in terms of the presence and severity of symptoms.
> 2. *Functional status* refers to the ability of an individual to perform age appropriate activities.
> 3. *Quality of life* measures have the "objective to bring the client perspective into outcome measurement." They measure "the importance of different decrements in functioning on an individual's perception of his or her quality of life."
> 4. *Adverse events* refer to negative outcomes (e.g., hospitalization, mortality, incarceration) that result from system problems that could be avoided with appropriate care.
> 5. *Satisfaction with care* refers to the consumer's perception of the quality of the care that she or he received.

While some would suggest that this list is comprised of many of the components of recovery, the concept of overall recovery from a disabling mental illness as a domain of outcome measurement is nowhere to be found. Contrast this with the recent statement by Substance Abuse and Mental Health Services Administration (SAMHSA) Director Charles Curie when his agency issued a consensus statement on the features of recovery:

> "Recovery must be the common, recognized outcome of the services we support. This consensus statement on mental health recovery provides essential guidance that helps us move towards operationalizing recovery from a public policy and public financing standpoint. Individuals, families, communities, providers, organizations, and systems can use these principles to build resilience and facilitate recovery." (February 16, 2006)

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This statement demonstrates that recovery has indeed become the new benchmark for evaluating mental health program effectiveness. However, even with such consensus statements, it remains remarkably difficult to define what is meant by the concept and even more difficult to agree on how to measure it. The features of recovery generally have not been formulated in a sufficiently coherent and measurable framework that would allow the systematic evaluation of the effectiveness of a particular mental health program or system in helping its consumers to recover.

We believe that much of the difficulty in defining and measuring recovery arises from the fact that the most "personally meaningful" characteristics of recovery are the internal subjective cognitive and emotional states of the person experiencing it. For example, many consumers speak of "feeling more hopeful," "becoming more empowered," and "deciding to take more responsibility for myself" as they recover. One approach to measuring recovery, then, would be to measure these internal cognitive/emotional states of hope, empowerment, and responsibility (or other similar states). Theoretically, it should be possible to measure a consumer's status on these dimensions at admission to a mental health program and then measure repeatedly as the consumer goes through the program and finally when the consumer is discharged. If the program is effective, the consumer should experience greater levels of hope, empowerment, and self-responsibility at discharge than she did at admission.

However, there are several problems that arise from such an approach. First, it is extremely difficult to reliably measure these sorts of internal subjective states. Because these are subjective experiences, it is extremely difficult for two outside observers (raters) to agree on an individual's level of hopefulness or sense of empowerment. Second, this problem is only partially solved by having consumers rate themselves on these dimensions because it is unclear to what extent reports of feelings of hopefulness or empowerment are influenced by relatively stable character traits regardless of outside "interventions" and life improvements. We all know individuals who are perpetually hopeful (or hopeless) almost regardless of the objective situation in which they find themselves. Third, even if we are convinced that we can induce meaningful changes in our clients' levels of hopefulness and/or empowerment through our clinical interventions, does it make sense to evaluate our effectiveness on this basis rather than on life improvements? We would argue that greater subjective feelings of hope and/or empowerment come about as a result of significant changes in the life circumstances of the individual (e.g., becoming housed after being homeless, making one's own decisions after being on conservatorship, getting a job after being unemployed) at least as often as the other way around. In evaluating program effectiveness, it seems to us to make more sense to hold programs and systems accountable for their ability to help their consumers to make these kinds of significant changes in their lives. Finally, we would also argue that when it comes to demonstrating our effectiveness to the public and to our funding sources, it is much easier to justify continued funding for our programs when we can show meaningful changes in the objective circumstances of the lives of the consumers we serve (e.g., more jobs, fewer hospitalizations and incarcerations, less homelessness) than in their internal subjective cognitive/emotional states.

Based on these considerations, we suggest that, *for the purpose of evaluating the effectiveness of mental health programs and systems in promoting recovery, we should measure the objective and easily observable behavioral correlates ("milestones") of recovery* rather than the

subjective internal experience of individuals experiencing recovery. Our challenge then becomes to identify a set of observable correlates that actually corresponds to the experience of recovery.

Our own approach to operationalizing and measuring recovery began in the Spring of 1997, under the leadership of Paul Sherman and Betty Dahlquist. The California Association of Social Rehabilitation Agencies (CASRA) sponsored several meetings including administrators, clinicians, consumers, and advocates to try to create tools for mental health managed care to divide consumers into service need groups and measure their outcomes from a rehabilitation/recovery point of view. Tools for this purpose already existed based on clinical acuity or level of care or cost of care, but none of these tools were recovery based. The objective of the workgroup was to create a system by which mental health providers could be held accountable for the outcomes of the services they provided to the different subgroups of consumers that were identified. Although it was not our original intention, we created a scale that describes what we believe are the most important objective and measurable correlates of the process generally referred to as "recovery." This paper describes the process by which this "Milestones of Recovery Scale" (MORS) came about, some of the development work that has taken place with it since, and some possibilities on how it might be used in the future.

Properties of the Milestones of Recovery Scale

So what are "the objective and easily observable behavioral correlates of recovery?" It should be pointed out that the underlying dimensions of the Milestones of Recovery Scale were arrived at "empirically" (experientially) rather than theoretically. By that we mean, the CASRA workgroup participants were given the task of assigning the population of all individuals with a severe and persistent mental illnesses into groups that would reflect the commonalities and characteristics of the consumers in that particular group. Some of the dimensions that were considered in creating the groups were items such as level of symptom distress, willingness to take medication, existence of co-occurring disorders (e.g., substance abuse), extent of social support network, level of danger to self or others, employment status, frequency of crisis incidents, engagement with the mental health system, and extent of meaningful roles in the community, just to name a few. Workgroup participants were also allowed to add their own dimensions with the single restriction that they could not differentiate groups based on the level or type of service they thought the consumer should receive. The aim was to create a classification system based on consumer characteristics and make no assumptions about the type or amount of services that those characteristics implied.

It turned out that, once the groups were created, they consisted of three underlying dimensions of the consumer's (1) level of risk, (2) level of engagement with the mental health system, and (3) level of skills and supports. The consumer's **LEVEL OF RISK** is comprised of three primary factors: 1) the consumer's likelihood of causing physical harm to self or others, 2) the consumer's level of participation in risky or unsafe behaviors, and 3) the consumer's level of co-occurring disorders. The consumer's **LEVEL OF ENGAGEMENT** is the degree of "connection" between the consumer and the mental health service system. Note that level of engagement does not mean amount of service. A consumer who willingly makes appointments once per month and works on improving his life should be considered more engaged and connected than a consumer who passively attends groups on a daily basis. Similarly, a consumer

whose only services are large numbers of involuntary hospitalizations but refuses all voluntary treatment would be considered to have no or minimal engagement. Finally, the consumer's **LEVEL OF SKILLS AND SUPPORTS** should be viewed as the combination of the consumer's abilities and support network(s) and the level to which the consumer needs staff support to meet his/her needs. It should include an assessment of their skills in independent living (e.g., grooming, hygiene, etc.), cognitive impairments, whether or not they are engaged in meaningful roles in their life (e.g., school, work), and whether they have a support network of family and friends. It should also include their ability to manage their physical and mental health, finances, and substance use, etc., and their ability to meet their needs for intimacy and sexual expression.

Again, it is important to note that we didn't start out with these dimensions. Nobody said, "We are going to create a system based on these three dimensions." They arose from the natural groupings that people in the mental health field (consumers, clinicians, advocates, and administrators) had experienced in their professional and personal lives, a fact that we believe gives the scale a certain credibility and validity. Although many other important dimensions have been suggested to us by both clinicians and consumers, none of them substantially add to the power of the MORS to differentiate clusters of consumers and all of them add more time and complexity to the tool. We created an extremely brief tool that could be easily used even if it is not completely comprehensive.

The groups that arose were given the following labels:

(A copy of the scale with the complete category descriptions appears at the end of this paper)

1. Extreme Risk
2. High Risk / Not Engaged
3. High Risk / Engaged
4. Poorly Coping / Not Engaged
5. Poorly Coping / Engaged
6. Coping / Rehabilitating
7. Early Recovery
8. Advanced Recovery

It should be mentioned that the scale originally consisted of 6 categories rather than 8. We were reluctant to include the "Extreme Risk" category for fear that people would overuse it. Also, the original version did not include a category of "Advanced Recovery" to describe individuals with mental illnesses who are doing very well and have either never been a recipient of public mental health services or have successfully "graduated" from the public mental health system. The lack of this category was pointed out to us by Kathleen Crowley (author of "Procovery") and probably resulted from the fact that the original focus of our CASRA workgroup was with the population of mental health consumers who were either currently receiving public mental health services or obviously needed services but were not receiving them (e.g., individuals who had a mental illness and were homeless). At that time, neither recovery without services nor graduation from services was part of our experience.

The manner in which the three underlying dimensions are expected to co-vary across the 8 groups can be visualized in the following table:

Milestone	Risk	Engagement	Skills and Supports
1. Extreme Risk	5	n/a	0
2. High Risk / Not Engaged	4	0	1
3. High Risk / Engaged	4	1	1
4. Poorly Coping / Not Engaged	3	0	2
5. Poorly Coping / Engaged	3	1	2
6. Coping / Rehabilitating	2	0/1	3
7. Early Recovery	1	0/1	4
8. Advanced Recovery	0	0	5

This table reflects our expectation that individuals will decrease their level of risk in a fairly linear fashion as their recovery progresses (i.e., the number in the "risk" column decreases). Similarly, we expect the individual's level of skills and supports to increase linearly as he recovers (again, the number in the "skills and supports" column increases). However, the Engagement dimension does not follow the same linear course. Generally, individuals will be less engaged with the public mental health system early in their recovery and will increase their engagement over time, only to decrease their engagement as professional supports are replaced by natural supports and interdependence in the latter stages of recovery.

While the concepts of risk and skills and supports are relatively straight forward, the concept of engagement is difficult and probably creates the greatest confusion in our classification system. Despite our attempts to make the milestones as objective as possible, assessing the consumer's current milestone requires interaction between service recipient and service provider and is therefore somewhat dependent on the provider's characteristics as well as the characteristics of the individual being served. For example, risk might tend to be assessed generally higher in a clinic where a staff member was recently injured by a consumer. Or a consumer may be judged to be "poorly coping" when she could be rated "coping / rehabilitating" if the program offered more support in the community.

However, our experience suggests that level of risk and the level of skills and supports are relatively easier to assess reliably than level of engagement. Because it is the provider who is judging the level of the consumer's engagement, it is possible for a consumer to be judged as "not engaged" because there are no services being offered that meet the consumer "where she's at." The classic example of this is a consumer who is denied mental health services because he refuses to be abstinent for some time period prior to being served. Such a consumer might be very willing to engage with a provider if this requirement was not imposed. But staff in such an environment is likely to view this response as an example of "treatment resistance" (i.e., lack of engagement) rather than as a something lacking in their service spectrum/culture.

Traditional mental health service providers usually evaluate consumers according to their levels of compliance with treatment and insight into their illness. As we define it here, *engagement is not the same as insight*. We are aware of and familiar with many consumers who do not believe that they have a mental illness or a psychiatric disability of any kind. Yet these consumers may

be highly engaged with the staff members who are providing them with service. Usually this is because the relationship is based on helping the consumer to achieve some very concrete goals. These goals may require the consumer to examine (and change) any *behaviors* that are interfering with the attainment of the goal, but that is not the same as requiring the consumer to acknowledge that his mental illness is the *cause* of those behaviors. For example, one consumer who was tortured by the idea of a machine sending destructive rays into his head improved dramatically – going to work and getting off the street and into his own apartment – when he discovered that the rays bothered him less when he took medication and stopped using street drugs. But he never had to acknowledge that the machine was a symptom of schizophrenia.

Similarly, as we define it here, *engagement is not equivalent with treatment compliance.* Many consumers have strong opinions about their services, particularly when it comes to their medications. Some consumers adamantly refuse the medications they are offered. In our definition of engagement, it is possible to refuse medications completely and still be engaged with one's treatment providers. An example of this would be a consumer who refuses medication, but otherwise participates willingly and enthusiastically in other aspects of his treatment. Conversely, it is possible to be completely compliant with one's medication prescription and yet not be considered engaged with one's providers. An example of this would be a consumer who passively takes the pills they give her at the Board and Care, but refuses all contact with her treatment provider.

To us, engagement means working with service providers out of your own motivation in any way that is contributing to your recovery. In most cases where a consumer would be described as "engaged," the consumer would typically be more accepting (rather than rejecting) of the help offered by mental health staff. This does not mean that the consumer passively accepts direction from the staff. What it means is that the consumer accepts the PRESENCE of the staff and continues to work with them even in those circumstances in which there are major disagreements between consumer and staff about what the consumer needs. Engagement does not require that the relationship between staff and consumer is positive or even neutral. The consumer may verbally abuse staff while remaining engaged with them.

Note also that the fact that a consumer is court-ordered to receive treatment does not automatically mean that she is not engaged. Regardless of the circumstances that bring the consumer into treatment (voluntarily or involuntarily), it is still the quality of the relationship with the provider that determines level of engagement. There are many consumers who began their treatment involuntarily as a condition of their probation or parole who respond quite positively and cooperatively to their mental health providers. These individuals would be considered engaged, even though they are required to be in treatment.

All of these factors contribute to engagement being the most difficult of the three dimensions for raters to agree upon. For example, the staff at one clinic that decided to employ the scale without any training independently decided that engagement was equivalent with compliance. This resulted in the decision not to rate any consumer who was not medication compliant any higher than 4 (poorly coping/not engaged), even though a consumer might be doing very well regardless of the lack of medication compliance.

Notwithstanding these difficulties, we continue to believe that the quality of "being engaged" (or "not engaged") is an important and real factor that significantly contributes to our understanding of and ability to assist the recovery process. Without a working relationship (i.e., "engagement"), our only means to influence the consumer are involuntary treatment and services. While these services may sometimes be necessary to keep consumers safe from harm, they usually don't result in the kinds of long-term changes, either cognitive, emotional or behavioral, that typify recovery.

From a system evaluation standpoint, it is also important to have categories that allow us to include consumers who are not engaged with mental health providers (e.g., homeless individuals with a mental illness). The engagement dimension provides us with a means to evaluate the effectiveness and efficiency of programs and systems in their ability to convince consumers to accept our services.

The table above also reflects our expectation, and we now have some data to confirm this, that these three dimensions are quite strongly related to each other. For example, while it's possible to become more engaged without lowering one's level of risk, and it's possible to decrease one's level of risk without building skills and supports, these changes usually occur together. Also, not all imaginable combinations are very likely to exist; for example, it would be unlikely to rate an individual as "at extreme risk, well engaged, with high skills and supports." And not all combinations are important to differentiate; for example, if someone is at extreme risk, does it really matter what their level of engagement or skills and supports is?

The manner in which the dimensions co-vary is important because it suggests that calling the MORS a "scale" is, in some ways, a misnomer. It is probably more accurate to think of it as a set of clusters. Even more important is to recognize that it is not a linear, uniform set of stages through which an individual passes on his way to recovery. It has been our observation that individuals will jump around from one milestone to another. For example, a hospital that pays special attention to community treatment engagement can help individuals progress from "Extreme Risk" (1) to "High Risk / Engaged" (3) without going through "High Risk / Not Engaged" (2) and thereby lower their risk of returning to the hospital. Similarly, it's usually preferable to avoid the "Poorly Coping" categories (4 and 5) on the way up because consumers can often become stuck there. Unfortunately, individuals can also move from a higher milestone to a lower milestone. In our experience, the path of recovery is not always smooth and positive.

Reliability and Validity

Over the last two years, we have been conducting reliability and validity studies with the MORS. The initial results have been very positive, with an inter-rater reliability co-efficient of .85 and test-retest reliability of .85. The MORS is also strongly correlated in the predicted direction with several other instruments, including the Level of Care Utilization System (LOCUS) and the Multnomah Community Ability Scale MCAS). We have also found that the consumer's milestone of recovery is highly correlated in the expected direction with his objective quality of life indicators such as residential and employment statuses as well as hospital and jail tenure.

Uses of the Scale

In discussing possible uses of the MORS, it is important to clarify is that the scale was designed as an *administrative* tool rather than a clinical tool. As mentioned earlier, we believe that the path of recovery is extremely idiosyncratic, particularly in regard to individuals' internal subjective experience. The scale is not intended to provide specific guidance to clinicians in their day-to-day work with their clients. Staff must still consider the particular reasons why a particular client is considered to be "high risk" and provide services based on the consumer's unique needs. For example, one consumer may be constantly abusing drugs and alcohol, another may be paying no attention to her HIV positive status, while another may be inflicting cuts on himself. While all of these individuals would be likely to be considered "high risk," the particular interventions that a clinician would use will no doubt be different in all three cases.

(Having said that, we will point out that many of the case managers at our own Village program have mentioned that the scale gives them a broad and general picture of what "recovery" looks like. They tell us that the descriptions of the higher milestones (6 and above) help to remind them of some of the features of recovery (such as meaningful roles, a natural support network) and this gives them a general framework from which to assist their consumers to individualize and personalize their own recovery goals. We consider this to be a significant advantage that adds to the appeal of the scale.)

We have identified two major uses for the MORS: 1) to assist administrators and funding sources in evaluating the effectiveness of mental health programs and systems, particularly the effectiveness of what are being called "full service partnerships" under the MHSA, and 2) to ensure that we are comparing "apples to apples" in judging the relative need of the consumers that we serve and ensuring that they receive the appropriate level of services. We will address both of these uses in greater detail.

1. Evaluating Program/System Effectiveness

It has been said that one of the strengths of the AB 34/2034 program has been its ability to demonstrate the effectiveness of its services by collecting Quality of Life data. The "data grids" published every month demonstrate how successful counties and agencies are in such quality of life domains as reducing homelessness, hospitalization and incarceration and increasing employment and education. Very importantly, it allows the administrators of the individual programs, as well as the state DMH, to compare their outcomes with the outcomes of similar programs across the state. In a similar fashion, the most obvious and straightforward use of the MORS is to allow programs and systems to easily and quickly evaluate their effectiveness in helping consumers to recover. In a sense, a consumer's movement up or down the MORS scale over time can be seen as a "shorthand" indicator for improvement or decline in promoting recovery itself.

For example, imagine a group of 100 consumers who are evaluated as "high risk / engaged" (Milestone 3) upon admission to Program X. After one year in the program, what percentage of these consumers has moved to a higher milestone and what percentage is at the same or a lower

milestone? How many of these consumers are at milestone 6 (coping/rehabilitating) and above and how many are at milestone 5 (poorly coping/engaged) and below? Where are people getting stuck? Most importantly, how does the movement across the milestones for the 100 consumers in Program X compare with 100 consumers who were evaluated as "high risk/engaged" when they were admitted to Program Y?

We believe that the answers to these types of questions will prove extremely helpful to program administrators trying to improve the quality of their services. One of the difficulties in measuring program effectiveness in the mental health field has always been the lack of benchmarks. There are very few data available to inform us about what are "good" outcomes when it comes to recovery. For example, what percentage of the individuals who enter a full service partnership at Milestone 3 (high risk/engaged) should we expect to reach Milestone 8 (Advanced Recovery) within one year of their admission? Within 2 years? Within 5 years?

The fact is nobody knows the answers to these questions. We have no data because we have had no way to reliably quantify the recovery status of the consumers in our system. The MORS rating provides a means for program administrators to compare the effectiveness of their own program to all other programs using the scale. It will also allow system administrators and funding sources to compare the performance of different programs within their systems and thereby hold providers accountable for their outcomes.

2. Assignment to level of care (Case Rating) with the MORS

One of the most intractable problems in our current mental health system is our inability to compare the relative needs of different consumers. This is important because it makes it extremely difficult for funding sources to hold providers accountable for their performance. For example, traditional outpatient service providers sometimes claim that their performance should not be compared to the performance of an intensive case management program because the average caseload of their staff members is significantly higher. While this is no doubt true (we have heard of caseloads of up to 150), it is our belief that the average milestone of recovery of the consumers in these traditional outpatient clinics is likely to be much higher than the average milestone of the consumers in intensive case management programs. In other words, a much higher proportion of the individuals being served in intensive case management programs would be rated 5 ("poorly coping/engaged") and lower than in traditional outpatient clinics.

We believe that the mental health system desperately needs a better means of assigning consumers to their appropriate level of care to replace the diagnostic and acuity of illness-based tools being used today. We believe that the MORS is ideally suited to serve as a recovery-based tool for identifying the level of service needed by consumers. What follows below is one possible system in which the level of services provided to consumers could be determined according to their milestone of recovery.

Milestones of Recovery Levels of Service (Recovery Based Spectrum of Care)						
Extreme risk	Unengaged		Engaged, but not self coordinating		Self-responsible	
Locked settings (State Hospital, IMDs, etc.)	Outreach and engagement	Drop-in center	Intensive case management	Case management team	Appointment based clinic	Wellness center
Extreme risk (1)	High risk, unengaged (2) Poorly coping, unengaged (4)		High risk, engaged (3)	Poorly coping, engaged (5) Coping, rehabilitating (6)	Coping, rehabilitating (6) Early recovery (7)	
1:1 supervision Legal interventions Community protection Acute treatment Engagement	Welcoming/Charity Evaluation and triage Documentation Benefits assistance Accessible Medications Drop-in services		Case management Full Service Partnership Accessible medications Supportive services (Supported Housing, Employment, Education) Direct subsidies Rehabilitation		Appointment based therapy "Medications only" Wellness activities (WRAP) Self-help Peer support Community integration	

Fortunately, in our view it is not necessary to have a different level or type of service for each of the different milestones. The first row of the table shows the four general categories into which we believe the consumer population can be assigned for service provision purposes: (1) Extreme risk, (2) Unengaged, (3) Engaged, but not self-coordinating, and (4) Self-responsible. The second row shows the type(s) of programs/facilities most likely needed by consumers in that particular category. The third row shows the specific milestones that make up the broader general categories. Note here that "Coping/Rehabilitating" (6) appears in both the "Engaged, but not self-coordinating" category as well as the "Self-responsible" category. Finally, the fourth row shows some of the specific kinds of services that should be available and offered to each of the subpopulations of consumers.

This type of system for assigning consumers to a level of care based on their milestone of recovery will go a long way toward promoting system accountability. It will enable system administrators to make meaningful comparisons between programs by ensuring that the programs being compared have the same "case mix" of consumers. It will help us to triage individuals to the programs that can best serve them and indicate which programs should be collaborating with each other because they are working on the same level of recovery. It will

also promote the flow of consumers through the system by establishing benchmarks for when consumers should move to a lower (or higher) level of care. This will help to eliminate the problem of consumers remaining in intensive case management programs long after their need for this level of service has passed.

Consumer and Staff Reactions

It is important to point out that some consumers have expressed a number of concerns about the MORS. Some consumers have expressed that they feel that it is inappropriate for non-consumers (e.g., the authors) to define their recovery for them. They say that it feels disempowering and not respectful of their individuality. As we have tried to make clear in this paper, the milestones are not intended to replace the consumer's individual experiences of recovery or the need for individualized goal setting and service planning, but rather for tracking the correlates of recovery to assess staff and program effectiveness.

Other consumers have expressed that these milestones are just another way of assigning individuals to "low functioning" and "high functioning" groups in order to decide who should be given what services. We don't believe that recovery-based classifications give staff the authority to override the consumer's choices any more than clinical considerations do. But they are a way of *clarifying the nature of the collaboration between staff and consumer*. Being aware of where individuals are in their recovery process can clarify how to handle common conflicts that sometimes arise between staff and consumers. For example, if a consumer wants to be driven somewhere and staff wants to teach him how to take a bus to get there, it helps to know what his level of skills and supports are. This also applies if he wants to be his own payee and staff doesn't think he is ready. On the other hand, if the staff wants to hospitalize a consumer or give her a life coach for overnight crisis support and the consumer believes she can manage on her own, the issue isn't just skills and supports, but also risk. This consideration of risk may also apply to getting off medication management. A final example is when a consumer complains that staff used to buy them lunch and now they won't – it may be that the consumer's level of engagement has changed from not engaged to engaged.

Recently we encountered a clinic that has been rating its clients with the MORS and is now using the milestones as a shorthand way to describe consumers: "She's a three." "He thinks he's a 7, but he's really a 5." While we are pleased staff are thinking in "recovery terms," (and certainly that is better than GAF scores or referring to consumers as "high utilizers"), we are concerned at the dehumanization this implied. We doubt that the creators of diagnostic schemas intended to turn individuals into "borderlines" and "schizophrenics" any more than we intend to turn individuals into "3s" and "5s," but it is a real risk. In our training on the MORS we express our concern that the scale not be used in this manner, but any categorizing tool can be used to replace really getting to know an individual and this tool is no exception. It is our belief that it is primarily the overall culture of a program that determines the manner in which staff generally treats consumers. Administrators who choose to use the MORS will need to ensure that their agency/program culture is consistent with a positive view of recovery.

The MORS has also had a number of positive reactions. For example, several programs with whom we have worked were having real trouble simply visualizing recovery. It just seemed too

vague a concept – until they saw the scale, which appeared to provide some staff with a powerful vision of what recovery might look like.

Another county used the scale to create a map of their system by determining which milestone(s) were the target groups for different programs. They were then able to see where individuals should be initially triaged to, rather than just sending them where it was easiest. Rather than keeping individuals in the same program indefinitely, they could see how flow could occur within their system by determining which programs each of them should be referring on to as individuals recovered and which programs should be their backup if individuals deteriorated. They could also see holes in their system and why certain programs were getting overwhelmed.

Other clinics are using the MORS to evaluate caseloads to help identify individuals who may be better served in an ACT program or a Wellness Center than in a standard outpatient program.

Present and Future Development

Overall, we have been pleasantly surprised at the mental health community's response to the MORS and we plan to continue to develop training materials for it and study it. Currently, the MORS is being used by the Village Integrated Service Agency where all consumers are rated by their personal service coordinators once per month. To ensure that the results at the Village are not an anomaly, we are also conducting a reliability study on the MORS with Vinfen Corporation, the largest non-government provider of behavioral healthcare services in Massachusetts. Vinfen is conducting an initial pilot study at four of its sites and, assuming that the reliability of the instrument is acceptable, plans to use the measure agency-wide beginning in July, 2006. We are hopeful that the data generated by Vinfen will help to demonstrate the broad usefulness of the MORS and the universality of its underlying dimensions.

The MORS is already being used at two of the seven clinics in Los Angeles County that have been tapped for transformation under the MHSA. Training on the MORS is also planned for 2 more of these clinics in the coming months. Ultimately, we plan to make the scale available for all seven of the clinics.

We are hopeful that other programs and systems will find the MORS useful and will adopt it as a means of evaluating their effectiveness in assisting their consumers to recover under MHSA. We invite others to share their experiences with it and we will be pleased to provide training and consultation on its use.

CONSUMER'S NAME: Mich mR #

RATER'S NAME: DATE:

MILESTONES OF RECOVERY SCALE

Please circle the number that best describes the current (typical for the last two weeks) milestone of recovery for the member listed above. If you have not had any contact (face-to-face or phone) with the member in the last two weeks, please check here ☐ and do not attempt to rate the member. Instead, simply return the form along with your completed assessments.

1. "Extreme risk" – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. "High risk/not engaged"- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. "High risk/engaged" – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

4. "Poorly coping/not engaged" – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. "Poorly coping/engaged" – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. "Coping/rehabilitating" – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.

7. "Early Recovery" – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.

8. "Advanced Recovery" – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

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