



Monterey County Behavioral Health Policy and Procedure

Policy Number	478
Policy Title	Milestones of Recovery Scale
References	Mental Health Services ACT (MHSA) SECTION 7 Welfare & Institutions Codes 5600.3, 5801, 5802, 5806 and 5813.5
Effective	January 1, 2011

1 Policy

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3 The concepts of wellness and recovery have become the cornerstone of California public mental
4 health policy. Section 7 of the Mental Health Services Act (MHSA) provides the guiding principle of
5 “Planning for services shall be consistent with the philosophy, principles, and practices of the
6 Recovery Vision for mental health consumers”. The key concepts of wellness and recovery for
7 individuals with serious mental illness are: hope; personal empowerment; respect; social
8 connections; self responsibility; and self determination. Those key concepts must have an impact
9 on all levels of the delivery of mental health services and requires mental health systems and
10 practitioners evaluate the effectiveness and outcome of the mental health services they provide.

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12 For more than a decade several mental health organizations of consumers, clinicians, advocates
13 and agencies have collaborated to develop the Milestones of Recovery Scale (MORS). That scale
14 was developed and has been tested to measure what seem to be the most important objectives
15 and measurable correlate of the process of recovery. That scale is meant to be a snapshot of the
16 individual’s level of recovery at that point in time. It is also meant to be used regularly so the path
17 of recovery for the individual is documented over time.

18 Procedure

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21 1. There are two major uses for the MORS. The first is in the most broad sense. The MORS can
22 assist programs in evaluating the effectiveness of services provided in a program, particularly the
23 effectiveness of what are being called “full service partnerships” (FSP), and an intensive “what ever
24 it takes” service programs. Secondly, to ensure that we are comparing the same variables in
25 judging the needs of the individual consumer we are serving especially over a time span as well as
26 between different service programs.

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28 2. When administering the MORS the staff person is considering current levels of risk,
29 engagement and community activity (usually within the last two weeks). If the staff person hasn’t
30 had contact with the consumer in the last two weeks they would not attempt to complete the
31 assessment. Ideally the staff person would complete the assessment with the consumer. If
32 working in an intensive FSP it is expected that the staff will have frequent contact with the
33 consumer and would complete the MORS on a monthly bases. If working with a consumer in the

34 System of Care it is expected the MORS will be completed at the annual plan time and then
35 quarterly.

37 **Properties of the Milestones of Recovery Scale**

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39 The aim of the milestones scales is to create a classification system based on consumer
40 characteristics and makes no assumption about the type or amount of services that might be
41 offered.

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43 There are three characteristics or levels assessed by the MORS:

45 **Levels of Risk:**

46 The consumer's **LEVEL OF RISK** is comprised of three primary factors:

- 47 ○ The consumer's likelihood of causing physical harm to self or others
- 48 ○ The consumer's level of participation in risky or unsafe behaviors
- 49 ○ The consumer's level of co-occurring disorders.

51 **Levels of Engagement:**

52 The consumer's **LEVEL OF ENGAGEMENT** is the degree of "connection"
53 between the consumer and the mental health service system. Note that the level
54 engagement does not mean amount of service. A consumer who willingly makes
55 appointments once per month and works on improving his life should be considered more
56 engaged and connected than a consumer who passively attends groups on a daily basis.
57 Similarly a consumer whose only services are large numbers of involuntary
58 hospitalizations but refuses all voluntary treatment would be considered to have no or
59 minimal engagement.

61 **Levels of Skills and Supports:**

62 **LEVEL OF SKILLS AND SUPPORTS** should be viewed as the combination of the
63 consumer's abilities and support network(s) and the level to which the consumer needs
64 staff support to meet his/her needs. It should include an assessment of their skills in
65 independent living (e.g.: grooming, hygiene, etc.), cognitive impairments, whether or not
66 they are engaged in meaningful roles in their life (e.g.: school, work), and whether they
67 have a support network of family and friends. It should also include their ability to manage
68 their physical and mental health, finances, and substance abuse, etc., and their ability to
69 meet their needs for intimacy and sexual expression.

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71 The scales have eight categories:

- 72 1. Extreme Risk
- 73 2. High Risk/Non Engaged
- 74 3. High Risk/Engaged
- 75 4. Poorly Coping/Not Engaged
- 76 5. Poorly coping/Engaged
- 77 6. Coping/Rehabilitating
- 78 7. Early Recovery
- 79 8. Advanced Recovery

TABLE

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 early 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, 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 services recipient and service provider and is therefore somewhat dependent on the provider’s characteristics as well as the characteristics of the individual being served. 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.

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 those 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. Those 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.

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,”

128 the consumer would typically be more accepting (rather than rejecting) of the help offered by
129 mental health staff. This does not mean that the consumer passively accepts direction from the
130 staff. What it means is that the consumer accepts the PRESENCE of the staff and continues to
131 work with them even in those circumstances in which there are major disagreements between
132 consumer and staff about what the consumer needs. Engagement does not require that the
133 relationship between staff and consumer is positive or even neutral. The consumer may verbally
134 abuse staff while remaining engaged with them. Just because a consumer is court-ordered to
135 receive treatment does not necessarily mean that he/ she is not engaged in services.