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. Just 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. “**Experiencing high risk/not engaged with mental health provider**” – 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. “**Experiencing high risk/engaged with mental health provider**” – These individuals differ from group 7 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. “**Not coping successfully/not engaged with mental health provider**” – 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. “**Not coping successfully/engaged with mental health provider**” – 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 successfully/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 jail. 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 neighbors.
Please circle the number that best describes the current (typical for the last two weeks) milestone of recovery for the older adult listed above. If you have not had any contact (face-to-face or phone) with the older adult in the last two weeks, please check here □ and do not attempt to rate the older adult. 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 emergency rooms, hospitals and/or jails for psychiatric reasons or are institutionalized in the state hospital, a locked SNF 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. “Experiencing high risk/not engaged”. These individuals often are disruptive and are often taken to emergency rooms, hospitals and/or jails for psychiatric reasons. Their behavior often brings them to the attention of the police, adult protective services, and the public health department. They often have high symptom distress. They are sometimes homeless and may be actively abusing street drugs, prescription drugs, or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes, COPD, cognitive impairment) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., hoarding, problem gambling, giving away personal property, allowing strangers or abusive family members to live with them, self-neglect, unsafe sex, sharing needles, wandering the streets at night, exchanging sex or social security checks for drugs, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications or any other intervention. They experience great difficulty making their way in the world and are not self-supportive in any way and tend to actively resist non-mental health external support (e.g., in-home supportive services, adult day care, meals on wheels, medical treatment, etc.). They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. “Experiencing 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. “Not coping successfully/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 emergency rooms, hospitals and/or jails for psychiatric reasons. It is unusual for them to be brought to the attention of the police, adult protective services, or the public health department. They may have moderate to high symptom distress. They may use drugs or alcohol or abuse prescription drugs which may be causing moderate but intermittent disruption in their lives. They may also be hoarding or socially isolating. They may not think they have a mental illness and may be unlikely to take psychiatric medications unless prescribed by a primary care physician. They may have deficits in several activities of daily living and need a great deal of non-mental health support which they may reject or only intermittently accept. They are not participating voluntarily in ongoing mental health treatment and/or are very suspicious toward mental health providers.

5. “Not coping successfully/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, take prescription medications differently than prescribed 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 emergency rooms, hospitals, and/or jails for psychiatric reasons. They may have moderate to high symptom distress. They are not functioning well and require a great deal of non-mental health support which they may reject or only intermittently accept.

6. “Coping/rehabilitating” – These individuals are abstinent or have minimal impairment from drugs or alcohol and/or are taking legal medications as prescribed. They are rarely being taken to hospitals, emergency rooms, or skilled nursing facilities for mental health reasons and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication and/or mental health rehabilitative services which may include supportive psychotherapy. They are actively setting and pursuing some quality of life goals and have begun the process of establishing “non-mental health disabled” roles. They often need substantial support and guidance but they aren’t necessarily compliant with mental health providers. They are engaged in some meaningful activities or roles (e.g., spiritual, social and recreational activities), but they are not necessarily working or going to school. They may be “testing the volunteer, 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 volunteerism, work or school, but they are more or less content and satisfied with their lives and the quality of their meaningful activities.
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 psychiatric 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., stable housing, involvement in community groups and activities, faith communities, social and recreational activities, adult school, part-time work, volunteering, etc.) and have established roles in the greater (non- mental health disabled) community. They are actively managing to the greatest extent possible any physical health disabilities or disorders they may have (e.g., HIV, diabetes, COPD, cognitive impairment). They are functioning in many life areas including healthy self-care and are very self-supporting or active in meaningful roles or meaningful activities. They usually have a well-defined social support network including friends, family and/or friendly visitors if homebound.

8. “Advanced Recovery” – These individuals differ from group 7 in that their level of independent living skills and/or their ability to access and utilize supports for independent living and the extent of their natural support system are so great that their mental health needs could be met through private insurance if it was affordable and available to them. They may be making use of any public or private benefits to which any older adult with or without a mental illness is entitled (e.g., IHSS, home health care, MSSP, senior center programs, home delivered meals, etc.). While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled and are indistinguishable from other non-psychiatrically disabled older adults.
**TRAINING: UNDERSTANDING & USING THE MILESTONES OF RECOVERY SCALE (MORS)**

**OVERVIEW:** This training course will introduce participants to the Milestones of Recovery Scale (MORS), a method of evaluating where consumers with severe and persistent mental illnesses are in the recovery process. The system is based on assessing the consumer's status on 3 distinct variables: level of risk, level of engagement with the mental health system, and level of skills and supports in the community. Based on where they fall on these three variables, consumers are assigned to a stage of recovery ranging from "extreme risk," in which it is unlikely that they can be served safely in the community, all the way up to "advanced recovery," in which they graduate from the community mental health system and are indistinguishable from their non-disabled neighbors.

**FACILITATORS WILL:**
- Help participants understand how use of MORS system can be used as a means of increasing service provider accountability and allow determination of our services ability to have the intended effect of promoting recovery. It will allow funding authorities to create systems of accountability that are based on outcomes rather than the mere provision of services.
- Demonstrate how determining consumers' stage of recovery can be used as a means to individualize their services and assign them to particular case rates.
- Present the results of various validity and reliability studies demonstrating the psychometric properties of this scale.

**COURSE OBJECTIVES & AGENDA** - As a result of attending this workshop, participants will learn:
- How the MORS measures Recovery
- Explore how the MORS assists in assigning consumers to appropriate levels of care and create “flow” through Community Mental Health systems
- How do we know this really works?
- How MORS informs Clinical work & its limitations
- Begin the process of learning how to apply the milestones to actual consumers when using the scale (vignettes)
- Summary…what do we do now

**INSTRUCTORS**

Dylan Schmidt, MHRS
Dylan began working at Momentum for Mental Health in January of 2011 as a Personal Services Coordinator (PSC) with the FSP-Adult program and was promoted to Lead PSC in 2013. Dylan began working in mental health as a Community Mental Health Worker at 7th Ave. Center in Santa Cruz, CA in 2008. While at 7th Ave. Center, he was promoted to Unit Coordinator and also worked in the programs office as a Caseload Mental Health Worker. Dylan then went to work for Front St., Inc. as a Housing Supporting Coordinator for the Housing Support Team, where he assisted individuals with severe and persistent mental illness in maintaining stable housing in the community. As a Personal Service Coordinator for Momentum FSP, Dylan provides intensive case management services to individuals with severe and persistent mental illness. Dylan received his B.S. in Neuroscience and Behavior from UC Santa Cruz, and continues to work towards a career in psychiatric nursing.
MORS Training Agenda (approx. length: 3 hours & 20 mins)

Part 1: Introducing the Milestones of Recovery Scale (MORS): 1 hr 30 mins
  I  Introduction & Housekeeping (5 mins)

  II How the MORS measures Recovery (1 hr 15 mins)
      i  What is Recovery: objectivity & subjectivity
      ii What is the MORS and where did it come from
      iii Billing & documenting for Medi-Cal
      iv Underlying Dimensions (Risk, Engagement, Skills & Supports)
      v  Uses of the MORS
      vi Stages of Change
      vii Growth-Oriented Services

  III Data (10 mins)
      i  How do we know this really works?
      ii Vignette & using data with your clients

  IV BREAK (15 mins)

Part 2: Using the MORS: 1 hr 35 mins

  V Uses (15 mins)
      i  Informing Clinical Work
      ii Limitations
      iii Culture

  VI Application of the MORS (1 hr 15 mins)
      i  Review of the Dimensions/Components
      ii Overall approach to the rating
      iii Applying the milestones to actual consumers when using the scale (Vignettes)

VIIClusion (5 mins)
      i  Summary
      ii Appendix materials
      iii Final thoughts & question/answer
EXECUTIVE SUMMARY

The recovery based transformation is clearly upon us. It seems like every week the proponents of this movement throw something new at us on top of our already too large work loads. Sometimes they are things that seem so obvious, like helping people get housing and jobs, that we respond, “We’re already doing that when we have the resources,” and sometimes they are things so strange and even potentially dangerous, like hiring a staff who has a mental illness, sharing restrooms, and promoting medication choice instead of medication compliance, that we feel like throwing them out entirely. Sometimes they are promoting values like hope, healing, authority, and community that seem strangely naïve and simple. Sometimes they bring touching client stories of gratitude for our help and make it seem like we may be onto something important. Sometimes they bring things like clinic restructuring and Wellness Centers that, like it or not, directly impact our work and can’t be ignored or waited out. The Milestones of Recovery Scale (MORS) is yet another product of the recovery transformation being thrust upon us.

Before we just throw the MORS into the pot and stir it around with everything else, it may help to give include some context, some explanation, and some instructions.

Measuring how well real people are doing is hard to do and hard to apply. We all know statistics can be misleading and slanted. On the other hand, we also know that when we keep track of how we’re doing, it’s more likely we can improve our work and convince other people our work is worthwhile. For the most part, mental health services have chosen not to measure outcomes and, as a result, we don’t really know how well we’re doing and outsiders don’t think we do much. People don’t come in for services because they think we don’t do anything anyway. Legislators cut our budgets. Chart audits get more and more extensive partly because they think we’re billing for doing nothing. The recovery transformation believes that we are doing important work and achieving better results than anyone, including ourselves, believes. We think we’d get more community support, more hopeful clients and staff, and more money if we could measure how we are doing.

We’ve all had experiences where statistics have been misused by administrators to pressure us. We’ve all seen colleagues distort their statistics to look better than us or do less work. The MORS can be misused just like any other measurement tool.

When our mental health system does measure anything (usually in pharmaceutical research and university settings) it tends to use symptom checklists like PANS, BPRS, and Depression and Anxiety inventories that we vaguely remember from school. These scales are designed to measure if an illness is being treated successfully. One of the fundamental shifts in the recovery movement is to move from focusing on treating illnesses to focusing on helping people with illnesses have better lives. Therefore, the first outcome tools created by the recovery movement were Quality of Life outcome scales instead of symptom relief scales.

It turns out that some Quality of Life outcomes (like housing situation, employment, jailing, education, and finances) are relatively easy to measure and some Quality of Life outcomes (like satisfaction with life, self esteem, social life and connectedness, disruption from substance abuse, and family relationships) are relatively difficult to measure. As time has gone on, we have increasingly emphasized those things that are easy to measure and dropped those that are not. This makes less work for you while keeping enough important achievements to be impressive. The AB2034 program grew into the MHSA by emphasizing just four outcomes that were relatively easy to measure – homelessness, jailing, hospitalization, and employment.

The MORS is not a Quality of Life scale. It is a “Where is someone in the process” scale.

The major “Where is someone in the process” scale presently used (and regularly misused) is the Global Assessment of Functioning (GAF) scale. This scale has built into it the major premise of the medical model: As symptoms are reduced, life is less disrupted and function increases. The recovery movement has found that this premise is only sometimes and somewhat true. We all know clients who, even after their symptoms are improved, still have poor function and a crippled life. We also all know clients who amaze us by functioning well and building a meaningful life even while experiencing severe symptoms.

The recovery movement would like to have a simple scale that measures where people are in the recovery process instead of where their illness is in the treatment process. That turns out to be incredibly difficult. After all, recovery is a strikingly individualized process. It is fundamentally a subjective process that belongs to the individual who is recovering. It encompasses processes incredibly hard to observe or measure. We persisted anyway.

The MORS scale began when over 100 consumers, staff, program directors, and family members tried to identify important indicators of recovery. (Note an important step there. We moved from trying to measure recovery itself to trying to measure indicators of recovery; or, to use more statistical language, the correlates of recovery. We’re not too bothered by this shift. Think about it. We don’t actually measure the temperature outside. We measure the expansion of mercury in a small tube which correlates with temperature. Almost all measurements are like that.)
Not surprisingly we came up with hundreds of items ranging from self esteem to avoiding conservatorship to taking medications. This time, instead of choosing items that were the easiest to measure, we tried to see if there were just a few items that would by themselves correlate with recovery so we could design a very short scale. We also wanted the items to describe properties of the person themselves – not of their illness or their treatment. Three items emerged: Risk, Engagement, and Skills and Supports.

These items aren’t obscure. They are already part of our daily thinking when we work with clients. They make sense to us: We’d expect someone who is recovering to have less and less risk of damage in their lives. We’d expect them to move from not working with professionals on improving their illnesses and their lives, to collaborating with professionals, to needing us less and less as they get more non-professionals in their lives. We’d also expect them to build their skills in dealing with their illness and their lives and to develop connections and support from their natural community as they recover.

Unfortunately, these three items are relatively hard to accurately describe, agree upon, and measure. That’s why you have to read this manual and practice a little to make sure you’re on the same page as we are. We’ve done a couple of reliability studies, one at the Village and one at Vinfen in Boston, and with a modest amount of training both sites were able to get very high rates of inter-rater and test-retest reliability. Of course, if you are trying to manipulate your data and “outsmart” the scale, it won’t be very reliable or valid.

Also, combining these three items didn’t lead to a neat linear scale. In some ways this is reassuring since recovery isn’t a neat linear process, but it does make things more complicated. Here’s a visual idea of what the 8 levels of the MORS looks like:

People move around in it, or get stuck in it, in a variety of ways, forwards and backwards, just like they do in real life.

We’re proud that we made a one-page single-item assessment that takes a minute to fill out instead of some long scale that only researchers or universities have time to use. Even one page, though, adds to your work. So what is the MORS for? Why do we need it?

1. The MORS provides a picture of your caseload and your work looks like. (See you really do have “harder” clients than your neighbor.) Over time, it also provides a picture of if they’re improving. (It is possible to achieve something worth celebrating without passing a milestone, but over time if someone is really making progress they will pass milestones.) It can identify your strengths and weaknesses. (Are you very good at engaging people or bad at losing them? Do your clients get stuck at “poorly coping, engaged” or do they tend to move on from there? Do your clients in “early recovery” move on and “graduate” or stay with you satisfied forever?)

2. The MORS provides a picture of your program overall. Who are you serving and what are your strengths and weaknesses? (Maybe you need more engagement services or re-engagement services. Maybe your community doesn’t have any supports or treatment for people outside of government supported services so hardly anyone moves from early to late recovery.)

3. The MORS can assist in service triage decisions. We create a lot of frustration and waste by mismatching our services to where people are in their recovery process because we too often create a treatment plan for their illness rather than their recovery. For example, someone may benefit from medications and DBT, but if they are “high risk, unengaged” they’ll never come for their appointments and you’ll be dealing with lots of “unexpected” walk-in crisis.

4. The MORS can help you identify what level of service other providers need to provide for them to succeed and make more targeted referrals. Someone may want to work, but because they are “poorly coping, engaged” they can’t make it through the
lengthy vocational rehabilitation process on their own. This doesn’t mean they don’t really want to work. It means we need to match them with employment services that include case management, sheltered workshops, or supported employment with job coaches for them to succeed.

5. The MORS can assist in creating flow in your program. Without flow caseloads go up and up, but who should be pushed? The MORS helps target people to move through and out of your program.

6. We have a dream that someday if we collect good Quality of Life Outcome data and Recovery progress data, those pesky auditors won’t feel like they have to go through our charts with fine tooth combs to figure out if we’re doing our jobs or not.

This guide contains more background information about the MORS and its reliability and validity, a step-by-step process to help you learn to rate people in a uniform manner, and a set of vignettes to walk you through the rating process. The MORS is not difficult to learn to use or time consuming. We hope it becomes an additional tool for you to promote recovery.

Why Santa Clara County is utilizing the MORS

In the early part of 2009, a mental health system redesign committee, consisting of representatives from Santa Clara County (SCC) Mental Health and several SCC mental health contract organizations, adopted the Milestones of Recovery Scale as a primary method of measuring how well clients are doing in their recovery. The MORS is a “where is someone in the process of their recovery” scale which the rater (service provider) looks at a two week period, or “snapshot,” of a client’s life and considers a range of life circumstances surrounding levels of risk, engagement into the MH system and skills & supports. This may include: stability of housing, psychiatric symptoms, development of goals & meaningful life roles, impact of substance use issues, ability to self-manage health, and ability to establish and maintain personal relationships. The rating scale goes from a “1”: Extreme Risk, to an “8”: Advanced Recovery (see below.)

In February 2009 we began administering the scale on a quarterly basis for Adult Outpatient clients and monthly for Adult Full Service Partnership clients. As of December 2011 we have been administering this scale on a monthly basis for all Adult Outpatient clients. In addition to helping staff and clients assess the success of their support, this information helps us evaluate staffing resource needs across the mental health system.

**MORS Levels: Primary Characteristics**

1. “Extreme risk” (unable to manage in the community)
2. “Experiencing high risk/not engaged with mental health provider” (many behavioral issues; not participating in mental health treatment)
3. “Experiencing high risk/engaged with mental health provider” (participating in treatment but still in significant distress)
4. “Not coping successfully/not engaged with mental health provider” (moderate distress, not participating in treatment)
5. “Not coping successfully/engaged with mental health provider” (moderate distress, but participating in treatment)
6. “Coping successfully/rehabilitating” (doing better, still need significant support)
7. “Early recovery” (doing well, need minimal support)
8. “Advanced recovery” (doing well, independently)

**EXECUTIVE SUMMARY - Recommended System Redesign**

The Santa Clara County Mental Health Department Adult System of Care redesign is being undertaken in response to the dual need of transforming the system while also gaining efficiencies to respond to broad reduction in resources – in other words, to increase the effectiveness of services for persons served as a means of maximizing increasingly limited resources. A critical enabler of this redesign and key contingency to its success is the availability of MHSA funding for some new services and supports. The mission of this redesign is: “to develop new and redesign existing services to more effectively promote individualized wellness and recovery for clients served – from initial access to appropriate “discharge” into the community.”

The redesign has four components which are interdependent, although have distinct redesign activities associated with each:

1. **Measurement:** This redesign will introduce two measures that assess stage of recovery, level of functioning/impairment and level of risk: a clinician completed client assessment (MORS), and a client completed self-assessment (such as CIOM). MORS will be introduced in February 2009, while pilot testing of the CIOM was completed in the Fall of 2009 implementation has been hampered by technical issues.

2. **Phases/Stages:** A second component of this redesign is the introduction of organization of service delivery around clients’ recovery phases. These phases represent the stages of recovery through which a client progresses in order to achieve their self-defined recovery and that allow the system of care to provide highly efficient, person-centered and culturally competent services.

   a. **Discovery & Engagement (MORS 2, 4):** This phase or stage serves those individuals who need intensive services due to their low functioning, high risk status - it supports the first phase of recovery.
Building & Mastering (MORS 3, 5): In this phase, clients are learning to master managing their mental and physical health with a greater emphasis on wellness and recovery, particularly through the addition of peer support services and psychoeducation.

Active Recovery (MORS 6, 7, 8): This new phase will serve those individuals whose recovery is well advanced and who require fewer mental health services as their community supports increase. They may require medication support and substantial support for their continued integration into the community. Individuals in this phase will receive substantial support from peers and some case management, along with regular monitoring of medication by the psychiatrist.

Community Supported Recovery: This stage represents the phase when clients’ mental health needs can be served by PCPs in the community. The PCPs will be linked to specialty mental health via access to psychiatry consultation.

3. Scope of Services: The third component of this redesign will enhance existing services and supports so they more successfully meet the needs of clients in the various stages of recovery and promote clients’ graduation from a given phase and transition into the next. This redesign will also include development of new services and supports, as funding allows, to fill identified gaps in the scope that otherwise impede clients’ progression through the phases of recovery. New and/or redesigned services will be developed based on identification of gaps in service that are revealed by the Measurement Feedback System.

4. Management Practices and Leadership Support: The fourth component of the redesign will address management practices. Comparable to the standardization of certain aspects of the delivery system, as described above, this redesign also recognizes and delineates standardized approaches to select management practices. This encompasses the development, application and support of management tools, methods and skills of program managers, supervisors and leads in effective clinical supervision and coaching, as well as use of data to manage performance. In conjunction with this, leadership from each agency will be responsible to support the adoption and effective use of these management practices.