Understanding & Using the Milestones of Recovery Scale

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of

Momentum | for Mental Health
in Santa Clara County

In collaboration with...
Mental Health America of Los Angeles
http://www.mhala.org/
Objectives of the Training

- How the MORS measures Recovery;
- Explore how the MORS assists in assigning consumers to appropriate levels of care and create “flow” through the System;
- 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;
- What do we do now.
What is in your handouts...

- MORS presentation slides
- Appendix A-H
- MORS form, training overview & MORS Executive Summary (with Santa Clara County use overview)
Recovery is...

“...having a safe place to live, a job and a date on Saturday night.”
-Charles Curie, Former Director of SAMHSA
Many Definitions of Recovery

- Many individuals speak of recovery in terms of their own internal experience – “becoming empowered,” “taking charge of my life.”
- Many providers talk about mitigation of psychiatric symptoms (or distress) and improvement in functioning.
- MORS sees recovery as the process of identifying and taking on meaningful roles in one’s life.
PANSS
7,6,6,5...

GAF = 45

CIOM
Social Support = 2.75

LOCUS
Comorbidity = 3

GAF = 45

A “5” on the MORS

DSM IV
295.10

08/2015
What the MORS Is & Does...

- Behavior-Based scale
- Reduces subjectivity
- Creates flow through the System
- Informs clinical work
- Encourages providers to help people move on

What the MORS Is NOT...

- Measuring consumer or staff satisfaction
- How providers are connected to consumers
- A moral judgment or using moral categories
- An abstinence model
- Medical Model tool
- Linear recovery
- Meant to be punitive
Why the MORS?

- A recovery-based evaluation tool that helps us identify where an individual is in his or her process of recovery over the last 2 weeks.

- A means for mental health programs and systems to objectively evaluate their effectiveness in helping clients to recover over time as well as assign clients to appropriate levels of care based on a person-centered assessment of where they are in the recovery process.
The MORS is not a Quality of Life Scale.

It is a “Where is someone in the process” scale.
Medi-Cal Documenting & Billing

- The short action of completing a MORS scale is not a stand-alone billable service.

- It is best to combine the MORS score and its justification with any clinical service provided. Add the time it takes you to complete the MORS to the service time and state at the end of your note, “MORS score ___.”
Understanding the Scale
Exploring the components and MORS definitions
SAMHSA: Recovery Dimensions

- **Health**: overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love, and hope.
Components & Milestones of Recovery

Components

- **Level of Risk**
  We’d expect someone who is recovering to have less and less risk of damage in their lives.

- **Level of Skills and Supports**
  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.

- **Level of Engagement with Mental Health Provider(s)**
  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.

MORS Scale

1. Extreme Risk
2. Experiencing high risk/not engaged with mental health provider(s)
3. Experiencing high risk/engaged with mental health provider(s)
4. Not coping successfully/not engaged with mental health provider(s)
5. Not coping successfully/engaged with mental health provider(s)
6. Coping successfully/Rehabilitating
7. Early Recovery
8. Advanced Recovery
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 (e.g.: medical issues, Alcohol/Drug abuse (AOD), Developmental Disabilities, etc.)
Understanding “RISKult”

- “RISKULT” is the result of the risky behavior

- The combined result of the risky behavior plus the level of skills and supports

KEY:
The existence of symptoms does not make risk high. The functioning level that is impacted by the symptoms what we focus the rating on.
What factors can you think of?

Some examples may include…

- **Co-occurring Disorders** (medical issues, AOD, DD…)
- **Harm to Others**
- **Social Isolation**
- **Homelessness**
- **Self-Harm**
- **Symptoms interfering with life**
- **Poor hygiene**
- **Excessive caffeine intake**
- **Unsafe sex**
- **Allowing strangers or abusive family to live with them**
- **Gang activity**
Skills & Supports

- The combination of the member’s abilities and support network(s) and the level to which the consumer needs staff support to meet his/her needs.
  - Is the consumer engaging in meaningful roles outside of being a mental health consumer (i.e. employee, student, caregiver, faith community, volunteer, involved grandparent, rec activities, etc.) and how much are they engaging in this?

- Is the consumer relying more on a professional MH support system (i.e. Psychiatrist & CM) or a natural support system (i.e. family & friends)?
What about Meaningful Roles?

- Meaningful Roles are the foundation for the underlying dimensions.
  - Meaningful roles are the first thing we consider when we use the MORS—it’s the first question on the logic model.

- Meaningful Roles are the observable, active and functional, positive, normative COMMUNITY roles a person has.
Even More about Meaningful Roles

- Bill says he signed up to volunteer at the food bank and usually goes once a month.
- Gerardo told you that in the last two weeks he has applied for work at 5 different companies although no one has hired him as of yet.
- Jeanette’s sister takes care of her daughter on the two days a week she attends school for her GED.
- Natalie has dropped 2 of her 4 classes at the community college as her drug use makes it more difficult for her to stay focused and take care of business.
- Grace called to reschedule her appointment with you because she has to work overtime on her job.
Even More about Meaningful Roles

- Nancy, who attends 12 step meetings 5 days a week, just let you know that she is now sponsoring someone in their recovery and she doesn’t think this will take time away from her studies for her classes.

- George states that he wished he was closer to his children who he has not seen in 8 months.

- Rick increased his hours from 10 to 20 per week in his peer supporter job at the Wellness center.

- Greg called you yesterday to tell you that he and his girlfriend are doing real well.

- Marvin lives with his mom. He cares for her and makes sure she takes her medications as well as preparing meals and cleaning her house.
Engagement ISN’T

- Total agreement or cooperation with the service and treatment approaches of staff

- Medication adherence

- “Insight” into or “acceptance” of one’s mental illness

- Frequency of receiving or accepting services
Engagement IS

- The relationship ("connectedness") between individual receiving services and staff.

- Individual’s “tolerance” of the presence of staff in his/her life.
  - Even a small opening into a relationship – despite refusal to accept treatment or liking/disliking you.

Please note, when looking at MORS 6-8 we do not consider engagement.
More about Engagement...

- Phil comes into the clinic four days a week and yells at his case manager about how the program does nothing for him.
- Susan has attended every group at her day treatment program for the past three weeks.
- Jim almost never comes into the clinic (the pharmacy delivers his meds to him). Staff call him every other week to see how he is doing, and he provides a full report.
- Ann has been in an IMD for the past four weeks. Last time you went to visit, she told you of her about her plans to escape from the facility.
More about Engagement...

- Carl has been an active member of the county Mental Health Board for the past three years. He refuses to speak to you, his case manager, stating that he much prefers his previous case manager.

- Mary keeps all of her appointments with you and her psychiatrist, and takes her medication as prescribed. During meetings with you, she openly discusses what is happening in her life.

- Ed came in last week and signed his Treatment Plan.

- While Larry was completing his Treatment Plan with you last week, he stated that one of his goals was to never speak to the psychiatrist about taking medications.
Extreme Risk (1)

- 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.
Extreme Risk-1

Cannot be safely served in the community during the past 2 weeks.
Experiencing High Risk
Not Engaged with mental health provider (2)
Engaged with mental health provider (3)

- “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.

- “Experiencing high risk/engaged with mental health provider” – 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.
Experiencing High Risk
2-Not Engaged
3-Engaged

Experienced significant life disruption as a “riskult” of behaviors in the past 2 weeks
Not Coping Successfully

Not Engaged with mental health provider (4)

Engaged with mental health provider (5)

- “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.

- “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.
Not Coping Successfully
4-Not Engaged
5-Engaged

- Generally stable life in the last 2 weeks
- Absence of community roles
- No significant life disruption
Coping successfully/Rehabilitating (6)

- 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.
Coping Successfully/Rehabilitating - 6

• Starting to explore community roles
• Relying on staff support to maintain roles and quality of life OR
• “Retired” – content and satisfied with life, some community roles; disinterested in the responsibility of work/school
Early Recovery (7)

- 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.
7-Early Recovery

Creating and maintaining community roles with limited staff support
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.
8-Advanced Recovery

Completely independent in creating and maintaining community roles
Uses of the MORS

- Creates a picture of your caseload and the overall program
  - Do you have a lot of people stuck in one MORS rating?
- Assists with your service delivery decisions
  - Are you good at engaging people or bad at losing them?
- Assists in choosing services to which to connect people
  - Do we mismatch services?
- Assists in promoting flow throughout the system using growth-oriented services
  - Without flow caseloads go up...and UP...AND UP!
How can we create flow throughout systems by using Growth-Oriented Services?

“Self-responsibility and stability aren’t enough to determine if someone is ready to move on. It is our duty & goal as providers to help get members to at least early recovery, if not to advanced recovery.” – Dr. Mark Raggins
It’s helpful to remember the “Stages of Change” when considering where someone is in their recovery – both the client’s stage of readiness as well as your own!
# What are Growth-Oriented Services?

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<tr>
<th>Stage of Recovery</th>
<th>Care taking services (what we have been doing)</th>
<th>Growth oriented services (What we aim to do – create flow)</th>
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| **Unengaged** (MORS: 1,2,4) | • Forced treatment  
• Protection/monitoring  
• “Putting out fires”  
• Benefits establishment  
• Acute stabilization | • Engagement & relationship bldg  
• Natural Consequences  
• Peer bridging  
• Quality of life goals  
• Drop-in services |
| **Engaged, but poorly self-coordinating** (1,3,5,6) | • Structure  
• “Putting out fires”  
• Making decisions for people  
• Case management  
• Chronic stabilization | • Skill building  
• Service coordination – making decisions with people  
• Supportive rehab & linkage services, incl. independent follow-through w/ referrals  
• Collaboration building |
| **Self-responsible** (6,7,8) | • Maintenance therapy & medication  
• Benefits retention | • Community integration  
• Peer support & Self-Help  
• Wellness activities  
• Growth-promoting therapy |
DATA

How do we know this really works and how can I use data to improve services with my clients?
Inter-Rater Reliability* of MORS

- Reliability testing done by California State University Long Beach at MHA Village in California (Oct 2005; r = .85, N=381) and Vinfen Corp in Massachusetts (Apr 2006; r = .86, N=105)
- Validity testing done against the LOCUS (Level of Care Utilization System)
- Findings:
  - Inter-rater reliability met or exceeded industry standards
  - Increasing the number of raters increases the reliability (the “consensus effect”)
  - Some evidence for the existence of the “prescriber’s” bias
  - Data validity met or exceeded industry standards

  **Keep in mind:**
  - Initially you will see very little change as this is a slow process.
  - At the Village in Long Beach it took an average 5-7 years for someone to go from a 2 (High Risk/Not Engaged) to a 7 (Early Recovery)

*Reliability has to do with the quality of measurement. In its everyday sense, reliability is the "consistency" or "repeatability" of your measures. ([http://www.socialresearchmethods.net/kb/reliable.php](http://www.socialresearchmethods.net/kb/reliable.php))
Stability of Ratings within Santa Clara County
Year 2 Quarter 4, Year 3 Quarters 1 & 2

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How to use data with an individual

K.A. is a 46 year old Creole/African-American woman. She was born & raised in New Orleans, but much more is unknown. She was enrolled into a mental health program due to her history of chronic homelessness and severe symptoms related to unmedicated schizophrenia (paranoid type), including hallucinations and delusions which manifest themselves into violent outbursts. K.A. believes that she must cleanse herself on a regular basis to keep the demons away. This includes bathing in bleach and dusting cleanser around her sleeping area (whether on the streets or in housing).

K.A. spends her SSI money on food and motel rooms, so she is usually broke by the first or second week of the month. She is not one to beg for money or food, but many people will offer her these things.

K.A. was housed in an apartment in March, taking her medications daily and meeting others in her complex to socialize. In April she began to experience severe hallucinations where demons were telling her to attack her neighbors. Following a hospitalization for pulling a knife out and threatening someone, she is now in crisis residential for on-going support.
For more on reliability & validity...

- Article in the Community Mental Health Journal on the reliability and validity of the MORS. You can download the article free of charge at: http://www.springerlink.com/openurl.asp?genre=article&id=doi:10.1007/s10597-009-9213-8

- ...or contact Dave Pilon at dpilon@mhala.org
It’s BREAK TIME!
We will resume the MORS training in

00:00
HOW THE MORS INFORMS CLINICAL WORK
How best to use MORS “Clinically”

- Designed as an administrative tool that can help inform our work clinically, but should not be used as the only tool to direct a person’s recovery.

- It is their relationship to us, as providers, that ultimately creates the ability to change (i.e., what is usually referred to as the clinical effect). The MORS are written to capture and take advantage of this.

- MORS is informing our System of Care to re-think the type of services & resources available to consumers.
Limitations of the Milestones

- The milestones are written in a way to take advantage of our experience with the “generalized client.” In reality, there is no such thing as a “generalized client.” It is our ability to understand the nuances and uniqueness of someone’s experience that ultimately creates the ability to support change and inspire hope.

- Many consumers resent (justifiably) any attempt to reduce their experience to a single number.

- MORS should not be used for those under age 18 (see CALOCUS or CANS for youth recovery rating scale)

- On the surface, MORS does not take into consideration various cultural factors. It is up to us to integrate this into the rating.
The Importance of Culture

- Culture includes many societal aspects: language, customs, values, norms, rules, tools, organizations, and institutions.

- Don’t underestimate the significance of co-culture values and norms.
  - This may include experiences, sexual orientation, religion, age, poverty, homelessness, mental health, drug, institutionalization (e.g., mental health, prison), military and regional.
Cultural Considerations

- The MORS definitions are broad enough so that “having a meaningful role in the community” can mean something different depending on your culture of origin and co-culture norms.
  - It is culturally normative for adults to have a meaningful role in their community?
  - In the majority of cultures having the support of family and friends is important and highly valued?
  - The essential thing to remember is this: Whatever is culturally normative for an adult without a mental illness should be our goal for adults WITH a mental illness.
USING VIGNETTES TO APPLY & PRACTICE
Reminder

- Although we take history into account for services, remember that we are only looking at a 2-week “snap-shot” of a person’s recovery.
- Base the rating on fact, not opinion
- What is the Level of RISKult
  - The presence of symptoms or use of drugs/alcohol does not automatically make someone “High Risk”. How do these things impair or not impair their overall functioning (RISKult)?
- What is their Level of Skills and Supports
- What is the Level of Engagement with Mental Health Provider(s)
  - Engagement is a small window into the connection between the service provider & the individual.
Does the person have positive, meaningful community roles?

YES
- 8 (Advanced Recovery)
- 7 (Early Recovery)
- 7 (Early Recovery) or 6 (Coping Successfully/Rehabilitating)

NO
- 1 (Extreme Risk)
- 2-3 (Experiencing High Risk)
- 4-5 (Not Coping Successfully)
- 2-3 (Experiencing High Risk) or 4-5 (Not Coping Successfully)
- 4-5 (Not Coping Successfully)
- 2 (Experiencing High Risk, Not Engaged)
- 3 (Experiencing High Risk, Engaged)
- 4 (Not Coping Successfully, Not Engaged)
- 5 (Not Coping Successfully, Engaged)

The Line

08/2015
Vignette Considerations

- Level of Risk
- Engagement
- Level of Skills & Supports
  - In the community
  - In the MH “System”
- Meaningful Role
  - Is it in the MH “System,” in the community or none at all
- Age (TAY or Older Adult)/Developmental Stage
- Health issues in relation to age & coping abilities
- Culture/Co-Cultures
  - Experience, Race/Ethnicity traditions, Gender, Institutionalization, Criminal Justice, Homeless, Sexual Orientation (LGBTQIA)
L.A. is a 20 y.o. Hispanic female with a diagnosis of Schizoaffective D/O. Ind has grown up in the system and is currently residing in a licensed B&C for women. She is on rep-payeeship and collects SSI. She takes her medication as prescribed, attends a day treatment program 3 times per week, and is actively working towards obtaining her GED. She has plans of attending college in the future and would like to become involved in a college theatre group.

In spite of her best efforts, L.A. remains socially awkward and isolated. She reports that she has no friends and her relationship with her adopted family is tumultuous. When L.A. is feeling lonely or depressed she will routinely threaten to harm herself. Most of the time her case manager can get her to utilize her coping skills and de-escalate the situation quickly. However, if L.A. is particularly seeking attention she becomes inconsolable & needs to be sent to the hospital. Once there, she demands a lot of attention from the nursing staff in order to ease her feelings of loneliness. L.A. has a great level of insight into this behavior and she can go for months without being hospitalized. Yet, in the last two weeks L.A. has gone to the ER once and to Emergency Psychiatric Services (EPS) twice.
F.G. is a 47 y.o. Caucasian female with a diagnosis of Bipolar D/O. She receives SSI and Medi-Cal. F.G. is a pleasant woman that enjoys being around others. Prior to her breakdown, she received many educational awards and was offered a full scholarship to a local University. She is a self proclaimed expert on the San Jose area and loves to discuss the cities history, architecture, and growth. In spite of her generally pleasant demeanor and her med compliance, F.G. continues to have poor hygiene, limited social skills, and no concept of personal space or boundaries. This is evidenced by the fact that she has been evicted from her last 4 placements for her incessant hugging of other residents and her refusal to stop getting into the bed with other residents at night, despite their objections.

Indiv meets with her case manager weekly and is very cooperative. She doesn’t believe that she has a mental illness and she has no insight into her problematic behavior. In fact, she feels like she is being “persecuted” when her case manager tries to educate her on boundaries and appropriate social behavior. Indiv has declined all opportunities to attend groups, attend agency sponsored events or volunteer in the community. Instead, F.G. chooses to spend the majority of her free time with her on-again, off-again boyfriend of 1 year. Despite her profession of love for her boyfriend, F.G indiscriminately attaches to men and routinely asks strangers to marry her or take her home when she is out in the community.

F.G. is unable to cook, ride public transportation or cross the street independently. Even though her general ability to care for herself independently is low, F.G. isn’t conserved and she hasn’t had any hospitalizations in the last 6 months.
The Rockstar

J.R. is a 25 y.o. Jewish-American male living independently in supportive housing. He has been diagnosed with Schizophrenia, paranoid type, for much of his adult life. J.R. is very religious, which can sometimes be mistaken as responding to voices when he is, in fact, calming himself by reciting bible verses. Indiv has many goals he would like to achieve, some often lofty. He would like to get a job, preferably as a used-car salesman, travel internationally and write books like his brother. He describes himself as an artist as he paints and both writes and plays music. It is his dream to become a recording artist so that everyone can hear his music. He frequently plans to go to local cafes to perform, but “forgets” to attend. He has a representative payee for his SSI, SSDI and VA benefits and has difficulty providing his payee with monthly bills, so prompts are needed from his case manager. Indiv tends to isolate to himself, but gets along with his house-mates, in particular one who does artwork with him. Indiv is able to take the bus, when motivated, but does not manage his time when related to appointments. Indiv depends on his elderly mother to do his laundry and provide him with balanced meals on a weekly basis, although he is able to prepare meals on his own.

Recently, Indiv has been displaying an increase in symptoms – he is loudly, and often in a negative manner, found talking to himself alone in his room and while walking down the street. Indiv denies he is doing such, but the volume of his yelling has started to worry his house-mates. Indiv refuses to speak to his case manager about this and denies that he is having any problems. He has misses several appointments and refuses to return case manager phone calls.
L.E. is a 47 y.o. Vietnamese divorced woman and is bilingual in English and Vietnamese. She was born in Vietnam and immigrated to the USA in the 80s. She lives with her boyfriend of 10 years and her 21 y.o. son in a rented house. Her older daughter lives in Southern California and is attending college. She is involved in her childrens’ lives and attends a local Vietnamese community center a few times a week. She does not work, but receives SSI and has financial support from her boyfriend.

L.E. is diagnosed with Major Depressive Disorder, recurrent, with psychotic features. She has a history of trauma from domestic violence and rape. L.E. is very guarded and shows some paranoia about people knowing about her life. She tells her counselor not to reveal to others that she has a mental illness because she is shameful and doesn’t want others to know (it’s considered shameful to have a mental illness in the Vietnamese culture). Initially she would not take psychotropic medication but after years of working with counselor, she has agreed to take medication but only if counselor consistently follows up with her then she is more medication compliant.

L.E. frequently sees her primary care physician for a variety of physical health complaints but has been told that she is fine or had repeated procedures for the same ailment. She has not disclosed to her primary care physician about her history of trauma.
J.J. is a 66 year old African-American divorced male, with 8 children and has contact with none. He has a girlfriend of a few years who caters to his every want and need. J.J has a history of symptoms including visual and auditory hallucinations, anger outbursts in social settings and anxiety. Indiv has a long history of alcohol abuse but reports he has been sober since 2005. He has been in MH services since 1992 with several jail episodes and a stint at Napa State Hospital for 3 years. J.J. also has a vast array of medical issues that he does not actively manage, such as hypertension and chronic pain from his hip, back and legs. J.J. is currently homeless and sits on the same bench every day. Indiv has Medi-Cal, Medi-Care and SSI, which he manages on his own.

In the past J.J.’s case manager had referred him to several different board & care homes or other housing options, but the he adamantly refuses, stating, “They will take all of my money! And I don’t want to go into a shelter!” This is fostered by Indiv’s belief that people in his surrounding community are his friends and assist him financially without even asking. Indiv’s case manager has witnessed persons coming up to Indiv attempting to give him jewelry, money, motel stays, food, electric wheelchair, cell phone, etc. Indiv’s case manager attempts to work on treatment goals and needs towards getting off the streets, but upon the case manager’s arrival J.J. demanded he leave with no explanation as to why.
Chronic Pain

C. S. is a 69 y.o. Caucasian female with a diagnosis of major depression, moderate, living in shared housing with a roommate in the community. Indiv was a homemaker in her youth, but divorced and has no children. She lived on alimony after her divorce and now receives SSI and Medi-Cal.

In addition to chronic symptoms of depression, including depressed mood, isolation and tearfulness, she tends to ruminate about her physical symptoms (fibromyalgia). She takes 3 different anti-depressant medications and uses several different OTC medications for pain management. She is evasive about her use of alcohol but staff suspect that she is drinking at least a moderate amount at home. C.S. depends a great deal on her roommate for assistance with independent living tasks such as cooking, grocery shopping, and cleaning. She does not drive and her chronic pain interferes with her ability to perform household chores. She has authorized staff to share information with her roommate, who has expressed concern about C.S.’s cognitive abilities, saying that C.S.’s memory and attention to detail have deteriorated significantly in the last 6 months.

C.S. does not participate actively in treatment planning and has refused therapy or day rehabilitation services. She does not leave her home often but calls her case manager at least once a week to complain of physical pain. She does not generally accept or follow through with suggestions from her case manager regarding strategies to cope with her depression and pain. C.S. has made several vague references to suicidal thinking, but denies any plan when asked by staff.
P.A. is a 35 y.o. bi-racial gay male with a diagnosis of Generalized Anxiety d/o. He is on SSI, SSDI, and Medi-Medi, which he has always successfully managed on his own. Indiv is currently employed part-time and actively participates in social outings in and outside of the mental health system. Indiv loves to go dancing or go to the movies with the few in-person friends he has, but prefers on-line relationships, of which he has many.

P.A. has maintained his own independent apartment for 5 years and has not had any hospitalizations in 7-8 years. It was found that Indiv has an opportunity to transfer his psychiatric services to his primary care physician. Despite case manager encouragement to move on, P.A. refuses to leave the program citing he cannot maintain his current lifestyle without intensive support from staff. However, case manager and other staff rarely provide support services to Indiv and are very confident that he can maintain his recovery on his own. Further, P.A. was reassured that he is always welcome back to the program as a peer mentor. Indiv continues to argue this, but has recently been more willing to talk his options out.
B.J. is a 40 y.o. African-American female. She has never been married, but has 1 adult son, who is currently incarcerated. Indiv is on rep-payee for her SSI, and has been conserved for the last 6 months. She is currently residing in a licensed board & care and is happy to finally be out of IMD where she has been in and out of for the last 20 years.

B.J. has a bright personality and loves to engage with others. Her dynamic traits makes her attractive to the opposite sex, so she frequently has a new boyfriend every time her case manager meets with her. She denies having sex, however, the B&C reports she is often found with various male housemates in their bed naked. Indiv has no insight as to how dangerous this is to her health and well-being. When confronted about this, B.J. will often speak with a child-like voice and scream, “I’m an adult! Don’t tell me what to do!” She recently found her “boyfriend” talking to another female in the house. B.J. immediately believed that they were having an affair and began destroying property. B.J. hit the female and when the case manager attempted to intervene to calm her down, B.J. continued to think others were making fun of her, screamed and kicked in the TV screen.
R.J. is a 20 yr old male who is 1st generation Cambodian-American. He resides with his parents who are immigrants and do not speak English. R.J. is single with two young children from a previous relationship (the mother of the children has full custody). R.J. struggles with symptoms of PTSD, including panic attacks. He takes his medications intermittently, but also smokes marijuana daily to cope with his life.

While in high school, he completed some special-ed courses. R.J. dropped out due to difficulty with behavioral problems leading to expulsion. He does not want to return to a “normal” classroom setting but is still contemplating his next educational move. In transition, R.J. became involved with a local gang. While involved with gang activity, he was shot in the arm which has prevented him from being able to engage in some employment activities. He feels hopeless about his future and a “failure” as his family culture supports a strong value to gain employment and support the elders.

R.J. attends appointments with his psychiatrist and CSS 1-3 times per month and states that he feels he needs this. He was recently denied SSI but there are efforts to appeal this decision. In recent weeks R.J. has suffered numerous setbacks which he feels has lead to an increased depressed mood and lack of motivation to engage in any services. He responds when staff attempts to reach him over the phone but has minimal commitment to consistently attend appointments. He is not currently involved in any day activity and spends his day with friends, some of which are gang members. However, if asked, he will watch his children if their mother drops them off.
Music Man

JD is a 19 year old male of Middle Eastern descent. He is currently homeless, however, he sometimes stays at his girlfriend’s home. JD does not have a lot of family support, but relies on girlfriend for financial and emotional support.

Likewise, JD depends heavily on his Momentum case manager and checks in regularly. Despite his connection with his girlfriend and case manager, JD continues to struggle with his social relationships due to a history of abandonment, lack of trust in others and feelings of hopelessness.

JD has never been to jail but has been cited for panhandling and loitering in local parks. He has not paid these citations and currently has a bench warrant out for failure to appear. He takes Prozac daily for depression and Ativan as needed for anxiety. He the benefits to taking his medication and is committed to following its regimen.

JD has no benefits at this time and his psychiatrist does not feel that JD meets the criteria for them. JD had started the process of applying for GA but did not follow through on attending orientation. JD is not involved in any structured activities, nor is he interested. His daily routine includes sitting around singing & listening to music.
S.H. is a 29-year-old single African-American female on the Intensive Services Team who has been diagnosed with Major Depressive Disorder. She comes into the program once per week to pick up her medications but otherwise refuses to have any contact with program staff. She is living in her own rent-subsidized apartment.

S.H. has participated intermittently in your work experience program, but currently she is neither working nor going to school. She spends most of her days watching television and it is believed that she uses marijuana and may be smoking crack. Approximately 6 months ago, she spent a month on the burn unit of a hospital after she (by her report) fell asleep while smoking, her apartment caught fire and she suffered third degree burns over 25% of her body. It is not clear whether this was truly an accident or whether she was making a suicide attempt. S.H. has a history of inflicting herself with razor cuts although she has not engaged in this behavior since she was released from the hospital.

Up until recently, she would attend the weekly “open mike night” at a coffee house in her neighborhood and read her poetry.
Maria is a 30 y.o. African-American woman who is a single mother raising two young children whom she had with her partner she had separated from several years ago. Maria was working full-time up until several years ago when she began experiencing high levels of anxious and depressed moods, inability to concentrate on tasks, & panic attacks. These symptoms have impaired her ability to be around people, as-well-as fulfill responsibilities and tasks at work. Involved in her weekly therapy and monthly med management sessions, Maria is motivated & reporting a desire to learn to manage her symptoms so she could go back to working full time to support her and her family. Her SSI benefits recently expired and, due to her having no income, she and her children were evicted from their apartment. Last week, they moved into her uncle and his family's home, who have been supportive to her recovery. The dynamics of two families living together has increased her stress level and causing her symptoms to intensify. Maria is resourceful, independent and cares for her children deeply as she tries to provide for them.

In the past two weeks, Maria reported she has been experiencing on average of about 7 panic attacks in a day where she has a hard time breathing, her heart pounds, feels nauseated and dizzy, & thinks she's losing control, She notes being "very depressed, has very low levels of energy, & unmotivated to do anything". Although these are the same symptoms Maria experienced before she was evicted, she reported feeling like her symptoms have gotten worse with the recent stressors of living with her uncle & his family since they do not have the personal space they once had in their own apartment. The children's school teachers have recently reported behavioral issues at school.
Travelin’ Man

Amsterdam is a 50 year-old Euro-American male who was diagnosed with bipolar disorder and ADHD. Before experiencing mental illness he was married with one child, held a job for a TV company and traveled the country performing in front of thousands. After his mental illness took a strong-hold, he divorced, became homeless and could not find work. Approximately 4 years ago, after being in treatment for several years, he got back into the work force as a self-help center group facilitator. He began to take trainings to not only help others in his work, but also would benefit his wellness. He valued the work he did, had a select group of friends he could debate politics with, and took care of his pet crow, Trixie, which he rescued when it was a baby that fell from a tree.

In the last year Amsterdam decided he wanted to move to another country and teach. With the help of his case manager and the rest of his mental health team, he was able to get on that airplane and move. He has many friends and an active social life that includes hanging out with his landlord, co-workers and taking care of various exotic animals. He continues to receive SSDI and Medi-Cal because work is unsteady, but hopes to find something more permanent in the near future.

Amsterdam has significant physical health problems including several heart attacks, gastrointestinal problems and poor eating habits. He sees a medical doctor for his conditions when it is urgent and takes both medical and psychiatric medications somewhat regularly. Amsterdam occasionally mixes up his medications, but he will consult on what do it rather than taking too much.
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To Summarize...

We all know folks who, even after their symptoms are improved, still have poor function and a crippled life.

We also all know folks who amaze us by functioning well and building a meaningful life even while experiencing severe symptoms.

It is our job to expose all consumers to all opportunities in the community – whether they are content in their current state or not.
Remember:

Mental health services are a bridge, not a destination.