Milestones of Recovery Scale (MORS)

Appendices (A – H)
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A) Better Defining the Coping successfully/Rehabilitating (6) Rating

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.
"What is “retired” according to the MORS:
Retired does not refer to those that “go into retirement” based on their age and stage of life. For the purpose of the MORS we see “retired” as persons who are content in where they are and do not wish to explore any more things or meaningful life roles to move forward in the community. These are folks that are “coasting” along in their life.

- Can a client be not engaged and still be considered a “6”? Yes. If the person is starting to explore quality of life goals outside of the MH system, but generally does not engage with you or the system, they can be considered in the “6” category.

- What’s the difference between Coping Successfully/Rehabilitating and Early Recovery? Early Recovery generally means the person has more skills & supports outside of the MH system and has more established and relatively stable on-going “non-disabled” roles. They also require much less support from staff over-all.

- What’s the difference between Coping Successfully/Rehabilitating and Poorly Coping? Level of risk and amount of skills & supports in the greater community are your core differences. Persons that tend to be “poorly coping” have little to no skills or supports and are almost always only connected to the MH system. They do not have meaningful roles outside of being a consumer. Many persons who are “lingering” in the system or board & cares (i.e.: sitting around watching tv all day, smoking cigarette after cigarette, etc.). Many of these folks slide “under the radar” and are given much less services than they may actually need. Persons who are in the “poorly coping” area frequently need more engagement and motivation to find their roles outside of the MH system.
B) Hard & Fast Rules
• To be rated at a level 8, “Advanced Recovery” a client cannot be receiving any government aide (i.e. SSI, SSDI, etc.) due to mental health reasons. The exception to this rule is public health insurance (i.e MediCal or Medicare).

• To be rated at a level 1, “Extreme Risk” a client is either currently in IMD or acute psychiatric hospital. You may also rate them a “1” if they are currently at imminent risk of harming themselves or others, or are gravely disabled – you would basically be performing a 5150 hold at that point.

• Clients who are homeless or who are living in homeless shelters will not be rated above a level 5, “Poorly Coping/Engaged.” Generally, those that are unhoused are in the “high risk” category, but can be considered “poorly coping” depending on how the status is impacting their well-being or if they are in the process of moving into a more permanent residence.

• Individuals rated “above the line” (ratings 6, 7 or 8), must be CONSIDERING, SETTING, PURSUING and/or ACHIEVING SOME QUALITY OF LIFE GOALS. These individuals are creating meaningful roles for themselves outside of being a mental health consumer.

• Culture and sub-cultures play a large roll in how you will rate someone. If they are single, 32 y.o and living at home with their parents, take into consideration that they do not have the money to live elsewhere or perhaps it is their cultural believes to remain at home until married.
C) MORS Cores…

Every client should be evaluated based on their level of:
- RISK
- ENGAGEMENT with MH Provider
- SKILLS and SUPPORTS
• **RISK:**

The consumer’s likelihood of causing **physical harm to self or others** (i.e. Is the client behaving in a way that he/she could be 5150’d?)

The consumer’s level of **co-occurring disorders** (medical, developmental, substance-related) – are they taking care of these areas or are they ignoring the needs? Is their mental illness limiting their ability to manage the co-occurring disorder?

The consumer’s level of participation in **risky or unsafe behaviors** (i.e. abusing substances, not managing co-occurring medical conditions, unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, promiscuity, etc.) This also applies to symptoms – actively experiencing symptoms and/or not taking medications does not mean they are at high risk. If this applies, how is this **impacting** their life and mental health? If not at all or very little, then they may not be at a high level of risk. Remember, this is not a moral judgment – don’t base their risk on what our perception is, but how the behavior is affecting their life.

In jail does not put people automatically as a “1, Extreme Risk.” When someone is in jail, they will most likely be a 2 or 3. If they are in jail because due to risk of harm to others and it is keeping others safe by them being there, they might be rated a “1.” If they are in there for a bench warrant, drugs, stealing, etc. you want to decide what other rating is most appropriate or do not rate them at all if you cannot meet with them or speak with them.

**Homeless status**- A client who is homeless or living in a shelter cannot be rated above a level 5, “Poorly Coping/Engaged.” Generally, those that are unhoused are in the “high risk” category, but can be considered “poorly coping” depending on how the status is impacting their well-being or if they are in the process of moving into a more permanent residence. Remember, Housing is a basic necessity – homelessness increases the risk victimization.
• **ENGAGEMENT w/ MH Provider:**
The level of “connection” between consumer and mental health service system (aka YOU, the rater/PSC/CSS/Clinician/MD)

Engagement merely requires that the consumer is “TOLERANT” of the presence of staff in his/her life. They may not like you, but they’ll tell you why they don’t like you.

Engagement is **not**: medication compliance, insight or acceptance into one’s mental illness, total agreement with service and treatment approaches of staff, or total amount of services received. Even if they come in every day and sit around, that doesn’t necessarily mean they are engaged.

• **SKILLS and 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, church go-er, volunteer, involved grandparent, etc.) and how much are they engaging in this?

Is the consumer relying more on a professional support system (i.e. Psychiatrist and PSC) or a natural support system (i.e. family and friends)?
D) Using the Scale: Engagement tools & techniques
# Milestones of Recovery – Matching Services/Care to Levels
## (Recovery Based Spectrum of Care)

<table>
<thead>
<tr>
<th>Extreme risk</th>
<th>Unengaged</th>
<th>Engaged, but not self coordinating</th>
<th>Self-responsible</th>
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<tbody>
<tr>
<td>Locked settings (Hospitals, acute care facilities, etc.)</td>
<td>Outreach and engagement</td>
<td>Intensive case management</td>
<td>Appointment based clinic</td>
</tr>
<tr>
<td>Extreme risk (1)</td>
<td>Experiencing high risk, not engaged with mh provider(s) (2) Not coping successfully, not engaged with mh providers (4)</td>
<td>Experiencing high risk, engaged with mh provider(s) (3)</td>
<td>Coping successfully, rehabilitating (6) Early recovery (7)</td>
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<tr>
<td>1:1 supervision Legal interventions Community protection Acute treatment Engagement</td>
<td>Welcoming/Charity Evaluation and triage Documentation Benefits assistance Accessible Medications Drop-in services</td>
<td>Case management Full Service Partnership Accessible medications Supportive services (Supported Housing, Employment, Education) Direct subsidies Rehabilitation</td>
<td>Appointment based therapy “Medications only” Wellness activities (WRAP) Self-help Peer support Community integration</td>
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Unengaged – Tasks

• Help them connect with staff
• Help them connect with program and peers
• Get them IDs and documentation
• Get them money to live on
• Try to begin a psychiatric and medical assessment and treatment
• Help secure safe and stable housing
• Get to know their families
• Try to keep the community from kicking them out – usually to jail and/or psychiatric hospitals
• Try to keep them from badly harming themselves and others
Unengaged – Time to Move On

• Engaged with the community
• Engaged with us, or someone else, to get help
• Engagement with their goals consistent with our mission and values
Engaged, but Poorly Self-coordinating – Get a Life

- Money
- Home
- Education
- Employment
- Managing Mental Illnesses
- Emotional growth and relationships
- Physical health
- Managing alcohol and drugs
- Sex and intimacy
- Pregnancy and parenting
- Family relationships
- Law abiding
Engaged, but Poorly Self-coordinating – Skill Building Focus

• The point isn’t to get things for them, but to teach them how to get it themselves.
• Don’t do it for them. Have them do it while you sit next to them guiding them.
• They have to learn things the hard way, by making mistakes, but don’t waste their suffering. Help them learn the life lesson.
• Help them expand their world. Expose them to new possibilities. Help them discover their own abilities.
Engaged, but Poorly Self-coordinating – Time to Move On

• Some people continue to need this level of services and support and remain at the Village or other FSP.
• Some people have built enough skills and supports to graduate to a lower level of care – standard outpatient or wellness center.
• Some people will be ready to move towards self-sufficiency and community integration to leave the public mental health system (even if they still need meds or treatment).
Self Responsible - Tasks

- Develop self-sufficiency: economic, housing, personal empowerment and self-responsibility, wellness, coping skills
- Develop community identity, roles, and supports to achieve community integration
- Develop self paid professional treatment, if needed

Community development and advocacy are key staff tools
Self Responsible – Time to move on

• Graduation is crucial. Many members have never successfully completed anything before. The high profile presence of graduation decreases “drop-outs”

• Gradually relationships change – not really “termination” – may remain “friends” or “extended family” or “mentors”

• May give back to program inspiring other members. Some chose to work in mental health.

• Need to celebrate and continue to follow their success stories for both remaining members and staff
E) Cheat Sheet
"Above the Line" references MORS scores 6-8
"Below the Line" references MORS scores 1-5

Above the Line – Individual is “doing ok/well”

Below the Line – Individual is “doing poorly/badly”

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**Above the Line**

- 8. Advanced Recovery/Self-Supporting
- Coping successfully/Rehabilitating
- OR
  - Early Recovery

**Below the Line**

- 1. Extreme Risk
  - Experiencing High Risk
  - OR
    - Not Coping Successfully

**The Line**

- 7. Early Recovery
- 6. Coping successfully/Rehabilitating
- 3. Engaged w/ MH provider
- 2. Not Engaged w/ MH provider
- 5. Engaged w/ MH provider
- 4. Not Engaged w/ MH provider
MORS levels: Primary Characteristics

- “Extreme risk” (unable to manage in the community)
- “Experiencing High risk/not engaged w/ MH provider” (many behavioral issues; not participating in mental health treatment)
- “Experiencing High risk/engaged w/ MH provider” (participating in treatment but still in significant distress)
- “Not coping successfully/not engaged” (moderate distress, not participating in treatment)
- “Coping successfully/engaged” (moderate distress, but participating in treatment)
- “Coping Successfully/rehabilitating” (doing better, still need significant support)
- “Early recovery” (doing well, need minimal support)
- “Advanced recovery” (doing well, independently)

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Considerations When Rating

- 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/Subcultures
  - Race/Ethnicity traditions, Gender, Institutionalization, Criminal Justice, Homeless, Sexual Orientation (LGBTQIA)

http://lgbcenter.ucdavis.edu/lgbt-education/lgbtqia-glossary
MORS Stages of Service: **Key questions**

- **“Unengaged”** (1, 2 & 4)
  - What is the engagement value of this activity?
  - How is this maintaining them in the community?
  - Are they pursuing shared goals?

- **“Engaged but poorly self coordinating”** (1, 3 & 5)
  - What is the rehabilitation value of this activity?
  - Are they building skills and supports?
  - Are they increasing self-responsibility?

- **“Self responsible”** (6, 7, 8)
  - What is the community integration value of this activity?
  - Are they building self-reliance?
  - Are they increasing community interdependence?
F) FAQ’s
What is the MORS?
Simply put, the MORS is a rating scale where we can determine where a person currently is in their recovery on a particular day in time and their dependency on the mental health system. The MORS describes the recovery process over a length of time. It also can allow for service providers to figure out what and how we can do things to better assist the client/partner in moving forward to be an independent and productive member of society. Managers will better understand the complexity of service needs on the teams they support so that they can do a better job of matching resources with service needs, help distribute workload more effectively, and use overall resources more efficiently.

How often do I have to do the MORS on each of my clients/partners?
It is recommended that ratings occur monthly, and no less than quarterly. Face-to-face contact is preferred, but phone contact is ok. This is a “snapshot” of how each client has been doing in the last two weeks of their life. The two week period refers to the period of time directly preceding the rating, so if the rating is being done on Monday, February 23, 2009, the period would be from February 9 through February 23. Please remember that if you are doing a rating based on your interaction TODAY, you rate from today for what has been consistent over the last two weeks. If you date your rating next week, it is invalid as you did not see the client that day.

What if I don’t see the client/partner in the time allotted?
If you do not see them, do not rate them. There is a check box at the top to indicate this information. Please bear in mind that if you have not seen someone in the time allotted (minus factors like hospital, IMD, jail), then you may want to discuss the case with your team to determine if our services are appropriate for them at this time.

If a client has a major medical problem that are considered “high risk” — HIV, Diabetes, Herpes, TB, cancer — are they considered high risk?
Medical problems are not the main focus of the MORS. The MORS is assessing a person’s mental health status. Therefore, if a person has a High risk medical condition this doesn’t automatically put them in the high risk category. The rater would need to assess how the medical problem is impacting the individual’s mental illness. For instance, is the individual attending to their medical problem? If so, the individual wouldn’t be considered high risk. They would be considered high risk only if their mental illness is interfering with their ability to manage their medical condition.
G) Using Prochaska & DiClemente’s “Stages of Change”
Transtheoretical Model of Change… aka “the Stages of Change”

• Finding someone’s place in their recovery: how to understand & approach recovery

• Helps us assess someone’s readiness to act on a new behaviour and provide strategies & processes of change to guide them through their recovery

• Balances advantages (pros) and disadvantages (cons) of what they are experiencing which affects their motivation to change

• Influenced development of Motivational Interviewing
It’s helpful to remember the “Stages of Change” when considering where someone is in their recovery.
Precontemplation…

*Discovery Track*

- Not considering change or more than 6 months from doing something about it
  - Goal: Consciousness-raising
  - Barriers/Risks:
    - No knowledge of risks/consequences
    - Contentment in their life
Contemplation…

*Discovery Track*

- Considering change with no plan – ambivalent & undecided
  - Goal: Consciousness-raising & Self Re-evaluation
  - Barriers:
    - Knowledge of risks/consequences
    - Self-efficacy
    - Contentment
    - Indecisiveness
Preparation…

*Discovery & Recovery Track*

- Committed to change within 1 month
  - Goal: Self- & Social Liberation, Commitment
- Barriers/Risks:
  - Loss of commitment
  - Knowledge of options
  - Making decisions about plans for change
Action…
Recovery Track

• Has begun changing behaviors & increase self-efficacy
  – Goal: Optimize plans & modify behaviors and surroundings
  – Barriers/Risks:
    • Failure and disillusionment
    • Overconfidence
Maintenance…

Recovery Track

• Behavior change is well-learned typically for 6 months
  – Goal: Stable, new lifestyle; attainment of original goals; Continue positive reinforcement & social support
  – Barriers/Risks:
    • Major losses and stresses
    • Failure to attain original goals
Relapse…

Recycling

• Resumption of undesired behavior
• Relapse is a normal, expected stage of behavior change
• Goals:
  – Identify relapse
  – Reframe as opportunity to learn
  – Restage
Termination/Exit

• Goal: exit the cycle of change without fear of relapse
• New lifestyle is stable
• Barriers/Risks:
  – Precontemplation about returning to behavior
H) Santa Clara County: Peer Support Design
MORS #1: Extreme Risk

- Peer counseling
- Peers reaching out to locked facilities
- Housing
- Peers developing trust with consumers
- Peer matching – making a connection
- Use “peer bridges” in the locked facility (see definitions for “peer bridge”)
- Have peer leaders lead group activities including psych education, check-ins, crafts, games, exercise, etc.
- Peer/Clinician conference with consumer
- Acknowledgement of consumer awareness
- Communication – One-on-One
- Listen to conversation even if one sided
- Resources/referrals – peer pals, mentor, etc.
- Encourage giving back
- Encourage and supporting either paid or volunteer work
- Benefits counseling

GOAL: Getting out of locked facility
MORS #2: Experiencing high risk/not engaged with mental health provider

- Peer counseling
- Peers advocating for homeless and drug offenders
- Housing
- Peers outreach to Mental Health Court/Probation
- Building on the peer trust relationship
- Peer matching - making a connection
- Peers active listening
- Peer home visits
- Matched peer visit 2-3x per week
- Peers, collaborating with treatment team, help inform and support mental health consumers in harm reduction education and promotion
- Peer/Clinician conference with consumer
- Working with staff at residential setting
- Ask staff to return/share any related subjects and engaging conversation
- Encourage giving back
- Encourage laughter
- Encourage support either paid or volunteer
- Benefits counseling

GOAL: Getting engaged
MORS #3: Experiencing high risk/engaged with mental health provider

- Peer counseling
- Peers supporting consumers with treatment
- Housing
- Peer matching - making a connection 1-2x weekly
- Begin hourly WRAP group
- Peers work with treatment team to support and educate mental health consumers regarding harm reduction
- Working with staff and residential settings
- Setting goals
- Peer counseling about dual diagnosis if needed
- Take them to 12 step dual diagnosis meeting, DRA or other 12 step meeting
- Peer/Clinician conference with consumer
- Peer home visit
- Encourage giving back
- Encourage laughter
- Encourage and support either paid or volunteer work/educational goals
- Continue to acknowledge with positive feedback
- Benefits counseling

GOALS: Keep engaged / Reduce Risk
MORS #4: Not coping successfully/not engaged with mental health provider

- Peer counseling
- Peer matching – making a connection
- Housing
- Peer intensive outreach
- Peer using motivational interviewing
- Find out what their goals are
- Talk to them about relapse experiences from jails or hospitals
- Advocating without dependency for their goals
- Introduction to WRAP
- Regular One-on-One sessions with matched peer 1-2x week
- Peer/Clinician conference with consumer
- Working with staff at residential settings
- Encourage giving back
- Encourage laughter
- Encourage and support paid or volunteer working
- Benefits counseling

GOALS: Get Engaged/Encourage Increased Coping Skills
MORS #5: Not coping successfully/engaged with mental health provider

- Peer counseling
- Having peer pals with similar interests especially to increase community integration; not only with the broader community, but also outside of mental health.
- Housing
- Peers support in groups and activities
- Peer matching - making a connection
- Do a WRAP with peer
- Peer/Clinician conference with consumer
- Working with staff at residential setting
- Encourage giving back
- Encouragement and support either paid or volunteer work
- Peer work support groups
- Benefits counseling

GOALS: Increase coping skills/Relapse prevention plan
MORS #6: Coping successfully/rehabilitating

- Peer counseling
- Peer “client” with support from peer pal
- Exploring: Volunteer opportunities, vocational ideas, engaging in NAMI Peer to Peer Recovery Education
- Housing
- Intro to WRAP, if not already
- Intro to Consumer Affairs opportunities
- Refine 1st WRAP, when needed
- Peer matching – making a connection
- Peer/Clinician conference with consumer
- Encourage giving back
- Encouragement and support either paid or volunteer work
- Peer support work groups
- Benefits counseling

GOALS: Get meaningful activities, work, school and/or hobby
MORS #7: Early Recovery

- Peer counseling
- Engage by inviting to them to become a Peer Pal themselves (giving back)
- Join advocacy activities
- Apply for work in mental health or other fields
- Any/All leadership activities and training
- Mental health meetings and planning
- Housing
- Peers follow up on goal setting
- Refine WRAP when needed
- Peer matching – making a connection
- Ticket to work
- Follow up / check in
- Encourage giving back
- Encourage alternatives to government benefits
- Educate that there’s a 3 year social security window if you need benefits again
- Peer work support groups
- Benefits counseling

GOALS: Getting off benefits / becoming self supporting
MORS #8: Advanced Recovery

- Peer counseling
- Continue peer networking and leadership activities
- Opportunities to service others both inside/outside of mental health community
- Support community education regarding mental health issues
- Housing
- Refine WRAP on regular basis—use WRAP to keep well and out of the system
- Peer matching—making a connection
- Encourage giving back
- Peer support groups
- Support independence
- Have work support groups
- Benefits counseling
- Keep work/independent self supporting

GOALS: Remain independent and remain self supporting