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Resources:

1. The California Department of Mental Health- MHSA Community Services and Supports (CSS) Plan Three-Year Program and Expenditure Plan Requirements¹ to counties on August 1, 2005
2. CCR, Title 9, Division 1, Chapter 14- check for completeness

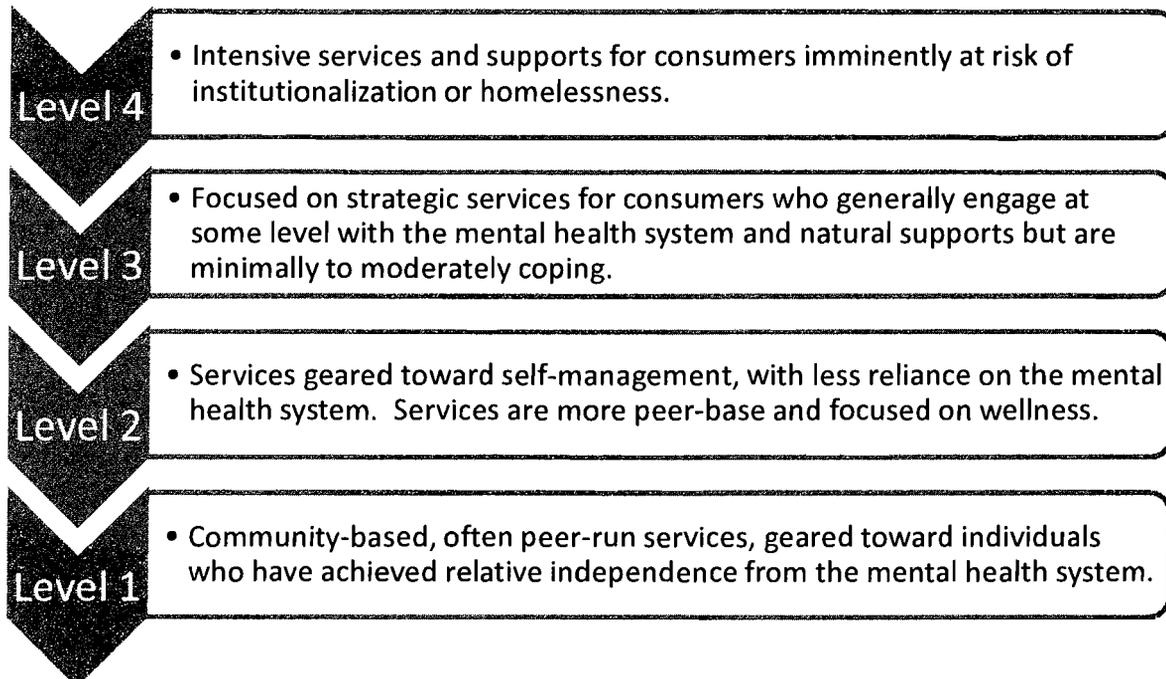
Tailoring Service Coordination to Client Stage of Recovery

Purpose:

To identify and to define levels of service and support that create a continuum of services based on the consumer's stage of recovery to ensure that clients are fully served.

Definition: Levels of Service¹

Levels of Service in the Adult System of Care



Definition: Stage of Recovery

While scales vary on specific terms, generally each scale defines recovery in terms of risk, engagement, skill and mastery and self-responsibility. Services are then geared toward those recovery elements.

Implementation Strategies:

1. Create a seamless set services at each level of service that focus on the milestones associated with each level of service.
2. Obtain training and utilize a recovery scale such as the Milestones of Recovery (MORS) or the Levels of Care Utilization Scale (LOCUS) to assist FSP teams in determining a client's level of recovery and associated services.
3. Review client recovery scores on a regular basis, tracking client and program progress.
4. Tailor services to client needs, interests and level of recovery in the following ways:

Key Elements of the Tool Kit for:

Clients at extreme risk → See Service Array, sections on reducing involvement with the criminal justice system, Crisis intervention and 24/7 team availability, Coordination of inpatient care.

Unengaged clients → See Philosophy, outreach and engagement and welcoming environment sections.

Clients who are building skills and mastery → See Service Array and Housing Domains

CONSUMER'S NAME:

MIS #:

RATER'S NAME:

DATE:

MILESTONES OF RECOVERY SCALE

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

1. "Extreme risk" – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.
2. "High risk/not engaged"- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.
3. "High risk/engaged" – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.
4. "Poorly coping/not engaged" – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.
5. "Poorly coping/engaged" – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.
6. "Coping/rehabilitating" – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing "non-disabled" roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be "testing the employment or education waters," but this group also includes individuals who have "retired." That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.
7. "Early Recovery" – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
8. "Advanced Recovery" – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

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

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

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