TURNING POINT COMMUNITY PROGRAMS INTEGRATED SERVICE AGENCY PROGRAM EVALUATION

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TURNING POINT COMMUNITY PROGRAMS INTEGRATED SERVICE AGENCY PROGRAM EVALUATION

A Project

by

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Abstract

of

TURNING POINT COMMUNITY PROGRAMS INTEGRATED SERVICE AGENCY PROGRAM EVALUATION

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The purpose of this project was to address the effectiveness of Turning Point Community Programs (TPCP) Integrated Service Agency (ISA) in providing mental health services. A literature review was conducted to assess the need and challenges for outcomes of Wellness and Recovery Oriented services. As human service organizations compete for available dollars to provide mental health services to those with severe and persistent mental illness, it is imperative to demonstrate the effectiveness of services. This researcher analyzed secondary data, Level of Care Utilization System and Milestones of Recovery Scale scores, obtained from TPCP ISA for all members served for fiscal year 2008/2009. The research supported that continuous Recovery based mental health services do positively impact TPCP ISA mental health consumers.

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Chapter 1

INTRODUCTION

This researcher's intent in conducting this project stems from her role as a social work student intern at Turning Point Community Programs (TPCP). TPCP is a provider of mental health services and has utilized the Wellness and Recovery model of treatment to "treat" people with mental illness. Unlike the traditional medical model approach which uses medication as it primary mode of treatment, Wellness and Recovery uses education, medication, and empowerment to treat mental illness. The goal of wellness and recovery is to enhance quality of life.

The purpose of this study is twofold 1) to evaluate the effectiveness of Turning Point Community Programs Integrated Service Agency and 2) to assess the congruence between two different instruments (Level of Care Utilization System and Milestones of Recovery Scale) that are use in the field of mental health.

As a Mental Health Service Act (Prop 63, 2005) stipend student this researcher recognizes that the effectiveness of providing services to individuals with severe and persistent mental illness using a Recovery Model is difficult to evaluate due to the unique challenges of measurement. The Milestones of Recovery Scale (MORS) tool allows service providers to effectively evaluate what level of recovery the members have achieved and to more effectively provide appropriate services and treatment. The Level of Care Utilization System (LOCUS)allows clinicians to identify what level of

psychiatric care mental health consumers require. The use of MORS is relatively new, in comparison to Sacramento County's LOCUS tool, but has been previously proven to be valid and reliable. This research paper will further assist Recovery Model based agencies with evidence that MORS and LOCUS scores are congruent.

Background of the Problem

The President's New Freedom Commission report, *Achieving the Promise: Transforming Mental Health Care in America* (2003), identified the concept of "recovery" as a guiding mental health policy and practice. The Surgeon General's unprecedented *Report on Mental Health* (1999) emphasized that mental health services should be consumer, and family driven, and highlighted that services should promote recovery-oriented services. Rehabilitation and recovery services for individuals with psychiatric disorders are an important focus of the Veterans Health Administration. In June 2004, *A Road Map for Transforming VA Mental Health Care* identified two recommendations: 1) emphasize the recovery model at every medical center, and 2) develop and implement the full continuum of recovery-oriented mental health services. Recovery oriented mental health services where identified as a system that fosters self-determination, hope, and empowerment. Other aspects to recovery include the mitigation of psychiatric symptoms and improvement in overall functioning, as well as identifying and taking on meaningful roles in life (McGlynn, 1996; Uehara et al., 2003).

The implementation of the concept of recovery will change the delivery of mental health services, as significantly as the de-institutionalization movement that occurred in the 1960s and 1970s changed access to services. Prior to the recommendations of *The President's New Freedom Commission* report (2003) and *The Surgeon General's* report (1999), Turning Point Community Programs had already integrated recovery-oriented services into its delivery model. In 1993, the Sacramento County Division of Mental Health (SCDMH) elected to deinstitutionalize 100 patients residing in 'locked facilities' hospitals or Institutes of Mental Disease (IMDs). The Recovery Model, as applied by TPCP, has proven to be much less costly than institualization. Sacramento County's general fund for services to 'locked facilities' hospitals or IMDs was reduced by $4.7 million, due to budget cuts (Cassin and Grice, 1996). Therefore, redirecting funds to community based organizations, to provide outpatient services, resulted in savings for the county.

Beginning in the fiscal year 1995/96, TPCP ISA was able to bill for over $2 million for the rehabilitation services provided, which then returned 50% federal revenues of at least $1 million as additional reimbursement to the county. In 1997, Turning Point Community Programs (TPCP) Integrated Service Agency (ISA) was one of the first mental health organizations in California to apply the principles and philosophy of member directed services in a program exclusively for individuals recently deinstitutionalized. Contracting with TPCP ISA in 1997, for approximately $22,000 per member, resulted in Sacramento County savings of $2.5 million, which

were returned to the Sacramento County general fund. In 2005, the contract with TPCP ISA resulted in an additional savings of more than $3.525 million. TPCP ISA savings has resulted in an almost 75% decrease in the cost to provide continuing care for individuals with persistent psychiatric disabilities compared to institutionalization costs (Cassin & Grice, 1996).

A challenge in providing Recovery Oriented Services is the limitations and lack of evidence to show the effectiveness of Recovery Oriented services, due to the unique and subjective nature of "improved functioning" or "improved quality of life". Assessment tools historically used to assess a mental health consumer's need for services were developed using the Medical Model of service delivery. This model identifies "success" as a reduction of the deficits and the negative implications of symptoms. It does not identify member's strengths or members preference regarding life functioning.

Statement of Research Problem

TPCP can document the amount of money saved (both federal and state funding) over the years but it has not significantly evaluated the effectiveness of its services using the Wellness and Recovery Model. As more and more human service organizations compete for the dollars available to provide mental health services to those with severe and persistent mental illness, it is imperative the TPCP demonstrate the effectiveness of its services.

Purpose of This Study

The purpose of this study is to evaluate the effectiveness of the ISA and its ability to achieve what it intends to. The ISA intends to maximize member's strengths while maintaining and increasing member's safety and autonomy. Effectiveness will be determined by comparing monthly Milestone of Recovery Scale (MORS) scores and Level of Care Utilization Scale (LOCUS) scores over the course of one year. Using an evaluative research design (outcome evaluation), this study will be used to assess the effectiveness of the program from the primary service coordinators aspect. This research project is conducted using quantitative secondary data and multivariate statistical measures.

Theoretical Framework

One of the major challenges for a mental health organization is to accurately measure the recovery of the consumers. Andersen et al. (2006, p. 972) reported that "there is a need for a model and a method of measuring recovery as the concept is described by mental health consumers". Recovery-oriented services concentrates on the consumer's perspective and goals as the focus of their treatment plan.

The "Strengths Model" is used as the theoretical framework because it is consistent with the Wellness and Recovery Model. The traditional Medical model of care emphasizes diagnosis, illness and problems. The Medical model focuses on deficits and identifies what the individual needs to change in order for them to fit into the current system. The belief of the medical model is that diagnosing individuals,

based on their deficits, is necessary to prescribe pharmacology and psychosocial treatment, to help the individuals with mental illness manage their symptoms. Contrary to this model the strengths model encourages providers to assist members in identifying and utilizing their own strengths; to achieve their personal treatment goals and to improve their quality of life. Additionally, the strengths model focuses on helping individuals identify community strengths and supports in order to enhance their quality of life (Russo, 1998).

Over the years the strengths model has been increasingly used in case management, due to its efficiency in improving the well being and quality of life of individuals with severe and persistent mental illness (Saleebey, 1992). The strengths model attempts to provide consumers services based on understanding their individual and community strengths as wells as the barriers that they may face to help meet client goals (Saleebey, 1996). The strengths model is practical from initial contact, assessment and treatment interventions since it recognizes that people have the capacity for growth and change and focuses on their strengths (Weick, 1992). Literature supports that the strengths model impacts the well-being of people with mental illness (Saleebey, 1996).

Definitions of Terms

Clinicians. Marriage and Family Therapists (including both licensed MFTs and unlicensed interns), Licensed Clinical Social Workers (LCSW), unlicensed Associate

(clinical) Social Workers (ASW), Masters of Social Workers (MSW), and psychologists (including PhD and PsyD) who specialize in clinical studies or practice.

Consumers. Individuals with psychiatric disabilities who utilize mental health services.

Deinstitutionalization. The process of relocating patients from State mental Health Hospitals and Institutions of Mental Disease of the community (Rowlett, 1997).

Proposition 63.An initiative that established *1%* tax on taxable personal income above $1 million to fund expanded wellness and recovery services for mentally ill children, adults, seniors.

Holding the Vessel. The process of providing unconditional support and hope to individuals you are privileged to served.

Psychiatric Disability. A mental impairment that prevents or restricts basic functioning in life as described by the diagnostic criteria in the DSM IV-TR as a mental disorder or illness of the mind.

Recover. The action that consumers of mental health services experience when regaining a sense of purpose and meaning in life including hope, empowerment, spirituality, and productivity.

Turning Point Community Programs Integrates Service Agency (TPCP ISA). A 501(c)(3) non-profit organization located in Sacramento County, which provides mental health services to adults. Additionally TPCP ISA is licensed and authorized by the state of California to provide social rehabilitation services (Rowlett, 1997).

Assumptions

The need for outcomes is extremely important to justify the success of Recovery Oriented psycho-rehabilitation services. The MORS scores will increase for individuals for whom Recovery Oriented services are effective. LOCUS scores will decrease over the course of one year for the same individuals.

Justification

Significant budget cuts to human services have drastically impacted the amount of available resources for individuals with severe and persistent mental illnesses. As social workers it is imperative to identify effective interventions and appropriate treatment services to assist people with mental illnesses. Analyzing the outcomes of consumers who received services from TPCP ISA could benefit other mental health service providers to identify effective ways to help this population.

Summary

Chapter one includes the introduction, a background of the problem, a statement of the problem, the purpose of the project, and the theoretical framework. In chapter one, the definitions for relevant terms and a section that describes the limitations of the project is presented. Chapter two is a review of the relevant literature with sections covering: history and evolution of the public mental health services, the Medical Model, the Psychosocial Rehabilitation Model, the Recovery Model and concludes with a description of the management tools used to asses effectiveness. Chapter three is a description of the methodology. Chapter four contains the results

and findings from the data collection. In chapter five, the findings are discussed, as well as recommendations and implications for social work practice.

Chapter 2

LITERATURE REVIEW

Over the past three centuries, the complex patchwork of the adult mental health system in the United States has become fragmented and referred to as the de-facto mental health system (Regier et al., 1993b). This chapter is an overview of the de-facto system as well as a review of the Medical Model, the Psychosocial Rehabilitation Model, and the Recovery Model. The first section will focus on the history and evolution of the public mental health services. The second section is a review of the Medical Model. The third section is a review of the traditional Psychosocial Rehabilitation Model. The fourth section is a review of the Recovery Model. The fifth section will discuss the importance of outcomes for recovery-oriented services.

Mental Health System History

In 1961, the report *Action for Mental Health* criticized the asylum-based American mental health care system and brought the critics to the attention of the Kennedy administration (JCMIH, 1961). The authors of the Action for Mental Health found that inpatient psychiatric care for individuals with severe mental illnesses was needlessly isolating and degrading (JCMIH, 1961). President Kennedy signed the *Mental Retardation and Community Mental Health Centers Construction Act* (CMHCA) after reviewing the *Action for Mental Health* report (Foley, 1975). The CMHCA required state and county hospitals and asylums to discharge patients who were not imminently dangerous to themselves or others for community based

treatment, and began the process of deinstitutionalization (Grob, 1994; Shorter, 1997). There was a gradual decline in the use of asylum-based care and a rise in community-based care. As a result the national inpatient census for mental hospitals and asylums declined seventy-six percent from 1955 to 1980 (Torrey, 1997). Deinstitutionalizing individuals with a mental illness from asylums into the community became a burden to the American mental health care system and gave rise to complex concerns.

Mental Health Treatment in America

Through the 1950s, the Mental Health Service System was almost exclusively provided through large state mental hospitals. In the mid 1950's the inhumane conditions of state hospitals (i.e.: restraints, seclusion, etc.) became known. California became a leader in providing community mental health services and civil rights for persons with mental illness during the 1960s, with the passing of the Lanterman Petris Short Act. This act began the process of transitioning California's mental health hospital patients into community-based care, using the traditional psychosocial rehabilitation model. During the 1960's California deinstitutionalization movement had begun, which resulted in individuals with a mental illness being discharged from large governmental operated facilities and into community based organizations (Felton, 2004).

The intention of deinstitutionalization was to provide enhanced care, in the least restrictive settings. However many districts lacked an infrastructure and the necessary resources needed to provide sufficient care in the community. Additionally,

resources and financial support that once went to state hospitals were not adequately reinvested into other community mental health services as anticipated. Insufficient funding in the 1970's revealed problems with providing adequate community based support for mental health consumers (Mental Health Association in California, 2006*)*. As a result, numerous individuals who had been discharged from institutions had nowhere to go for follow up care. Ultimately they did not succeed in the community. Many of these individuals became homeless and only received treatment through the criminal justice system (Felton, 2004).

Realignment Legislation.

The de facto mental health system arose over time. The de facto system underwent a metamorphosis under the influence of a wide array of factors, including reform movements and financial incentives based on who would reimburse and pay for specific types of services (Goldman, 1998). Unfortunately, individuals with complex needs are the individuals with the least financial resources. The continuing lack of health insurance, specifically mental health coverage, is one of the reasons that prevent people from seeking necessary services (U.S. Department of Health and Human Services, 1999).

In 1991, a major change occurred in the funding of human service programs in the State of California with enactment of the Bronzan-McCorquodale Act, referred to as "realignment" (Mental Health Association in California, 2006). Realignment transferred financial responsibility for most of the state's mental health and public

health programs, and some of the social service programs, from the state to local governments, and ultimately provided counties with a steadfast revenue source to pay for these changes. For mental health, realignment transferred the amounts of money associated with pre realignment categorical programs, general community mental health funding, state hospital civil commitment funding, and Institutions for Mental Disease (IMD) funding (Mental Health Association in California, 2006).

In order to fund the program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991 (Mental Health Association in California, 2006). The first was the statewide half-cent Sales Tax (1991) and the second was the Vehicle License Fee (VLF) (Mental Health Association in California, 2006). Realignment funds represented a new partnership between the state and the counties governing the provision of services. The objective of realignment funds was to transfer program and funding responsibilities from the state to the counties (Mental Health Association in California, 2006). Over the past nineteen years, the revenue from Realignment has benefited mental health programs by providing stable funding.

Adult Systems of Care/Integrated Services for Homeless Adults (AB 34/2034.)

In 2006, the Mental Health Association in California (2006) estimated that there was over 50,000 homeless Californians with severe and persistent mental illness. Many mental health service consumers do not utilize community mental health services, because of the lack of effective and appropriate resources available. Often the stigma from mental illness results in increased involvement in the criminal justice

system due to minor crimes, which often leads to multiple citations and/or arrests. Additionally, mental health consumers often experience recurrent inpatient psychiatric hospitalizations, due to the limited access to early intervention care. *Integrated Services for Homeless Adults: Assembly Bill 34/2034* (AB 34/2034) allocated funds to provide outreach and comprehensive services to adults with severe and persistent mental illness who were homeless, or at risk of being homeless (Mental Health Association in California, 2006).

Integrated Services for Homeless Adults: Assembly Bill 34/2034 began in 1999 as a $10 million three county pilot project for people who were homeless and mentally ill, or mentally ill and at risk of being incarcerated (Mental Health Association in California, 2006). The main goal was to provide immediate housing and intensive services focused on recovery and wellness, with a "whatever it takes" philosophy and approach to assisting consumers to improve their quality of life. AB 34/2034 grants were commended for successful service delivery, and recognized for the fundamental principle of the flexible funding program (Felton, 2004). This funding source assured that counties could provide whatever services were necessary to help the homeless individual access needed resources.

According to the Mental Health Association in California (2006), AB 34/2034 outcomes demonstrated a reduction in homelessness, recidivism, and unemployment. The success of the pilot programs provided the momentum and support from the

California Administration and the Legislature to increase funding and the target population, and to expand the program into 32-34 counties.

Proposition 63 (2005), was designed to expand funding resources for existing AB 34/2034 programs (Protection and Advocacy, Inc., 2004). Proposition 63 sought to change the AB 34/2034 programs from pilot programs serving limited numbers of individuals into fully funded programs that would provide services to all individuals who need them (Protection and Advocacy, Inc., 2004).

Since the 1990s, and with a long history of mental health reform, program and funding realignment, meaningful consumer and family involvement, and strong state and county leadership, California was able to re-establish it's leadership in providing public mental health (Mental Health Association in California, 2006). Important principles underlying the mental health system in California included the value of choice and self-determination in treatment for Californians with psychiatric disabilities (Mental Health Association in California, 2006).

In California, there have been only 12 initiatives affecting taxes which have passed and only three, Proposition 99 (1988), Proposition 10 (1998), and the newly passed Proposition 63, increased taxes. Propositions 99 and 10 both increased taxes on cigarettes and dedicated the revenues to health programs (Adams & Scheffler, 2005).

Finally, California had been moving its public mental health system toward a more integrated and outcomes oriented one, with a focus on consumer empowerment. Realignment legislation, children's system of care, Mentally Ill Offender Crime

Reduction (MIOCR) grants and funding of local mental health grants (AB34/2034) all laid the groundwork for the development and passage of Proposition 63, also known as the Mental Health Services Act (MHSA). The intent of Proposition 63 was to provide funding for new public mental health services in the State of California using a wellness and recovery model.

Medical Model

The Medical Model has been the driving treatment option for mental health consumers since the early 1900's (Carpenter, 2002). The Medical Model describes recovery as an outcome of treatment for severe and persistent disorders by utilizing evidence based practices and treatments (EBTs) (Corrigan & Ralph, 2005.) The Medical Model uses the best available evidence, clinical, and professional knowledge to develop and provide interventions.

The Medical Model patronizes mental health consumers and claims to identify what schizophrenia is, but never explains the interpersonal experiences that a person has experienced. Additionally, the Medical Model focuses on people's deficits, rather than their strengths. According to the Medical Model when individuals refuse to take their medications they are at risk for hospitalization due to being "non-compliant", versus adherent. The Medical Model has been viewed as a negative influence on an individual's ability to recover (Carpenter, 2002). Shifting the influence of the pathology-based Medical Model on the mental health system is an intimidating but necessary task.

Traditional Psychosocial Rehabilitation Model

In an effort to provide former asylum-based patients with the skills they needed to reintegrate into the community, the *Community Mental Health Center Act* (CMHCA), and following legislation, offered mental health consumers' community based services (Foley, 1975; Grob, 1994). The traditional psychosocial rehabilitation model promotes deinstitutionalization and the return to the community, in a holistic approach aiming at compensating for the psychosocial handicap induced by the mental illness. In the 1980s, the theoretical framework for community support services developed into what is now known as the Traditional Psychosocial Rehabilitation (PSR) Model. The traditional PSR model addresses the biological, psychological, and social features of mental illness (Anthony & Liberman, 1986).

Traditional Psychosocial Rehabilitation (PSR) services are focused on lessening the associated negative impacts of mental illness on the individual by helping clients identify and manage their treatments, along with offering skills training in "social skills," employment skills, and "daily living" (Anthony &Liberman, 1986). The PSR model acknowledged that psychiatric treatments should provide life skills training and social support to reduce dysfunction and disability in relationships, work and daily living; and to reduce the stigma of people with mental illnesses (Anthony and Liberman, 1986). However the PSR model did not focus on the individuals personal goals, rather it focused on reintegrating them into the community.

Persons with psychiatric disabilities rarely successfully reintegrated into the

community, and often experienced a decrease in their feelings of self worth and motivation (Estroff, 1989). Individuals who experienced a psychotic breakdown often identified and thought of themselves as their illness such as a "schizophrenic", rather than a person with an illness (Barham & Hayward, 1998). This resulted in individuals losing their indentified social roles and identities, due to the implications of labeling them as their illness. Additionally, in the traditional PSR model individuals with psychiatric disabilities did not regularly interact with non-consumers during their mental health treatment (Angell, 2003). Failure to transform individuals to the status-quo resulted in individuals becoming identified as an illness such as a "schizophrenic," resulting in exclusion from the community, which profoundly negatively impacted these individuals (Estroff, 1989; Barham & Hayward, 1998).

Providing services to individuals with a mental illness, in a community-based setting became costly, and these "chronic" mental health care consumers were identified as being dependent on mental health professionals to manage their lives (DeSisto, Harding et al., 1995; van Dongen, 2004). The traditional PSR case management model of mental health care unintentionally trained people with schizophrenia to value their illness, and to accept their limited life options and roles, as a form of adaptation (Estroff, 1981). The traditional psychosocial rehabilitation may have been dangerous for consumers by encouraging them to adopt an identity based on their diagnosed illness, with all the interpersonal and political disenfranchisement and stigma it entailed, and become reliant on the mental health

system as a means of surviving in the community (Estroff, 1981). The traditional PSR model's goal of reducing impairments, dysfunctions, disabilities and disadvantages, did not offer consumers enough independence, empowerment, and hope to mental health consumers to achieve healing (Anthony, 1993). The quest for healing became synonymous with the quest for recovery.

Recovery Model

Historically, individuals diagnosed with a severe and chronic mental illness were not expected to be cured. In the late 1960s, mental health consumers and alarmed providers came to believe that the traditional psychosocial rehabilitation was unacceptable. They shaped the "anti-psychiatry movement." The National Alliance on Mental Illness and the consumer movement combined resources and strengths and advocated for the "Recovery Movement", which motivated local and national recovery-oriented initiatives (Jacobson, 2004). The *Americans with Disabilities Act* (1990), which prohibits employment discrimination against "qualified individuals with a mental or physical disability", was one of the original national initiatives that supported the Recovery Movement.

Anthony (1991, 1993) acknowledged recovery as the primary focus for the mental health system after hearing the personal stories of struggles reported by consumers'. Anthony (1993) explained that service providers or clinicians must understand and be tolerant of the range of intense emotions experienced by mental health consumers during their recovery, without diagnosing behavior as abnormal or

pathological. Anthony argued that the mental health system should provide an environment that stimulates and encourages recovery. Anthony's conceptualization of recovery recognizes that people can recover from mental illness even when the illness is not cured, and that the process of recovery can proceed in the presence of continuing symptoms and disability (Roberts & Wolfson, 2004). Anthony is credited with challenging mental health services to make Recovery their practice in the 1990s (Carpenter, 2002).

The Recovery Movement declared that "recovered" consumers were able to provide mental health services in peer-run or consumer-run programs, as positive role models and the reciprocity would provide the consumers continued personal growth (Solomon & Draine, 2001; Deegan, 2003). Participation in peer services was expected to provide recovery-oriented service-providers the opportunity to effectively support consumers, because the relationship would be more egalitarian and less hierarchical than "traditional" case management relationships (Solomon & Draine, 2001). In addition, peer support was expected to "provide opportunities for bearing witness", and holding the vessel, which would allow peer staff and consumers the opportunity to establish new relationships and to validate the idea that recovery is attainable (Jacobson & Greenley, 2001).

President Bush's New Freedom Commission on Mental Health (2003) was the first federal mandate for the Recovery Movement. The New Freedom Commission required the United States mental health care system to shift from a "traditional" PSR

model to a "recovery-oriented services" model. Consumer advocate Bill Anthony (1993) popularized the term "recovery-oriented mental health system" in the early 1990s to describe what would become known as the Recovery Movement's guiding vision.

Recovery advocates anticipated that a recovery-oriented mental health system, would increase treatment utilization processes and would better assist people with mental illnesses achieve recovery. This became the focus, rather than the treatment processes that destined consumers to permanent service dependence (Solomon & Stanhope, 2004). The recovery model took the traditional PSR model one-step further by providing consumers the opportunity to increase independence through empowerment and hope, in an effort to achieve successful healing (Anthony, 1993). The pursuit for healing has become indistinguishable for the mission of recovery. Using the Recovery Model, personal service coordinators respect consumers' right to autonomy and do not patronize their members. Advocating and encouraging consumers to manage their own mental health through the process of trying and failing, also known as the "dignity of risk," provides members the opportunity to increase their resilience (Crowley, 1996; Mead & Copeland, 2000; Ragins, 2003). The current recovery movement is a result of consumer participation in the mental health system for over 30 years and is based on the idea that consumers can, and do recover from mental illnesses.

Recovery Defined

A common theme revealed in the literature is that there are numerous definitions of what recovery means. Ultimately, recovery is identified as an individual process that is shaped by each person's unique experience of mental illness, and the meaning that each individual attaches to this concept (Meehan, 2008). Recovery can be viewed as an ongoing, non-linear journey that creates numerous experiences and stages, where a person is capable of recovering even if their mental illness is not cured (SWAHS Mental Health Network, 2008). Recovery from mental illness, as defined by the National Consensus Statement on Mental Health Recovery is, ‘‘a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential’’ (SAMHSA, 2004). Once the term "recovery” was officially in the treatment dictionary, empirical researchers scrambled to define the healing process and make it measurable (Bellack, 2006). When empirical researchers described recovery from severe mental illness, they were not talking about complete remission of symptoms, but rather "practical recovery," specifically a reduction in symptoms that precipitates "premorbid" levels of functioning and the life an individual with a mental illness seemed likely to live before they became ill (Jacobson, 2004; Torgalsboen, 2005).

When the empirical and experiential definitions of a "practical" recovery are combined, we can see that the process of recovery was thus thought to be produced by

both "internal conditions" like "attitudes, experiences, and processes of change of individuals who are recovering," and "external conditions" like "the circumstances, events, policies, and practices that may facilitate recovery" (Jacobson & Greenley, 2001). As recovery gained serious consideration, the hope was born that the American mental health care system could be saved from failure and so could its consumers if the treatment processes they were using became more "recovery-oriented" and promoted external conditions that encouraged internal recoveries for consumers. Advocates of Recovery hoped and believed that anyone could achieve recovery: a meaningful life and the ability to live, work and love in the community (Fisher & Chamberlin, 2004; Fisher, 2005).

Substance Abuse and Mental Health Services Association (SAMHSA) issued a National Consensus Statement on Mental Health and Recovery (2006) outlining ten recovery principles mental health treatment programs should adopt to become more "recovery-oriented." The report highlights "*10 Fundamental Components of Recovery*," including (excerpts):

1. Self-Direction: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life.
2. Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and

cultural background in all of its diverse representations.

3. Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions . . . that will affect their lives, and are educated and supported in so doing. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. Holistic: Recovery encompasses an individual's whole life . . . including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports.
5. Non-Linear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.
6. Strengths-Based: Recovery focuses on valuing and building on the multiple capacities and inherent worth of individuals. By building on strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. Peer Support: Mutual support . . . plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and

provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. Respect: Societal acceptance and appreciation of consumers -including protecting their rights and eliminating discrimination and stigma-are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital.
9. Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery.
10. Hope: Recovery provides the motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is the catalyst of the recovery process. Mental health recovery benefits individuals by focusing on their ability to live, work, learn, and fully participate in our society, and enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

The Recovery Movement hoped that a transformed recovery-oriented mental health care system that is congruent with these principles, would transform mental health treatment delivery and achieve greater success (Ware, Hopper et al., 2007).

The new "recovery-oriented" treatment processes significantly changed the traditional case management relationship between mental health professionals and the

consumers they serve. Initially providers needed to embrace the principles and the "hope" that all mental health consumers can achieve independence, healing, empowerment, and connection, regardless of their current baseline. The service providers belief and hope that all consumers can achieve recovery begins with the provider focusing on the individual, not the illness, and on the consumer's strengths and identified goals (Jacobson & Greenley, 2001). The role, and expectations, of case managers were to provide consumers the opportunity to be empowered, and to take control of their own treatment goals (Crowley, 1996; Ragins, 2003; Townsend & Glasser, 2003).

By allowing consumers the opportunity to independently try and fail, service-providers were increasing the consumers' right to autonomy and self-determination. The opportunity to increase their sense of personal control and empowerment, provided consumers an opportunity to increase their resiliency to life's challenges (Holter ,2004; Mead & Copeland, 2000; Ragins, 2003). Recovery-oriented services shifted the locus of control from the service provider to the consumer, adding components of personal responsibility and agency, which consumers identified as necessary to heal from the effects of both symptoms and the stigma of mental illness (Jacobson & Greenley, 2001). The goal of the recovery-oriented treatment relationship is distinguished from the PSR model's primary aim, which focused on the case manager's goal of preventing consumers from recidivism and rehospitalization (Floersch, 2002; Lunbeck, 1994).

It was hoped that "recovery-oriented" practices would assist individuals with psychiatric disabilities learn and practice to “live, work, learn and participate fully in their daily communities" (DHHS, 2003). The United States government requested that the mental health care system make changes from their "traditional" institutionalized treatment and intervention processes, to the Recovery Model in the hope that this would create valued individuals rather than chronic mental patients (SAMHSA, 2006). In turn, mental health service providers and policy developers attempted to institutionalize "recovery-oriented" practices to meet the demand that people with psychiatric disabilities could recover if they were offered "recovery-oriented" treatment processes continuously throughout the mental health system (Anthony, 2000; Corrigan & Boyle, 2003). Advocates believed that recovery-oriented services would assist consumers in gaining confidence to pursue and maintain meaningful social roles in society and find a quality of life for themselves, beyond that of being identified as a chronic mental patient (Jacobson & Curtis, 2000; Jacobson, 2001; DHHS, 2003).

Uniformly, recovery has been identified as an individual process that is produced by each person's unique experiences relating to their mental illness, and the meaning that each individual attaches to the idea of mental health. Recovery is viewed as a journey; an ongoing, non-linear process that encompasses a number of experiences and stages where a person is capable of recovering even if their mental illness is not cured.

Throughout the literature there are many variations of the “uniform definition”

of recovery. These variations have broadened our understanding and acceptance of the concept and goal of recovery. At its simplest, recovery can be defined as 'a subjective experience of having regained power over one's life.' (Knight, 2000). The achievements of those who have recovered embrace hope, empowerment and social connectedness. Ridgeway (2001) analyzed four early consumer recovery narratives (Deegan, 1988; Lovejoy, 1984) with a constant comparative method to find common themes. These variations are as follows:

1. Recovery is the reawakening of hope after despair
2. Recovery is breaking through denial and achieving understanding and acceptance
3. Recovery is moving from withdrawal to engagement and active participation in life
4. Recovery is active coping rather than passive adjustment
5. Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self
6. Recovery is a journey from alienation to purpose
7. Recovery is a complex journey
8. Recovery is not accomplished alone - it involves support and partnership

In a review of recovery literature, Ralph (2000) identified four dimensions of recovery found in personal accounts. These are:

1. Internal factors - those factors which are within the consumer, him/herself

such as the awakening, insight, and determination it takes to recover;

2. Self-managed care, an extension of the internal factors where consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face;
3. External factors which include interconnectedness with others, the supports provided by family, friends, and professionals, and having people who believe that they can cope with and recover from their mental illness; and
4. Empowerment - a combination of internal and external factors - where the internal strength is combined with interconnectedness to provide the self-help, advocacy, and caring about what happens to ourselves and to others.

Recovery is often described as a practice, viewpoint, vision, and/or a guiding principle. Ultimately, all recovery-oriented approaches support individuals in their own personal growth, empowerment, and finding meaningful roles in society. Recovery does not necessarily mean full independent restoration of functioning, based on the status-quo. However, it does mean developing effective support systems and coping skills to be able to manage personal symptoms rather than being given supports by mental health services, traditionally known as rehabilitation.

Outcomes

The fifth theme identified in this literature review includes the importance of appropriate assessment tools in the Recovery Model. It is important to have outcome measures to identify what is effectiveness, what works well, and what needs to be

changed or improved. Outcomes are necessary to report to stakeholders the effectiveness of a program. In addition, outcomes assist to identify role clarity and provide motivation for staff and consumers.

Few instruments accurately measure recovery compared with the number of instruments that measure other areas in mental health, for example, symptoms or satisfaction (Ralph, Kidder & Phillips, 2000). Instruments often measure something about recovery rather than recovery itself. Qualitative studies are often used to further describe or classify an individual's perception of recovery. Specific recovery indicators or variables have not yet been accepted, although it has been widely accepted that measures of recovery can facilitate the mental health system in recognizing whether people with mental illness are experiencing improvements in their quality of life.

Empirical researchers faced great challenges defining what exactly this kind of "practical recovery" might look like (Bellack, 2006). To identify "practical recovery," research often focused on measurable facets of recovery, including benchmarks such as employment and stable housing (Jacobson, 2004). Contrarily "recovered" consumers describe recovery as more of an emotional state or a feeling, rather than a return to adequate community integration. However, the varieties of recovery definitions lack validity (Bellack, 2006).

The literature regarding outcome measures in the recovery model is sparse, and there is conflicting opinions about the use of outcomes measures. Lakeman (2004)

reported that outcome measures are dehumanizing, and counter productive because they force consumers to be placed in a specific box. Furthermore Lakeman (2004) explains that the use of outcome measures is inconsistent with a recovery approach to mental health care and that it seems to reinforce the old institutional way of thinking. Browne (2006) reported that if we are to embrace outcome measures, they must be consistent with the relevant factors in the recovery model and not focus on immediate results, but long-term evolution.

The implementation of recovery-based approaches to providing mental health services has resulted in traditional outcome tools that do not accurately capture the effectiveness of programs. Recovery approaches emphasize identity, social inclusion, and hope, and if these outcomes can be captured then measures of individual recovery will be appropriate to measure the effectiveness of a program and to report to consumers, providers, and stakeholders the program's effectiveness. Two tools that have been introduced as a way of measuring outcomes are the Level of Care Utilization System (LOCUS) and the Milestones of Recovery Scale (MORS). The LOCUS was developed as a clinical assessment tool by the American Association of Community Psychiatrists to evaluate and determine level of care placements for psychiatric and addiction services for adults (Sacramento County, 2009). The MORS was developed by Dave Pilon in the Los Angeles Mental Health Department, and has become the primary tool for assessing adult mental health consumers appropriate level of care (Pilon & Ragins, 2007). These tools are further explained in chapter three.

Chapter 3

METHODOLOGY

The Mental Health Services Act (MHSA) in California acknowledged that MHSA programs need to evaluate the recovery based effectiveness of their programs (Mental Health Services Act, 2004, Section 7). The MHSA describes the need for consumer outcomes to identify the effectiveness of Wellness and Recovery services. Within this context, this researcher designed a program evaluation for Turning Point Community Programs Integrated Service Agency (TPCP ISA) using two standardized tools specifically developed for mental health service programs. The expected outcomes for an effective program are 1) an increase in engagement, 2) decrease in risk of harm, 3) increasing coping skills, and 4) and increase in support.

Study Design

This research project is a program evaluation; specifically it is an outcome evaluation. This study incorporates an evaluative research design, utilizing standard outcome measures for mental health programs providing MHSA services in Sacramento County.

Data Collection and Population

The source of these data was Turning Point Community Programs Integrated Service Agency (TPCP ISA). The data set examined included one years worth of indicators from the Milestones of Recovery Scale (MORS) and Level of Care

Utilization System (LOCUS). Copies of each assessment tool are located in Appendixes A and B.

This researcher evaluated Turning Point Community Programs (TPCP) Integrated Service Agency (ISA) for fiscal year 2008-2009. TPCP ISA members are adults who have a severe and persistent mental illness diagnoses that qualifies them for Wellness and Recovery psychosocial rehabilitation services, as identified by Sacramento County. Members of the ISA are identified as individuals who require the highest level of outpatient mental health services to successfully reduce utilization of inpatient mental health facilities. The sample size for this project includes secondary data for all TPCP ISA cases. This researcher will also assess the demographic arrangement of the members of TPCP ISA as it relates to primary psychiatric diagnosis, age, and gender to evaluate the availability of appropriate services.

Instrumentation

Levels of Care Utilization System

Level of Care Utilization System (LOCUS) was developed by the American Association of Community Psychiatrists in 1996 as a clinical assessment tool. Its purpose was to guide assessment and evaluate appropriate level of care placement for adults with mental health and substance use disorders (Sowers & George,1999). Sacramento County (2009) utilizes LOCUS as the primary decision tool to identify services needed. The required semi-annual assessment allows clinicians to identify changes in consumer's intervention needs. In addition, LOCUS links assessment to

need for and focus of treatment and to identify continued treatment criteria. LOCUS provides clinical outcomes to identify the impact of treatment provided (Sacramento County, 2009). Additionally, LOCUS is utilized to promote community program and county mental health system accountability. If TPCP ISA is effective, LOCUS scores for consumers should decrease over time.

According to the developers, The Level of Care Utilization System (LOCUS) focuses on six assessment dimensions: Risk of Harm; Functional Status; Medical, Addictive and Psychiatric Co-Morbidity; Recovery Environment; Treatment and Recovery History; and Engagement (Sacramento County, 2009). Risk of Harm measures two different things: the degree of suicidal/homicidal ideation, behavior and/or intentions and the degree to which the client's perceptions/ judgment/or impulse control is impaired creating danger for themselves or others.

The Functional Status evaluates four factors: an individuals ability to fulfill current obligations at work, school, home, etc.; participation in usual activities; ability to interact and engage with others on a personal level; ability to make personal decisions and care for self (i.e. appearance and hygiene); and additionally evaluates vegetative status, as it relates to eating, sleeping, activity level, and sexual appetite.

Medical, Addictive, Psychiatric Co-morbidity looks at the individuals interactions and the interactions with co-existing illnesses, not psychological issues. Recovery Environment assesses Level of Stress, the stressors that the individual is exposed to including exposure to drugs and alcohol, performance pressures, and

interpersonal challenges. The second area assessed in the Recovery Environment is the level of support the individual has that will assist them in their recovery. Treatment and Recovery History looks at the individual's historical exposure, usage, recovery and duration of usage of mental health services. Engagement asses two factors: client's understanding of illness and treatment and the client's willingness to engage in treatment and recovery.

The six levels of care identified by the LOCUS are Level I: Recovery Maintenance and Health Management, Level II: Low Intensity Community Based Services, Level III: High Intensity Community Based Services, Level IV: Medically Monitored Non- Residential Services, Level V: Medically Monitored Residential Services, and Level VI: Medically Managed Residential Services (Sacramento County, 2009). Level I: Recovery Maintenance and Health Management identifies clients who can live independently or with minimal support and who have achieved significant recovery at a different level of care in the past and do not require supervision or frequent contact with support. Level II: Low Intensity Community Based Services identifies clients who live independently and need minimal support through clinic based programs, although they do not require supervision or frequent contact. Level III: High Intensity Community Based Services identifies clients who need intensive support, through contact several times a week through clinical base programs, and are capable of living independently or with minimal support, however not requiring supervision. Level IV: Medically Monitored Non- Residential Services

refers to individuals who are capable of living in the community either in supportive or independent setting and need intensive case management by a multidisciplinary treatment team. Level V: Medically Monitored Residential Services identifies individuals who require residential treatment provided in a community setting, non-hospital free standing residential facilities. Level VI: Medically Managed Residential Services identifies individuals who need the most intensive level on the continuum care available, often provided in hospital or free-standing non-hospital settings, individuals may be independently and/or may be involuntarily committed to treatment.

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) is a tool that is intended to assist service provider's determine where an individual is in their journey of recovery, based on eight levels of service, from the agency perspective (Pilon, 2008). MORS was designed as an "administrative" tool to describe the process and was not intended to direct the process (Pilon, 2008). The MORS scale is not intended to provide specific guidance to service providers regarding treatment interventions with their clients. Staff must still consider the reasons why a particular client is considered to be "high risk" and provide services based on the consumer's unique needs. The scale can be used to identify the level of service that is needed by the consumers (Pilon, 2008).

According to Fisher, D., Pilon, D., et al. (2009) sufficient evidence supports that MORS is reliable and valid with regard to identifying aspects of recovery from the providers perspective. Furthermore, as consumers transition from one level of

service to another the MORS score provides an illustration of their recovery (Pilon, 2008). It is important to recognize the MORS is the primary strength based consumer assessment tool that has been embraced and accepted by the providers and consumers who use it. The MORS provides assessment for consumers Risk, Engagement, and Skills and Support. MORS is used to assess levels of support from intensive to minimal. A minimal level of support indicates that individuals have achieved an advanced level of recovery and are no longer part of a system of care (Pilon, 2008). If TPCP ISA is effective than consumers MORS scores will increase over time.

The Milestones of Recovery Scale (MORS) identifies eight levels of care: Extreme Risk, High Risk/ Not Engaged, High Risk/Engaged, Poorly Coping/ Not Engaged, Poorly Copping/ Engaged, Early Recovery, and Advanced Recovery. Extreme Risk refers to individuals who are at a high risk of harm to self or others, and who have a high utilization rate of hospitals and/or incarcerations. High Risk/Not Engaged refers to individuals who are a risk to self and/or others and who are not engaged with mental health providers. High Risk/Engaged refers to individuals who are a risk to self and/or others, but do engage with treatment providers. Poorly Coping/Not Engaged refers to individuals who are generally not a danger to self and/or others, however they are not engaged with the mental health system and are not actively participating in their mental health treatment. Poorly Coping/Engaged refers to mental health consumers who are generally not a danger to self and/or others, but require a great deal of support, and are engaged with their providers and treatment

plan. Coping/Rehabilitating refers to individuals who have minimal impairment from substances, rarely are hospitalized or incarcerated. Individuals at this level of recover are able to self manage symptoms and are actively utilizing mental health serves supports, but they aren't necessarily compliant with mental health providers. Early Recovery identifies individuals who are self managing their mental health treatment and rarely are engage in problematic behaviors with minimal support from staff and have an established support system. Advanced Recovery identifies individuals who are completely self-supporting and often no longer self identify as having a mental illness.

Data Analysis

After gathering the data from both the MORS and LOCUS tools, the Statistical Package for the Social Sciences Program (SPSS) was utilized to manipulate the data. The researcher used descriptive statistics, specifically frequency distributions and correlations to analyze the data across and within the two different instruments to determine the degree to which Turning Point Community Programs Integrated Service Agency (TPCP ISA) consumers improved over one year. If TPCP ISA is effective than the mean scores of MORS will increase and the LOCUS scores will decrease over time.

Ethical Considerations

Authorization and cooperation was obtained from the Turning Point Community Programs Integrated Service Agency to successfully complete this

research study. In order to protect the participants, the subjects' rights to privacy and safety will be protected. An informed consent will not be utilized in this research project, as all data are secondary. Confidentiality has been protected as all identifying information has been removed prior to this researcher gathering it. Once the secondary data is gathered and processed, the data will be destroyed. The information obtained from conducting this study will only be used for purpose of this program evaluation.

Protection of Human Subjects

This study was presented to the Human Subjective Review Committee of the Division of Social Work California State University, Sacramento's Committee in October of 2009. It was approved in November of 2009. The "Request for Review by the Committee for the Protection of Human Subjects" was submitted and approved by the University as "exempt" research (approval # 09-10-058). All of the personal identifiable information was removed from the data by TPCP prior to this researcher having access to the data. The identifiable information will be retained by the data supplier at TPCP. No subject's identifiable information will be included in the project.

Chapter 4

STUDY FINDINGS

This research project aims to assess the effectiveness of Turning Point Community Programs. In doing so, this study hopes to find evidence that deems Wellness and Recovery services effective in increasing mental health consumer's quality of life. This research project is guided by the following major questions: Is Turning Point Community Programs Integrated Service Agency effective, regarding; a) increase in recovery and b) increase in engagement. This chapter reports the major findings of the study, particularly those most relevant and significant to the subjects in question.

Demographics

The demographic data are shown in Tables 1-3. A total of 275 member's data was reviewed for 2008/2009 fiscal year. Among research participants the average age was 46, and the age range from 23 to 81 years old. 53.2% of participants reported were male and 45% were female. Over half of the participants were identified as having Schizophrenia (73.9%), with 29.3% of the participants diagnosed with Schizophrenia, Paranoid Type. This primary diagnosis is consistent with the literature.

Table 1.
Age

	N	Minimum	Maximum	Mean	Std. Deviation
Age	275	23	81	46.13	12.304
Valid N	275				

Table 2.
Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Invalid	5	1.8	1.8	1.8
Female	126	45.0	45.0	46.8
Male	149	53.2	53.2	100.0
Total	280	100.0	100.0	

Table 3.
Diagnosis

	Frequency	Percent	Valid Percent	Cumulative Percent
Invalid	6	2.1	2.1	2.1
Amnestic Disorder NOS	1	.4	.4	2.5
Schizophrenia	4	1.4	1.4	3.9
Schizophrenia, Disorganized Type	13	4.6	4.6	8.6
Schizophrenia, Paranoid Type	83	29.6	29.6	38.2
Schizopreniform Disorder	56	20.0	20.0	58.2
Schizoaffective Disorder	14	5.0	5.0	63.2
Schizophrenia, Undifferentiated Type	37	13.2	13.2	76.4
Major Depressive Disorder	15	5.4	5.4	81.8
Bipolar Disorder NOS	11	3.9	3.9	85.7
Brief Psychotic Disorder	1	.4	.4	86.1
Psychotic Disorder NOS	37	13.2	13.2	99.3
Borderline Personality Disorder	2	.7	.7	100.0
Total	280	100.0	100.0	

Level of Care Utilization System (LOCUS)

Overall, this research supports that participants in Turning Point Community Programs Integrated Service Agency was effective. The evaluative measures identified by the LOCUS, showed a minimal average decrease in level of care necessary over a one-year period from 3.40 to 3.34, for all 275 members, as identified in Table 4. Additionally Table 5 shows that at the six-month LOCUS review the majority of members at TPCP ISA were identified as needing Level 3 services (31.9%), however 38.4% needed at least Level 4 services. Table 6 shows that at the Annual LOCUS review the majority of participants utilized Level 3 services (29.2%), with an increase in Level 4 and Level 5 services (40.8%) being provided to TPCP ISA members. Table 7 shows that members who received a LOCUS review during December 2008 and June 2009 showed minimal change in LOCUS scores between the two assessments.

This supports the notion that TPCP ISA provides support to individuals identified as needing Level III: High Intensity Community Based Services and Level IV: Medically Monitored Non- Residential Services Particularly, as discussed in chapter 3. The increase in LOCUS Level 4 and Level 5 at the Annual LOCUS review may have been attributed to the Sacramento County Mental Health system changes that occurred in the summer of 2009. However, the LOCUS scores support that TPCP ISA is providing services constantly to individuals within their target population, who are in need of Intensive support and treatment needed, due to their recovery history,

and supervision or contact by the agency several times per week by a multi-disciplinary team.

Table 4.
LOCUS 6mo vs LOCUS Annual

		6mo LOCUS	Annual LOCUS
N	Valid	135	120
	Missing	145	160
Mean		3.4074	3.34
Median		3.0000	3.00
Mode		3	3
Minimum		1	0
Maximum		6	5

Table 5.
LOCUS Six Month

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Level I: Recovery Maintenance and Health Management	1	.4	.7	.7
	Level II: Low Intensity Community Based Services	39	13.9	28.9	29.6
	Level III: High Intensity Community Based Services	43	15.4	31.9	61.5
	Level IV: Medically Monitored Non- Residential Services	11	3.9	8.1	69.6
	Level V: Medically Monitored Residential Services	38	13.6	28.1	97.8
	Level VI: Medically Managed Residential Services	3	1.1	2.2	100.0
	Total	135	48.2	100.0	
Missing	System	145	51.8		
Total		280	100.0		

Table 6.
LOCUS Annual

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Invalid	1	.4	.8	.8
	Level I: Recovery Maintenance and Health Management	1	.4	.8	1.7
	Level II: Low Intensity Community Based Services	34	12.1	28.3	30.0
	Level III: High Intensity Community Based Services	35	12.5	29.2	59.2
	Level IV: Medically Monitored Non- Residential Services	18	6.4	15.0	74.2
	Level V: Medically Monitored Residential Services	31	11.1	25.8	100.0
	Total	120	42.9	100.0	
Missing	System	160	57.1		
Total		280	100.0		

Table 7.
LOCUS 6mo vs LOCUS Annual

6mo LOCUS	Annual LOCUS					Total
	Invalid	Level II: Low Intensity Community Based Services	Level III: High Intensity Community Based Services	Level IV: Medically Monitored Non-Residential Services	Level V: Medically Monitored Residential Services	
Level II: Low Intensity Community Based Services	0	4	8	2	6	20
Level III: High Intensity Community Based Services	1	6	5	3	3	18
Level IV: Medically Monitored Non-Residential Services	0	2	0	2	1	5
Level V: Medically Monitored Residential Services	0	4	4	1	7	16
Level VI: Medically Managed Residential Services	0	1	0	0	0	1
Total	1	17	17	8	17	60

Milestones of Recovery Scale (MORS)

Using frequency data, there was not an increase in MORS scores when reviewing all 275 participants during the 2008/2009 fiscal year (as reported on Table 7). Table 8 shows that the 169 participants that received services from TPCP ISA continuously from July 2008 to June 2009 had an average increase in MORS scored from 4.95 in July 2008 to 5.03 on June 2009.

As discussed in chapter 3, an improvement in Recovery is supported by MORS scores increasing. The reason for the MORS scores not changing can be related to the fact that TPCP ISA has a constant influx of members attaining services from them, and that individuals who enter the program are usually going to be identified as having a lower MORS score. As reported in chapter 3, MORS Level 4 and Level 5 identifies individuals who are Poorly Coping/ Not Engaged and Poorly Coping/ Engaged, respectfully. Table 9 shows that TPCP ISA provides the majority of services to individuals who are Poorly Coping/ Engaged. It is vital to recognize that engagement is necessary in providing effective treatment. Individuals who reach Level 6, Coping/Rehabilitation are often referred to lower intensity community based programs, and thus are not often provided treatment through TPCP ISA. This research supports that notion that Recovery is a process that takes substantial time and that administration can review if their members are showing improvement.

Table 8.
MORS Review of Continuous Members 2008/2009

		07/08	12/08	06/09
N	Valid	162	164	165
	Missing	8	6	5
Mean		4.94	4.99	5.09
Median		5.00	5.00	5.00
Mode		5	5	5
Std. Deviation		1.348	1.164	1.418
Minimum		1	1	2
Maximum		7	7	7

Table 9.
MORS Continuous Members 2008/2009

	N	Minimum	Maximum	Mean	Std. Deviation	Variance
07/08	162	1	7	4.94	1.348	1.817
08/08	165	1	9	4.92	1.385	1.920
09/08	169	1	10	4.96	1.331	1.773
10/08	157	1	9	4.99	1.298	1.686
11/08	168	1	11	5.12	1.428	2.038
12/08	164	1	7	4.99	1.164	1.356
01/09	164	1	9	4.99	1.414	2.000
02/09	168	1	8	4.92	1.510	2.280
03/09	168	2	8	5.05	1.344	1.806
04/09	168	1	9	4.99	1.331	1.772
05/09	162	2	7	5.03	1.325	1.757
06/09	165	2	7	5.09	1.418	2.010
Valid N	129					

The data presented in Table 8 shows that a significant number (N=14) of members who had been assessed during December 2008 using both the MORS and LOCUS tools were identified as needing LOCUS Level III: High Intensity Community Based Services and using the MORS as Level 6, Coping/Rehabilitating. An equal number (N=14) of members were identified as a LOCUS Level V: Medically Monitored Residential Services and MORS Level 5. Poorly Coping / Engaged during the same month. Table 10 shows that a significant number (N=16) of members who had been assessed during June 2009 using both the LOCUS and MORS were identified as needing Level III: High Intensity Community Based Services and as MORS Level 6. Coping / Rehabilitating. An equal number (N-16) of members were

identified as needing LOCUS Level V: Medically Monitored Residential Services and at MORS Level 5. Poorly Coping / Engaged.

The data presented in Table 8 and 10 show that the target population for TPCP ISA are consumers identified as needing at least LOCUS Level III: High Intensity Community Based Services and as MORS Level 5. Poorly Coping / Engaged or lower. The relationship between the LOCUS and MORS scores does not significantly show that the LOCUS and MORS provide corresponding assessments. However, it is important to recognize that LOCUS and MORS have not been previously identified as congruent tools.

Table 10.
MORS Comparison for 07/08 and 12/08

07/08 MORS	12/08MORS								Total
	1. Extreme Risk	2. High Risk / Not Engaged	3. High Risk / Engaged	4. Poorly Coping / Not Engaged	5. Poorly Coping / Engaged	6. Coping / Rehabilitating	7. Early Recovery	8. Advanced Recovery	
1. Extreme Risk	0	0	0	0	1	0	0	0	1
2. High Risk / Not Engaged	0	2	3	1	2	0	0	0	8
3. High Risk / Engaged	0	0	3	6	10	4	0	0	23
4. Poorly Coping/ Not Engaged	0	5	2	8	12	3	0	0	30
5. Poorly Coping/ Engaged	0	1	7	7	36	5	1	0	57
6. Coping / Rehabilitating	1	0	7	4	14	29	2	1	58
7. Early Recovery	0	0	1	0	6	9	4	2	22
Total	1	8	23	26	81	50	7	3	199

Table 11.
MORS Comparison for 07/08 and 06/09

07/08 MORS	06/09MORS							Total
	1. Extreme Risk	2. High Risk / Not Engaged	3. High Risk / Engaged	4. Poorly Coping / Not Engaged	5. Poorly Coping / Engaged	6. Coping / Rehabilitating	7. Early Recovery	
1. Extreme Risk	0	0	0	0	1	0	0	1
2. High Risk / Not Engaged	0	4	3	0	2	1	0	10
3. High Risk / Engaged	0	2	6	0	9	5	0	22
4. Poorly Coping / Not Engaged	0	5	4	7	11	2	1	30
5. Poorly Coping / Engaged	0	1	4	12	24	13	3	57
6. Coping / Rehabilitating	1	3	3	4	15	21	10	57
7. Early Recovery	0	0	4	0	5	8	6	23
Total	1	15	24	23	67	50	20	200

Analysis of Data

All data reviewed support that TPCP ISA is serving the target population identified by Sacramento County. Additionally, the data supported that the consumers who receive continuous support do show improvement. The results from this research show that in regards to directional change, TPCP ISA program is an effective program. The results are supported by the frequency data gathered from LOCUS and MORS scores. All data reported are based on the responses of the providers and no

consumers responses were utilized in this analysis. The program is deemed effective according to data regarding participants who maintained in the program over the course of the fiscal year reviewed.

Reviewing the results of this research process spoke volumes to the challenges in identifying success of this program using only numbers alone. However, the positive increases in LOCUS and MORS scores show the effectiveness of the therapeutic services that TPCP ISA provides. TPCP ISA uses strength based Recovery services to educate and empower members to gain skills and increase their quality of life.

Chapter 5

SUMMARY AND RECOMMENDATIONS

Based on the one-year's review of quantitative data using Level of Care Utilization System (LOCUS) and Milestones of Recovery Scale (MORS) results, this researcher found moderate directional change using frequency comparisons. Directional change occurs when the frequencies of MORS and LOCUS scores show improvement.

This researcher found that Recovery is challenging to measure, even with reviewing two separate yet valid and reliable tools. The literature supports that Recovery is a personal journey that is difficult to quantitatively measure. This research was able to demonstrate that Turning Point Community Programs Integrated Services Agency is effective: Recovery scores for individuals who received continuous services for at least one year demonstrated improved quality of life (MORS) and a decrease in service necessity (LOCUS).

Program Recommendations

The findings of this research support the literature that identify Schizophrenia as the primary treated mental illness in outpatient mental health clinics. This researcher suggest that TPCP ISA providers should continue to provide treatment groups to teach coping skills related to the commonly identified symptoms and behaviors related to Schizophrenia. Additionally, because the MORS scores indicate that TPCP ISA members usually are at Level 5, Poorly Coping / Engaged, this

researcher suggests that TPCP ISA provide Wellness and Recovery Oriented interventions that will strengthen coping skills to decrease symptom distress and increase social and occupational functioning.

TPCP has the internal capability to collect data and analyze consumer's progress. This study is a pilot evaluation for TPCP. This researcher recommends that TPCP use this evaluation to develop an ongoing program evaluation system.

Evaluation

A limitation to this research was LOCUS scores for July 2008 were not recorded in the internal database, so analysis for the full fiscal year was not able to be completed. If this researcher was repeating this program evaluation this researcher would compile the data herself. Being able to compile directly from the case files over a consistent period of time would insure accuracy and provide a qualitative aspect to the LOCUS and MORS scores. The compilation of secondary data is difficult to obtain when limited personnel are able to collect it. This researcher was not able to take into consideration any changes in employment, housing, or other quality of life factors that measure an individual's recovery.

According to the results of this program evaluation, TPCP ISA program does have an effect on Recovery. Whether or not environmental factors influence the changes identified is not addressed in this study. That may be a consideration for future studies. In retrospect the development of this thesis has provided this researcher

the opportunity to understand the administrative responsibility that direct providers provide the members they serve and the agency they represent.

Implications for Social Work

The findings of this research provide social workers with an understanding of the need for reliable outcomes measures to improve the services that we provide the individuals we are privileged to serve. As professionals it is vital that social workers obtain on-going and accurate documentation regarding demographics and quality of life factors of the individuals they serve. Outcomes promote accountability to the providers and encouragement, as well as reassurance, to stakeholders. Because of the current economic climate it is more crucial than ever for social workers to embrace the utilization of program evaluation. Only with evidence will social workers continue to gain support and public funding to promote services to better meet the needs of individuals in need.

Licensed Clinical Social workers account for a large proportion of mental health providers and are more likely to be employed by county funded mental health agencies (Scheffler & Kirby, 2003). A 2000 survey conducted by the National Association of Social Workers found that 39% of social workers identified mental health as their focus. It is important that social workers understand the unique challenges associated with measuring Recovery and mental health.

This research has proven that effective services require adequate time to provide services that will empower individuals to improve their own quality of life.

Furthermore, this research has shown that routine instruments are required to collect more information on the patterns of recovery that individuals experiences.

APPENDICES

APPENDIX A

LEVEL OF CARE UTILZATION SYSTEM

Sacramento County
ADULT MENTAL HEALTH SERVICES
LOCUS Summary Sheet

Client Name:	Client ID Number:	Date:
Staff Name:	Program / Cost Center:	

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Enter your scores in the LOCUS Decision Tool and answer the two decision tree questions. The Decision Tool will provide a level of care recommendation. Enter the rating below.

I. Risk of Harm

- ☐ 1. Minimal Risk of Harm
- ☐ 2. Low Risk of Harm
- ☐ 3. Moderate Risk of Harm
- ☐ 4. Serious Risk of Harm
- ☐ 5. Extreme Risk of Harm

II. Functional Status

- ☐ 1. Minimal Impairment
- ☐ 2. Mild Impairment
- ☐ 3. Moderate Impairment
- ☐ 4. Serious Impairment
- ☐ 5. Severe Impairment

III. Co-Morbidity – Psychiatric and:

☐ Medical and/or ☐ Addictive

- ☐ 1. No Co-Morbidity
- ☐ 2. Minor Co-Morbidity
- ☐ 3. Significant Co-Morbidity
- ☐ 4. Major Co-Morbidity
- ☐ 5. Severe Co-Morbidity

IV-A. Recovery Environment - Level of Stress

- ☐ 1. Low Stress Environment
- ☐ 2. Mildly Stressful environment
- ☐ 3. Moderately Stressful Environment
- ☐ 4. Highly Stressful Environment
- ☐ 5. Extremely Stressful Environment

IV-B. Recovery Environment - Level of Support

- ☐ 1. Highly Supportive Environment
- ☐ 2. Supportive Environment
- ☐ 3. Limited Support in Environment
- ☐ 4. Minimal Support in Environment
- ☐ 5. No Support in Environment

V. Treatment and Recovery History

- ☐ 1. Fully Responsive to Treatment and Recovery Management
- ☐ 2. Significant Response to Treatment and Recovery Management
- ☐ 3. Moderate or Equivocal Response to Treatment and Recovery Management
- ☐ 4. Poor Response to Treatment and Recovery Management
- ☐ 5. Negligible Response to Treatment

VI. Engagement

- ☐ 1. Optimal Engagement
- ☐ 2. Positive engagement
- ☐ 3. Limited Engagement
- ☐ 4. Minimal engagement
- ☐ 5. Unengaged

Composite Score:	**LOCUS Decision Tool Level:**

See Progress Note for program recommendation and rationale. Progress Note Date:

Original: Client Record
Copy: Adult Access or IPT as indicated

LOCUS Summary Sheet (Form AMH-029)
Revision 04/25/08

APPENDIX B

MILESTONES OF RECOVERY SCALE

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. 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. "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 neighbors.

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