Rating Engagement on the MORS

(2010)

Engagement can be the most confusing of the correlates on the MORS to rate. It is described in the scale as "voluntarily participating and cooperating in ongoing mental health treatment." Engagement is the difference between levels 2 and 3 and between levels 4 and 5. People at levels 1, 6, 7, and 8 may be either engaged or unengaged. Here are some guidelines and examples to assist in rating engagement.

1) Although we're rating people as either engaged or unengaged, engagement, participating, and cooperating are not "yes or no" phenomenon, they are "more or less" phenomenon. A rating of engaged is made if the person is "engaged enough"; if they meet a threshold of sufficient engagement. We want to have a low threshold, so be lenient, and be an easy grader.

   Example1 : John has been coming for food, showers, and mail for several years. Recently he has been willing to see the psychiatrist for medications and to participate in applying for SSI. He misses most of his appointments and gets angry when we're not available when he drops in. He mostly loses his meds. He disappears on drinking binges for days a t a time. He says if he needs a payee, he'd like it to be us. That's "engaged enough" with mental health treatment.

2) Engagement is fundamentally a rating of the relationship between the person using services and the staff providing services rather than an internal characteristic of the person themselves. Someone can be engaged with one mental health program and not with another one, or engaged with one staff in a program but not another one. Rate them as engaged if they are engaged with any provider.

   Example 2: Mary refuses to see the psychiatrist and all medications, but she comes regularly to the Wellness Center and has completed a WRAP plan that helps her use coping skills and friends to deal with her depression. She also comes to the Sunday morning women's support group. Even still, she's overwhelmed whenever her boyfriend gets out of jail and beats her and cuts herself deeply enough to need medical attention. She won't go to a battered women's program or leave him. She's engaged with the WRAP facilitator and the support group, but not the psychiatrist or the battered women's shelter. She's engaged with someone.

   The relationship doesn't have to be pleasant, "professional", reliable, or even effective to count as engaged, but both sides have to be involved in it. It doesn't matter which side is to "blame" for the relationship not existing. Even if someone is potentially "engagable" they only count as engaged if they only count as engaged if they are actually in a relationship with a mental health provider.

   Example 3: Jane complains that she gets the runaround at the local clinic. They don't have enough psychiatrists and there's never anyone available when she comes in and the case workers never

return her calls. The staff report that she misses any appointments they give her and shows up drunk so they tell her to come back when she's sober. She's unengaged.

It may be neither side's fault, but there's a system barrier keeping the two sides apart.

Example 4: Sam is uninsured. Due to cut backs ongoing services are only available to people with MediCaid and/or MediCare so Sam is turned away because it's not an emergency. He's unengaged.

The relationship must be voluntary. Participating in coercive services alone does not qualify as engaged.

Example 5: Alice is regularly hospitalized involuntarily when she becomes manic and aggressive. In the hospital she takes the medications she's given and comes to groups. When she is discharged she doesn't fill her prescriptions or make her appointment at the clinic. This time the hospital placed her in a Board and Care where she must take her medications to live there, so she does. She is forced to have a payee who she picks up weekly money from. She doesn't participate in any other services. She's unengaged.

3) Different mental health services have different treatment relationship requirements; different "rules of engagement". Though the MORS was written from a recovery perspective, at present there are a wide variety of models and rules in our system. Engagement must be with the actual provider and program available, not with some idealized recovery based provider.

   Here are some common non-recovery "rules of engagement" in our system today: In a professionally driven program, to be engaged a person has to comply with the treatment plan and orders staff make. In an illness centered, medical model program, to be engaged a person has to have insight and be compliant with medications. In a therapy based program to be engaged a person has to "work" in therapy using psychological mindedness. In a 12- step program to be engaged a person has to be sober and work their program one-day-at-a-time. In an appointment based program, to be engaged a person has to have enough skills, supports, and self responsibility and few enough interfering symptoms and barriers to come to appointments regularly. Programs like these will likely find themselves with very few MORS 3's and 5's because they can't really engage people at those levels. To recover using these programs someone would have to take the unlikely path 1 -2 – 4 – 6 - 7, or the even less likely 1 -2 – 6 - 7.

   Example 6: David hears a lot of voices that distract him so badly he can't focus on a conversation even when he's taking medications. He is also too restless to participate in therapy sessions or attend groups. His local clinic informed him that he was too impaired to be treated in their program. Despite his desire for treatment and willingness to take medications, he was unengaged. His father, an aggressive mental health advocate, was so outraged he pressured heavily for the passage of AB3777, the creation of the Village, and the spread of system transformation. Now David is engaged in a recovery based program.

Recovery also has "rules of engagement" the two most important being: (a) Recovery services are relationship based, and (b) Recovery services are goal-driven.

Recovery services are relationship based. An underlying premise of the recovery movement is that recovery isn't something someone does to you. It is a change and growth individuals make. Some people recover without receiving mental health services and some people benefit substantially from having a provider alongside them providing guidance, coaching, emotional support, caring, and compassion. To provide these supports, there must be a relationship between the person and the provider. "Treating strangers" doesn't have much impact. Therefore, for someone to be engaged in treatment they must have a relationship with their provider. The relationship doesn't have to be pleasant or free from conflict, but it has to include some genuine emotional connection.

Example 7: Steve comes into the program every 2 months to get his medications refilled. He doesn't know his psychiatrist's name. His psychiatrist needs to have the chart to read his previous note to refill Steve's medications because he doesn't remember Steve from visit to visit. Steve says that getting medications is all he needs and refuses all other services when the case manager tracks him down once a year to renew his service plans. Steve is unengaged. (Note that Steve could still be a MORS 6 or 7 which do not require engagement, but not a 3 or 5 which do.)

Recovery services are goal-driven. Just having a relationship isn't enough to count as participating in mental health treatment. There must be purposefulness to the relationship. If the person meets with their provider just for a pleasant cup of coffee or to talk about the Lakers they aren't really engaged in recovery based mental health treatment. Recovery services should be trying to improve the person's quality of life and/or help them progress in their recovery. (Note that although some pursuits of quality of life goals may not be "billable" to some of our present payment systems, they are recovery based services nonetheless.)

Example 8: Paul won't take any medications or go to therapy, but he is coming to the work training program getting paid to do janitorial work while building his work skills and coping with his symptoms at work. He likes his boss who he describes as tough but fair. His boss thinks Paul has grown a lot in the last 4 months and will soon be ready for community job development. Paul is engaged.

Although recovery programs are client driven rather than professional driven – goals should be chosen by the person – for someone to be engaged there must be some agreement and willingness to collaborate on the stated goals by both the person and the provider. If the person has one goal that is in the chart, but the staff is really working on their goal for the person instead, they are not engaged.

Example 9: Stanley comes in once a week to share his latest writings with his case manager hoping that his case manager will realize that Stanley is a prophet of God. He won't work on any goals. His case manager agrees to this activity because he hopes that they will strengthen their relationship so that Stanley will agree to apply for SSI and take antipsychotic medications to be more in reality. He

keeps talking to him about how pills could help with the stress and sleeplessness from fighting demons. Stanley is unengaged. After 3 years Stanley agrees to apply for SSI and with his case manager's help gets it, moves into an apartment, and reconnects with his mother. He still believes that he is a prophet of God and refuses medications. His case worker still believes that Stanley has a mental illness and is not a prophet of God, but they are able to agree on the next Quality of Life goal – seeing a physical doctor for the first time in 20 years- and are working on it together. Now Stanley is engaged.

Just because someone is unengaged, doesn't mean they shouldn't be receiving services or won't benefit substantially from them. It does mean that the focus of the services should be on engagement – building a relationship and/or shared goals – rather than on focusing on treatment. People who are unengaged should really have an "engagement plan" rather than a "treatment plan".

Example 10: Maurice gets high almost every day. He comes to see his psychiatrist mostly trying to get Klonipin to combine with street drugs to improve his highs. He wants help getting SSI so he can afford more drugs. His psychiatrist is giving him some Klonipin and helping with SSI while doing motivational interviewing in the hope that Maurice will eventually decide to try to get off drugs. Maurice is unengaged and receiving appropriate services that match his MORS level. 2 years later, Maurice decides to try to get sober and checks into a rehabilitation program. He sneaks out within a week using drugs and is caught and thrown out. He still wants to stop using drugs, but thinks he's not ready for another program yet. His visits with his psychiatrist now focus on what changes he'd have to make to be able to succeed in a program – their shared goal. Maurice is now engaged even though he is still using drugs.

One of the main purposes of including engagement in the MORS is to get us to realize that many people receiving services are actually "unengaged" and to focus on what alterations in our often unspoken "rules of engagement" and our service relationships and plans we should be making to more effectively serve unengaged people.