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Change is difficult—whether it is changing our personal habits and behaviors, how we approach our work, or programs and systems. Whether a personal resolution or a system change initiative, effective change requires certain ingredients:

1. **Motivation or incentive.** What is the reason for change? What factors drive the change?
2. **Direction or vision.** Where are you going? What are you trying to accomplish?
3. **Readiness and preparation.** What are your existing strengths and challenges? What barriers may influence the process and how can you address them? What are your priorities?
4. **Measurement.** How will you know if you are successful or even moving in the desired direction? How might what you measure shape what you get?

This issue of the RTP newsletter looks at readiness for change. Keris Myrick describes some of SAMHSA’s activities to promote recovery-oriented practices within the behavioral health system. Larry Davidson offers some self-assessment tools that can help organizations transforming to more recovery-oriented cultures to answer the questions above. Sandra Steingard shares her professional journey of learning how to embrace recovery approaches in her clinical practice and programs.
Ready for Change?

Someone once said, “If you always do what you’ve always done, you’ll always get what you’ve always got.” The goal of system transformation is not to get what we have always gotten, but to increase opportunities for recovery for people with mental health and substance use conditions.

Behavioral health treatment, services, and supports are undergoing transformation to increase recovery outcomes for people with behavioral health conditions. System transformation is a term used to communicate incorporating recovery into the organizational culture, policies, and practices. Transformation means change, including change within the people providing services within systems and change within the people receiving services.

To make this transformation, we must first ask what recovery is and how we will measure it.

The Substance Abuse and Mental Health Services Administration (SAMHSA) established a working definition of recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their potential. SAMHSA delineated four major dimensions that support a life in recovery:

- **Health**—overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being
- **Home**—having a stable and safe place to live
- **Purpose**—engaging in meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and having the independence, income, and resources to participate in society
- **Community**—having relationships and social networks that provide support, friendship, love, and hope

After developing the working definition of recovery and 10 guiding principles, SAMHSA convened a Recovery Measurement Expert Panel to identify an appropriate recovery instrument consistent with the four dimensions of recovery. The panel included content experts from the recovery field, people in recovery, and staff from SAMHSA’s Center for Behavioral Health Statistics and Quality. Based on a literature review, SAMHSA and the panel identified the World Health Organization Quality of Life (WHOQOL-8) scale as the tool best suited to capture the four dimensions of health, home, purpose, and community.

Change is not easy. Change takes time, patience, and perseverance. Change starts with asking if we are ready for change. Change readiness is the ability to initiate and respond to change in ways that create advantage, minimize risk, increase recovery, and sustain performance. Sustaining success depends on an organization’s ability to adapt to a changing environment.

**Keris Myrick, MBA, MS**
Director of Consumer Affairs
Center for Mental Health Services

A leading mental health advocate and executive, Keris is renowned for her innovative and inclusive approach to mental health reform. Through the Center for Mental Health Services Office of Consumer Affairs, she supports the inclusion of peer concerns and perspectives throughout the agency and across programs, such as the Voice Awards, SAMHSA Wellness Initiatives, and Wellness Week. Before joining SAMHSA, Keris was president and CEO of Project Return Peer Support Network, a Los Angeles-based, peer-run nonprofit, which manages more than 150 self-help groups and a range of peer-run services.

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A NOTE FROM THE FIELD

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Assessing Organizational Readiness for Recovery-oriented Practice

By Larry Davidson, PhD

Upon first hearing of the concept of “recovery-oriented practice,” many behavioral health professionals think that they “do it already.” Since recovery-oriented care includes broad concepts—such as being respectful and person-centered, and promoting autonomy and improved quality of life—most practitioners believe that their practice reflects these core, underlying values.

Recovery-oriented practices move beyond the conventional policies and structures of most behavioral health agencies, necessitating a transformation of behavioral health services. This transformation, according to the U.S. Department of Health and Human Services (2005), will require “profound change—not at the margins of a system, but at its very core.”

Over the past decade, several tools have been developed to help agencies and practitioners learn about the profound changes required to implement recovery-oriented practices. These tools include the Recovery Enhancing Environment (REE) Measure (Ridgway & Press, 2004); Recovery-Oriented Practices Index (Mancini & Finnerty, 2005); Recovery-Oriented System Indicators (ROSI) Measures (Dumont, Ridgeway, Onken, Dornan, & Ralph, 2005); Recovery Promotion Fidelity Scale

Larry Davidson, PhD

Larry Davidson, PhD, is a professor of psychiatry and director of the Program for Recovery and Community Health at the School of Medicine and Institution for Social and Policy Studies of Yale University. Larry’s research, consulting, and training focus on the processes of recovery from serious mental illnesses and addictions. His work to promote the recovery and community inclusion of individuals with these conditions includes designing and evaluating policies to promote the transformation of systems to provide recovery-oriented care. Larry has produced more than 200 publications, including the books A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care and The Roots of the Recovery Movement in Psychiatry: Lessons Learned. You can reach Larry at larry.davidson@yale.edu.
(Armstrong & Steffen, 2009); and the Recovery Self-Assessment (RSA) Scale (O’Connell, Tondora, Croog, Evans, & Davidson, 2005).

While these various measures overlap considerably, they differ in terms of length (i.e., the number of items and domains) and the stakeholders by and for whom they were developed (e.g., administrators, practitioners, individuals using services). The RSA, used most frequently in research and program evaluation, has four versions—one each for administrators, practitioners, clients, and family members or advocates—and has been adapted for different settings, including a version for nurses providing inpatient care (McLoughlin & Fitzpatrick, 2008).

These measures assess the degree of “readiness” for implementing recovery-oriented practice on a number of distinct, but related, dimensions. The dimensions of the RSA, for example, are

- life goals
- stakeholder involvement
- diversity of options
- client choice
- individually tailored services

The first dimension, life goals, speaks to the degree to which the agency has shifted from a narrow, problem-focused approach to treatment to a strengths-based approach that supports individuals in pursuing their own hopes, dreams, and aspirations. Stakeholder involvement focuses on the degree to which stakeholders—clients, family members, and allies—are involved in all aspects of agency operation, from policy and program development and quality improvement to staff training and availability of peer support. Diversity of options addresses the availability of a range of service and support options for people using services that support recovery.

Client choice considers where the agency falls on a continuum spanning from coercion to choice. Aspects of client choice include staff behaviors such as how often staff members use bribes, threats, or involuntary measures to shape client behavior, as well as the degree of client choice in matters such as changing practitioners or accessing their medical records.

Finally, the dimension of individually tailored services relates to how person- and family-centered the organization’s services and supports are. This dimension examines whether services are responsive to individual cultural, ethnic, and racial identity and affiliations; attentive to trauma histories; appreciative of the significance of spirituality; and geared toward connecting individuals to naturally occurring community roles and activities of their choice.

This transformation, according to the U.S. Department of Health and Human Services (2005), will require “profound change—not at the margins of a system, but at its very core.”

Once an agency collects responses and feedback on each of these dimensions from a variety of perspectives—including those people who use its services—the resulting scores provide a profile of the organization’s strengths and weaknesses. Agencies can then build on their positive activities in their transformation efforts, as well as examine and improve areas needing work. Collected on a regular basis, these data can help an agency to appreciate its progress toward a culture in which recovery-oriented care is not only possible, but truly thrives.

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To learn more, join us for the webinar, Implementing Recovery-oriented Practices: Assessing Strengths and Priorities, on April 5, 2016, 12:30 – 1:30 p.m. (ET)
Let me be clear: I was never anti-recovery. I admit, however, that when the concept of "recovery" in mental health came to my attention in the 1990s, it did not attract me. Whenever I attended a presentation on recovery, I felt defensive and unable to listen openly. At the time, Vermont was pushing hard to close its state psychiatric hospital. The policy mantra of recovery seemed to be promoted by fiat: since people were expected to recover, we no longer needed a state hospital.

Another factor was that my colleagues and I had to determine how to help people with serious mental health conditions live within our communities. Simply saying, recovery is possible did not magically transform the lives and minds of individuals who were clearly struggling. For many years, therefore, I regarded recovery as a buzzword instead of seeing it as a helpful, instructive practice.

Today as I meet people advocating for recovery-oriented approaches, I listen to what they say in a new way. Perhaps the key lesson I have learned is that the power differential inherent in the "doctor–patient" relationship distorts my connection with the person in my office. Furthermore, listening to people who have experienced being “psychiatric patients” is invaluable. Their stories of recovery prompt me to examine the myriad ways I may undermine the person’s autonomy in my earnest attempt to be helpful.

An experience that crystalized the power inherent in the recovery approach came from my own clinic. In 2011, after Hurricane Irene (ranked as the seventh-costliest storm in...
U.S. history) closed the Vermont State Hospital, the long-standing debate over the hospital’s fate was suddenly over. The state asked community mental health centers like Howard Center to develop programs that would help people avoid needing psychiatric hospitalization. At that time, our crisis intervention service focused on evaluation and referral; we typically saw a person once and then made a referral for outpatient or inpatient treatment. I wondered if our practitioners could help individuals with mental health and substance use conditions by extending our crisis intervention services to include supports.

Howard Center formed a team, called START—Stabilization and Recovery Treatment—which we modeled on Open Dialogue, a community network-focused approach for people diagnosed with psychoses, such as schizophrenia. START respects the individual’s decisions and supports the individual’s network of family and friends. The program is responsive to staff and those using our services, rarely turning down referrals. Satisfaction with the program is high, and for these reasons, START is incredibly popular.

At the suggestion of the Vermont Department of Mental Health, we hired peer support specialists as experts who are going to “fix the problem.” This assumption can bring a sense of inherent superiority into clinical relationships, resulting in professionals not fully appreciating the strengths and abilities of the people using our services. This unequal relationship can diminish the individual’s notion that he or she has the ability to work through their own problems. With humility, I realize that even on my best days, a peer offers something that I cannot. “I have been there and made it through” are potent words indeed.

I have witnessed the transformation of individual START team members and seen this approach positively affect the agency’s culture. Practitioners who did not think peers could be effective are now among the most ardent supporters. Several START peer staff members have entered the workforce after living for years on disability insurance; some have gone on to full-time employment or graduate school. Agency clients regard these team members as role models. It has been humbling, instructive, and inspiring to work as a member of this remarkable team and to be part of our collective journey of discovery and recovery.

“I have been there and made it through” are potent words indeed.

START team members. These peers have taught me so much. Intentionally or not, professionals are often regarded as Hurricane Irene. Image courtesy of Wikipedia.
Nearly 20 years ago, researchers Carlo C. DiClemente and J. O. Prochaska introduced a five-stage model of change to help professionals understand people with substance use disorders and help them make important life changes. The five stages are precontemplation, contemplation, preparation, action, and maintenance/relapse.

The Prochaska and DiClemente five-stage model captures the iterative, nonlinear nature of organizational and systemic transformation, not just individual behavioral change. This framework may help organizations assess and answer the questions: Are we ready for change? Are we ready to integrate recovery-oriented practices into our behavioral health services? The model can also help practitioners as they reflect on their practice and ask themselves: Am I ready for change? Am I ready to fully embrace recovery-oriented treatment and service approaches in my work?

As we move toward recovery-oriented behavioral health systems, it is not just individuals using services who are asked to make important changes. Administrators, staff, practitioners, and others supporting the person receiving services must also change and engage in the transformation process.

President Obama said, “Change will not come if we wait for some other person or if we wait for some other time. We are the ones we’ve been waiting for. We are the change that we seek.” So ask yourself: “Am I ready for change?”

References


June is PTSD Awareness Month
Upcoming RTP Webinars and Conference Presentations

Want to hear more about the topics in this newsletter? Please join us for a webinar that highlights tools to help agencies and practitioners identify strengths and prioritize areas of development for shifting toward recovery-oriented treatment and services.

Implementing Recovery-oriented Practices: Assessing Strengths and Priorities
April 5, 2016 | 12:30 – 1:30 p.m. (ET)
Register to attend.

Be sure to check your e-mail inbox for the announcement of an upcoming RTP Spring Webinar Series that we will host in May 2016. This series will examine how recovery-oriented practitioners and organizations can identify, access, and collaborate with common community resources to help individuals expand their circles of support within communities of their choice.

American Occupational Therapy Association
2016 Annual Conference & Expo
Evidence & Outcomes: Empowering the Profession
Chicago, Illinois
Learn more or register to attend.

Psychiatric Rehabilitation Association
2016 Recovery Workforce Summit
The State of Recovery in the World of Psych Rehab: Our Collective Vision Put into Action
Boston, Massachusetts
Learn more or register to attend.

May is Mental Health Month!

6th Anniversary of the Affordable Care Act
MAR 23

American Psychiatric Association Annual Meeting
Atlanta, Georgia
Learn more or register to attend.

National Anxiety and Depression Awareness Week
MAY 2 – 8

National Children’s Mental Health Awareness Day
MAY 7

This product was developed [in part] under contract number HHSS283201200038I/ HHSS28342001T (Reference No. 283-12-3801) from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.