



## Assessing Organizational Readiness for Recovery-oriented Practice

By Larry Davidson, PhD



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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

# Life Goals

(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

# Client Choice

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.

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)



## Ready for Change? Continued from page 3

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?" ●

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June is PTSD Awareness Month

PTSD

# Practicing Recovery: Implementing and Measuring a Recovery Orientation

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