Implementing Recovery-Oriented Practices: Assessing Strengths and Priorities

Good afternoon, everyone, and welcome to today's Recovery to Practice webinar, titled Implementing Recovery-Oriented Practices: Assessing Strengths and Priorities. My name is Elizabeth Whitney and I'll be your host today. After some housekeeping and a short overview of Recovery to Practice, we'll begin the presentation.

On behalf of the Substance Abuse and Mental Health Services Administration and the Recovery to Practice team, we'd like to welcome you all and thank you for joining us. We have almost 180 people in attendance already; I expect that we may have more joining us. I'd also really like to thank our presenters, Janice Tondora and Wesley Sowers, for sharing their knowledge and experience with us today.

At the bottom of your screen, you'll notice the download materials box, where you can download our presenters' biographies as well as a pdf of the presentation slides. To maximize the presentation area, this box will be removed once our presenters start speaking, but you will be able to access this information at the end of the webinar as well. In addition, at the end of the session you will also be able to download a certificate of attendance that you can use to apply for continuing education credits for your professional association and this webinar has been pre-approved for continuing education hours from NAADAC, the Addiction Professionals Association. To qualify for these continuing education hours, you have to attend the full webinar, complete a brief quiz and the evaluation. More information will be available at the end of the webinar.

Finally, at the completion of the webinar today, you will be given the opportunity to provide feedback to us and that will automatically open on your screen. To register for the webinar, you will be emailed a link to view the archived recording. This link will also be available on the RTP website, where you will also find links from past RTP webinars.

This webinar series is hosted by SAMHSA's Recovery to Practice. The overarching goal of this initiative is to improve the knowledge and ability of the behavioral health workforce to use recovery-oriented practices every day. What do we mean by recovery-oriented practices? In 2011, SAMHSA released a working definition of recovery and a set of guiding principles that incorporate aspects of recovery from both substance use and mental health conditions. SAMHSA's working definition of recovery and behavioral health is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. The 10 principles of recovery shown on this slide, along with the four major dimensions of recovery, home, health, purpose, community, form a solid foundation for developing recovery-oriented lives and for building recovery-oriented services and systems necessary to support them. SAMHSA's Recovery to Practice initiative helps you to turn these principles into workforce practices.

RTP offers a set of discipline-based curricula to promote understanding and uptake of recovery principles and practices. Developed by these six professional disciplines, shown on this slide, for educating their membership about recovery and behavioral health, these materials are adaptable for use by other disciplines and organizations who are seeking resources to build a recovery-oriented workforce. Links to these curricula are available at SAMHSA's Recovery to Practice website.

RTP is expanding its discipline focus to embrace multidisciplinary services and integrated settings. Those of us who work in behavioral health or integrated healthcare organizations have opportunities every day to promote wellness and recovery. We can powerfully communicate hope for recovery and the value of self-care and wellness just in how we approach our work. RTP can help you strengthen your recovery-oriented practice through free webinars, newsletters, and training and technical assistance opportunities.

Today's webinar explores ideas and themes raised in the March Recovery to Practice newsletter on implementing and measuring a recovery orientation. You will have a chance to more fully explore themes from the newsletter, including using tools to measure and guide recovery transformation efforts, at the personal, program, and organizational level.

I'd now like to introduce our speakers for today. Dr. Janice Tondora is Assistant Professor in the Department of Psychiatry at the Yale University School of Medicine. Based at the program for recovery and community health, Dr. Tondora's professional interests focus on the design, implementation, and evaluation of services that promote self-determination, recovery, and community inclusion among individuals living with serious behavioral health disorders. She has provided training and consultation to nearly 20 states seeking to develop person-centered planning models and programs and has shared her work with the field in numerous publications. These include a 2009 book, co-authored with several colleagues, entitled A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Healthcare, and a 2014 text, Partnering for Recovery in Mental Health: A Practical Guide to Person-Centered Planning. Dr. Tondora's consultation and publications have been widely used by both public and private sector service agencies to significantly advance the implementation of recovery-oriented practice across the behavioral health field.

Dr. Wesley Sowers is Clinical Professor of Psychiatry at the University of Pittsburgh Medical Center. He's also the Director of the Center for Public Service Psychiatry of Western Psychiatric Institute and Clinic, which offers a one-year fellowship in public service psychiatry. He's Board Certified in Adult Psychiatry with subspecialty certifications in addiction and administrative psychiatry. He's past President of the American Association of Community Psychiatrists and has served on the Board of Directors at that organization since 1988. He is on the Board of Directors of the American Association of Psychiatric Administrators and is also a member of several other professional organizations. Clinically, he has extensive experience in the provision of treatment and services to special populations such as homeless men and women, criminal offenders, sexual minorities, and people with substance use disorders.

I'm delighted to have you both. Janice, I'll turn it over to you.

Hello, everyone. It's great to be with you all this afternoon and share a little bit about what I think is an exciting topic, as the assessment of recovery-oriented practices I think is really an opportunity to take things to the next level in our transformation change efforts. By that, I mean building off of some of the [inaudible] models like the SAMHSA 10 Dimensions that Elizabeth just reviewed, but fleshing that out a bit more so that we can offer the field some concrete guidance around what a recovery-oriented approach actually looks like in practice. I think this is especially true and important because in my experience, the recovery-oriented approach fits with the values that many providers hold in their hearts and that they bring into the field, but they're often unsure about how to translate that into new ways of doing business and supporting people in recovery.

Just to give you a sense of what I hope to cover, briefly before I turn it over to Dr. Sowers, I'm going to tell you a little bit about the structure and development of a tool called The Recovery Self-Assessment, but also what I hope to do is share a brief case example with you that really demonstrates once you have data from an agency recovery orientation, how do you actually use that in a meaningful way? Before I do that, let me just start with the basics, a little bit about why is it important to assess agency recovery orientation. Certainly to promote transparency so that the expectations around recovery-oriented care are clear to all stakeholders, including to people in recovery, so that we can increase their expectations about what they can and should expect from the systems that are supporting them and can help you to evaluate your progress or your lack thereof, as you look to evaluate the impact of the change efforts that you're undertaking at the organizational level, and it can help to inform personal choice, as well, specifically among people in recovery, who increasingly do have some choices in the providers and agencies that they choose to work with.

Last, but not least, it can have utility from an administrative perspective, in terms of contract management and establishing some quality standards in terms of the expectations that we hope agencies are striving to meet, and a few more critical benefits here of assessing agency recovery-orientation. This on the far

right, I think, is really important because this notion, widely-held assumption that we already do it, we already do recovery-oriented care, is one that can oftentimes hold us back in our change efforts because we don't have the necessary sense of urgency around moving forward. Making recovery-oriented practice more concrete through these assessment efforts can really help to challenge some of those assumptions.

That's not to say that there's not some critical strengths that are out there and that there isn't some great stuff happening in the field, because, in fact, another benefit of assessing agency recovery orientation is that it can help highlight those areas in which you're doing a really good job, so that we can take a closer look at that, hopefully replicate what's working well, but at the same time it will help you to identify some of your team need areas or priorities that could be in need of attention, moving forward. Part of the reason that's helpful from a practical perspective is that you can't tackle all things at the same time, so having a sense of what those priority needs are can help you then tailor your training in the technical assistance that you might offer to programs as they strive to move forward in their change efforts.

Let me shift and just tell you a little bit about the background of the RSA. We began in early 2000, came out of a partnership between our Yale program for recovery and community health, our Connecticut Department of Mental Health and Addiction Services, and our Connecticut Recovery Community, in particular a collaboration with our local advocacy organizations. We had been working on the recovery model for quite a long time, but had decided we really were in need of a tool to help programs and agencies really assess the degree to which they were operating in accordance with the recovery model that we had been working to develop. That led us to what we think was the first known statewide assessment of Recovery-Oriented Practices.

We did a very extensive literature review, we had some key informant interviews, and conducted a lot of focus groups around the state, in particular with people in recovery, which led us to a draft recovery self-assessment instrument, which we instituted statewide and we collected over 1,000 responses to that initial pilot project, which led us to the original version of the recovery self-assessment, which was a 36-item inventory. It has four parallel versions, has a version for people in recovery, a version for practitioners, a version for family members, and also a version for administrators or leadership. The 36 items fall out around five core conceptual domains and we did the factor analysis. I'll just give you a brief sense of what some of the items looked like.

In the life goals category, this would include looking at things like the content of recovery plans and do we have goals on recovery plans that go beyond medication compliance and clinical stability, to actually focus on those personally-valued recovery outcomes of employment, community participation, meaningful faith participation, valued roles, et cetera. Then, do people have a diversity of treatment options to actually reach and achieve those goals, including things like the availability of peer support, potential collaboration with naturopaths and indigenous healers? We also look critically at client choice, as one of the five dimensions. That could include items around people having an ability to readily access their treatment records, do they understand and know how to use grievance procedures, do they have the ability to request changes in providers, et cetera.

We look at individually-tailored services as one of the core domains, which might include things around the availability of trainings for practitioners around culturally-responsive services.

It could include trainings around the extent to which we're building our capability to connect people to their chosen communities of choice. Then, finally, the fifth dimension is around consumer involvement, which includes items that really have to do with the active participation of people in recovery in the design, the delivery, and the evaluation of services at each step in the process.

Before we go further, having presented the five key domains to you and the RFA, I'd like to just get a quick sense from those of you that are on the line, if you have any sense of which of those might be the most important in predicting your overall agency recovery orientation. If you could go ahead and do a quite vote here. Where do you think you get the most bang for your buck? Great. We've got a bunch of folks responding. Just give it a few more seconds.

All right, it looks like our responses are dwindling down here. It looks like we've got a veteran group on the line. We've got a winner at 57.6% indicating that folks believe that consumer involvement is perhaps the most critical dimension when you think about how you can impact your overall agency recovery orientation.

You hit the nail on the head. We have lots of experience using the RFA and really the key [inaudible] methods is that if you get one thing right in terms of investing your resources and your energy, we've at this point, since the original publication of the RFA in 2005, the tool has been used in over 40 states. It's been translated I think in nine languages. It's used in a dozen or so different countries and probably one of the most robust findings that holds up consistently across those administrations is the fact that agencies that score highest on this dimension of consumer involvement, most often have the highest overall recovery orientation.

It's a really nice reflection of how the data does demonstrate that the most critical thing that you really can do is partner with people in recovery at all aspects of your change process.

Let me just give you a few quick administration tips. There's no one right way to administer the RFA. Some folks have found it helpful to use online administration, things like through Survey Monkey. We've had confidential DropBoxes scattered throughout agency behavioral health centers. We've used self-addressed mail-in envelopes. We've done focus groups, etc. The important thing to keep in mind is that no matter what strategy works for your particular system, if you want to actually compare your results across programs, but you administer the tool too, you want to think about administering them consistently in a consistent structure there.

Of course you want to maintain anonymity and offer people reassurances that, of course, their responses are not in any way going to negatively impact their treatment or their care from their primary team at the agency. We would obviously advise against having a primary clinician or a primary caregiver being the one to directly offer the tool and then collect it. Then also, when you think about the sample that you want to reach out to, particularly as it relates to collecting the data from people in recovery, there can be a tendency to want to choose the folks who are ready and willing, so to have clinicians self-select a group of people that would be willing.

What we have found in those circumstances is that those are folks who are highly engaged in the program and, for a variety of reasons, you can get artificially inflated results that don't necessarily generalize across the program. At the same time, something else you want to avoid is that you don't want it to sample from a convenience group. We've had agencies when if, for example, there's a certain day of the week where there's a medication clinic, for example, and there are large numbers of individuals who gather, but they might administer the tool at that point. Certainly while you want to collect data in those contexts, you need to recognize that, if we're only collecting data in that particular context, you're going to be missing the perspective from a whole additional set of individuals who receive your services.

You're going to have difficulty generalizing the result, so be thinking about really a diverse array of avenues that you can tap into your constituents to get their perspective on things. Then just a last tip on that is that we have had some agencies have quite a bit of success providing some support around the administration of the RFA. We've had peer supporters at agencies host events where they're both describing and then collecting RFA surveys from individuals. We've had kiosks set up in waiting rooms where again there might be somebody available to answer questions as needed, etc. That can be another way to help collect the data.

In terms of the advantages of the RFA, overall it's pretty user friendly, ease of administration. On average, it takes about five to seven minutes to complete. We have had some feedback from people in recovery that it can be a little bit dense and we need to take a look at the literacy levels. We do have some efforts underway to create an even greater streamlined version of the tool for use out in the field. Again, you can compare some of the findings across stakeholder groups. I'll give you an example of that in a minute

because sometimes your most interesting findings are really in triangulating what an executive director might think as opposed to what the direct care practitioners think or folks in recovery.

It really doesn't require a sophisticated statistical analysis. We really would suggest keeping it simple and presenting the data in a way that it's user friendly and really creates a profile for an agency that they can use in their change efforts.

The primary limitation of the RFA I would say is that, again, the items on it, although we try to be tapping into concrete recovery practices, it's still the respondents' subjective perception of the extent to which we're doing those things or not. We don't know the extent to which that actually maps on directly to the actual implementation of recovery-based practices, so while it's a step in the right direction, we would suggest, in order to round out the data you're collecting, that you follow up an RFA administration with things like observational audits, so doing ride-alongs in the field. The staff are doing home visits, sitting in on treatment team meetings. Maybe doing some chart audits. Certainly conducting focus groups with stakeholders and so forth.

Then after you've collected your RFA data and hopefully also done some of the more qualitative and observational work, we want to really be thinking about how can we present the data in a meaningful way so the program can actually use it. A couple of things to keep in mind that we typically will point out in RFA reporting is looking at things like if there's notable discrepancies in perspective across stakeholder groups.

As one example, there's a set of items within the RFA that really look at the extent to which things like threats or bribes or coercion, subtle or not so subtle, can sometimes infringe upon the rights of people in recovery. We had worked with agencies with their staff or administrators did not perceive this to be a problem in any way, shape or form, but in fact had gotten very clear evidence in the RFA data from people in recovery that there was a host of practices at play in the agency that people really felt like were blending over in that area of coercive practices. It opened up a dialogue around everything from how [inaudible] programs are run to how guardianships are put in place, decisions that are made around involuntary medications, even things seemingly as subtle as in residential programs how people do or do not have access to everything from cigarettes to food.

Again, it opened up a very vibrant and important and overdue conversation around what we needed to do to really address some of that coercion that was in place. It can help you do some external benchmarking to get a sense of where your program fits relative to other agencies and also look internally about your own internal strengths and needs as it relates to a recovery orientation.

Let's talk about how you actually use the data. There's nothing more frustrating than that never-ending black hole that data seems to disappear into, never to be seen again. If you do see the data again, it can sometimes be like reading hieroglyphics as this poor gentleman is having this experience up here, we not only want to get the information back to people, we want to really make sure they understand how to use it in a meaningful way.

I do want to talk a little bit about what that feedback group might look like and give you a case example about in practice how you can use the data to really inform some of your ongoing quality improvement efforts. This just gives you a quick snapshot of that external benchmarking. It's just a sample from one of the RFA reports that we generate in a particular system. What you can see up here is that you get an overall agency recovery orientation, but then you also get a score on each of the five domains and what these little yellow boxes show up here is where your agency sits relative to other counterparts in the state, for example.

It can help you to identify areas where you need to make some improvements, but also places where you're really already excelling in your recovery-oriented change effort. Then we also, as a consistent strategy, try to point out both the highest-rated areas of recovery orientation, but the lowest-rated areas of recovery orientation. The font is a little bit small up here, but just to give you a little bit of information about this case example. This is the psychiatric rehabilitation program that we are working with and they had a

range of services, including drop-in center and some skills training and employment programs and so forth.

This is actually an agency that had been looked to for many years and rightfully so, as a leader in recovery-oriented change efforts, but one thing that they learned in going about the RFA was that they were really struggling in this area of supporting folks in connecting to their chosen community of choice. Some of the items that reflected that, the lowest items where that activities were not taking place, by and large in more natural integrated settings. They were struggling to involve those natural supporters in the planning and the recovery process. They weren't doing as much outreach as they wanted to their partners in the broader community, for example, employers, landlords and so forth.

Part of the way that I capture this dilemma is by often sharing this quote where we talk about the importance of community life in overall recovery. You can go ahead and read this quote up here while I'm chatting. Just to give you a context behind it, this came out of a person-centered care planning meeting where a gentleman was having a really hard time identifying a goal that he wanted to work on and I was helping co-facilitate this meeting and I just interjected and I said to [Jerry], "So, [Jerry] tell me a little bit. Where do you feel most at home in the community? Where are you happiest?" He goes on to share this quote up here talking about visiting his local pub and having a tonic and lime and just chatting with the patrons. He talks about being in the pub and when he's in the pub, everybody knows his name. It's just [Jerry]. He's not [Jerry] the mental patient.

What happened in this planning meeting, unfortunately, was that many people in the room automatically jumped to the assumption that they needed to go to whatever lengths to keep [Jerry] out of the pub, out of concern that it might jeopardize his recovery. There were questions being raised about substance use, despite the fact that he did not have a substance use history or an issue with that. Really what was happening is that in [Jerry's] recovery, the things that were important to him, things like getting a job, finding a partner in life, getting a lead on a cheap apartment, he was a middle-aged Irish Catholic man living in an Irish Catholic neighborhood.

All of those things, the job, the lead on the apartment, the girlfriend, for those of you that are Irish, the pub is really your central community where many of the things that are important to you can make those connections.

I think the quote in that example really illustrates that sometimes we can inadvertently undermine people's efforts to connect to their communities.

We talked about being conscious to avoid this track of the one-stop shop rather than creating an artificial segregated setting, recreating things that might be available in the broader community, challenging them to really think about are we creating pathways to opportunities in a broader community as well.

Some of the recommendations that this led to with this agency, we said, "Follow rule number one, nothing about us without us. Talk to your members. Ask them how do you define community, how are we helping you, what else can we do. We offered some tailored training around how to help people combat stigma and discrimination that they may face in the community, how you uncover and tap into natural assets in the community.

We talk to them also about how could they model their community building efforts over internal strengths they already had. This is an agency that had a really amazing and long lived collaboration with the city around the creative arts and what could they learn from the creative arts in terms of translating that into their efforts around employment, on faith-based connections and so forth.

Within that, we had them maximize a unique talent of staff including using peer specialists as community connectors and [bridges]. The community connectors, it wasn't their job to become someone's social network, but to help people either build for the first time or build a new circle of support that could then sustain them in their recovery moving forward.

We also talk to them about the importance of really asking this question around the one-stop shop dilemma. Meaning that as one example, they had a very vibrant adult education program and they were offering, I think, then adult education and GED classes internally inside the clubhouse on a weekly basis.

While we wanted that program to continue, we also challenged them and said, "Instead of offering ten of those classes, can you just try offering nine? On that last day, why don't you go have a cup of coffee with the person who runs the local adult ed office and why don't you talk about co-teaching a class that will be open to your stakeholders and your membership?"

In that moment, you create a naturally sustainable pathway to the local adult education office which hasn't previously been acceptable to the folks that you're serving. Let me just say briefly in conclusion. I hope that gives you a sense of the tool and how you might use it in a meaningful way.

The intent of the RFA certainly is not to take just a static snapshot or to criticize the really valuable work that's already being done, but we have found that it really is helpful in making more concrete and transparent what it is we mean when we say recovery oriented care so that we can then, in turn, really offer the support to programs, so they can move closer to that vision.

Just to end with a quick quote here on a testimonial of a very passionate and talented leader of a program we worked with in the state of Texas. She talks about the utility of doing these assessments and she says, "I was a student of client centered therapy. I really saw [inaudible] recovery focused organization, but it wasn't until we did the survey that I realized we had a long way to go. It was eye-opening.

No matter how much you believe in this, you have to be intentional in everything you do if you are really going to walk the walk. What I love about this quote is that she really talks about the fact that there are true change efforts and started with their recognition that, yes, there are some things they were doing really well, but they still had a way to go. That humility and openness to that change really prompted them and put them in a great position to then take it to the next level.

On this note, I'm going to go ahead and sign-off on my camera. I'm going to ask Wes if you can pull yours up. Wes, I'm afraid that you're -- I believe you're on mute. Your phone might be muted still.

You missed all that?

You have to start again.

Sorry. I forgot to take my cellphone off mute. Anyway, I will not delay with what I said. Only to say thank you to Janice for a great presentation. I'm going to be talking a little bit about evaluating psychiatric performance in the delivery of recovery oriented care. Let me get my notes up here. I'm going to be talking about that and an instrument that was developed to help psychiatrists gauge their progress in recovery oriented care that was developed as part of the recovery to practice curriculum for psychiatry.

This curriculum development project that was a joint effort between the American Association of Community Psychiatrists and the American Psychiatric Association was really developed over the course of about five years beginning with the process of information gathering from a variety of sources. That led to the curriculum development and design based on that research and eventually the development of nine multimedia modules.

Those modules were piloted and then modified, and left us with our final product which is available online. The last part of the process was really to figure out how to disseminate this information, how to expose psychiatrists to this training, and to do that in a way that really allowed interaction. While the modules can stand alone online, they really are more effective when viewed in a group and there's opportunities for conversation and interaction.

To do that, we wanted to train facilitators for those conversations and those facilitator [inaudible] consisted of a psychiatrist and a person with experience using the system and with recovery. That was

really the challenges, kind of developing that network of facilitators that is diverse in its geographic distribution and really allowed us to make this training very accessible. That's still a work in progress.

While this conversation is focused primarily on evaluating psychiatrists, we think that it has applications fairly broadly with some minor tweaking. We just thought we would get a little bit of an idea from all of you, whether you have a process of self-evaluation, and whether that process is a formal or an informal one. I can see that about almost 50% do have some kind of self-evaluation process and about half of those people do it on an informal basis. That's pretty much in sync with what I would have expected.

We're going to go on here for a little bit and talk again about -- The recovery to practice curriculum really attempts to create a new vision for psychiatry and in some ways, a return to an old vision of psychiatry which really emphasizes the relational aspects of care and recognizes the power of hope and belief in healing. Rather than the psychiatrist being the director, the role is really more one of an advisor, a coach, a partner, or even a friend. That's a little bit different from more traditional conceptions of what the psychiatrist's role ought to be.

We want to get, obviously, so idea of how effective the training is. As I go through here, I think you'll notice that many of the things that we'll be talking about are similar to what Janice talked about when talking about evaluating an agency. We're looking at individuals a little bit more with the instrument that I'll be telling you about and so we could get immediate feedback on how people experience the training.

What we were really interested in is how that impacted the practice, how did it translate to practice, and how psychiatrists actually think they're doing with these services. To think about that in terms of what changes have they actually made, and if they've made some, do others note it, and how did the psychiatrist's perception match those he or she works with, and how does that change over time.

Before I tell you a little bit about how we hope to do that, we wanted to, again, ask you how you receive regular feedback from clients or colleagues to evaluate your practice. As we're waiting for these to come, if I don't have a consistent method for doing this, I receive feedback verbally from my sessions with clients, clients complete a satisfaction survey. I only receive regular feedback from my supervisor.

I use the formalized process or [inaudible] scale or a I use another process not listed. It looks like most folks have clients complete a satisfaction survey of some kind and many don't have a consistent way to do this evaluation. Some folks get verbal feedback from their session.

Anyway, that's, again, I think it's sort of consistent with what my experience has been. I'm going to go ahead and move on to look at [Proper] which is the Recovery Oriented Practice Evaluation and Rating. That took some effort to come up with that acronym.

This is a tool that was developed in conjunction with the recovery to practice project. It was developed in collaboration with the American Association of Community Psychiatrists, the American Association of Psychiatric administrators. GAP is a little bit out of line there, but GAP is the Group for Advancement of Psychiatry and particularly the mental health services committee, but we also got input from the International Association of Peer Supporters. It's a national mental health consumer self-help clearinghouse and the national alliance for mental illness.

I got you on that without [inaudible] that up too much. It was really a process of several iterations, getting feedback along the way, and coming up in the end with this instrument to help psychiatrists gauge their practice. We use the categorization. It was developed for psychiatric services and systems by Julie [Lance] from Columbia in conjunction with the Group for Advancement of Psychiatry's mental health services committee.

The domains of service were relationship building, facilitating collaboration, planning and problem solving and health promotion. Hello.

Similar to what Janice was talking about, we wanted to really get at this from three different perspectives. We wanted to know, number 1, how the psychiatrists view themselves, but also how did their colleagues, supervisors, teammates, view the way they provided services? Third, what's their client's views and perceived about the services that they received?

In this picture, things can look and feel very different depending on your perspective and your environment and culture that you're accustomed to. In this case, the cow may feel like it's doing an excellent job being in that different environment, but the dolphin may see some opportunities for improvements that evade the cow, in this case.

Just to reiterate a little bit, Proper uses 4 domains for assessments, three corresponding scales, the psychiatrist, colleague, client scale. There are 27 items, and each item is rated 1 through 5. The overall survey yields a composite score that kind of gives an idea of what one's level of achievement is in delivering recovery oriented services. To let you know what the rating scale is, for the psychiatrist, number 5 means "I strongly agree with this statements" or "I do this all the time". Number 1, "Strongly disagree" or "I never do this". For colleagues and clients, basically, the same things, just for in person. That's not to complicated.

What I'm going to do now, I'm just going to go through and give you an idea of a couple of samples from each one of the four categories to give you an idea of how this survey looks and feels. The psychiatrist will be, obviously, talking about the general feelings about how they relate to patients. That's often going to be the case with their colleagues and supervisors as well. Obviously, the client version is going to be a very personal one. Usually, several of those would be more useful to get a broader view of how clients experience their relationship.

Anyway, before I go on, this first item, "My clients feel that I understand them", is really aimed at the idea of empathy and how well the psychiatrist seems to connect with the client that they're serving. A second item from that category is, "I do all that I can to get clients what they need". This question speaks to a broader role, or holistic approach, for the psychiatrist beyond simply managing medication. Attending to a whole array of needs that they may have, and ability to put together a comprehensive treatment plan. In this cartoon, the psychiatrist says, "Okay. But just this one time." This is indicative of the fact that all changes are difficult. Some psychiatrists are going to be uncomfortable at first taking on different kinds of roles and developing new kinds of relationships, different from what they've been accustomed to.

From the second category, collaboration facilitator, these statements refer, really, to a willingness and enthusiasm for including members of the client support system in the treatment planning process. The client statement includes people I choose, who are important to me, by talking with them and answering their questions.

Another item from this section is aimed at the idea of recognizing the importance of a team and getting input, broadly, from people who work with a person to assure that all their needs are met. The client statement in this case is "Works with all those who are working with me to create a complete plan for recovery". In this slide, the team says to her parents, "Oh yes. It's a chance to ruin my life in my own way." This is indicative of the need for respect for autonomy, and allowing people to learn from what sometimes may be unwise decisions without fearing humiliation or being judged. This can be a big shift from, traditionally, more paternalistic paradigms that have dominated in the past.

The third category, planner and problem solver. "I assist my clients in identifying the steps needed to accomplish their long term goals". This whole idea here on the psychiatrist is as an advisor and someone who can help people identify strategies to reach where they eventually want to go. Emphasizing that that's often a journey. The journey is often more important than the destination. In any case, if somebody wants to be a rocket scientist, what kinds of things do they have to do to get there?

Another item is, "I inform my clients of the treatment options, and the pros and cons of each". Here, again, is the psychiatrist's responsibility to provide information; to inform the choices that clients are offered.

In this slide, the TV says, "Ask your doctor if taking a pill to solve all your problems is right for you." I think this is a great depiction of many people's expectations of medication in our current culture. That's largely been driven by the intense marketing of the pharmaceutical industry. It contributes to a more narrow view of what people think a psychiatrist's roles are. It's a real obstacle to the change process in general and struggles against all the things that go into a comprehensive recovery plan.

Finally, the last category, and I know we're getting short of time. I want to make sure we have time for questions. This statement refers to a psychiatrist's emphasis on health. Health maintenance and prevention rather than exclusive focus on illness.

Finally, the need to both be a collaborator and recognizing the importance of integrated care and the intertwined relationship between physical and mental help. Here, again, the idea is for the psychiatrist to really pay attention to that and make sure that those issues are addressed. In this final cartoon, it says, "Your appointment with the doctor is at 11:15, but his appointment with you is at 12:15." I think we've all had this kind of experience to some extent. It's funny, but it's also not funny, right? We make people late, we send a message, and that message really impacts the relationship that we have with them.

Just to finish up, and talking about this instrument, this scoring guide is 27 times 5 is 135, so if you get all 5s, you're in good shape. But anything over 120 is pretty good. In selecting these appellations, we were erring on the side of being encouraging, so "Excellent" is 105 to 119, but there's room to improve. "Good", 85 to 105, and people are getting closer. Under 85 you've got some work to do. This is, basically, a general guide.

It's a good place to note that, obviously, this survey is a bit objective and measures perceptions, not necessarily observable or quantifiable behaviors. It's really a way of guiding the practice of psychiatry and giving them some reminders of what they should be thinking about as they provide care. As I said earlier, this was designed primarily for psychiatrists, but really I think it's adaptable, in many of the items on it, with some general tweaking can really be helpful for other clinicians as well. We have ways, then, not only to gauge the progress of our agency, our system, in providing recovery oriented systems, but how well we as individuals provide recovery oriented practices and really assist people on their journey.

I think I'll stop there. I want to make sure we have some time for questions, and I think I'm going to turn this back to Elizabeth now, to help us with that.

You are. Thank you so much, Wes. That was great. Janice, I know, is going to be coming back up as well. Let me start with just saying thank you for both of your presentations. We often, as administrators and practitioners, feel a little stuck in how to proceed with how to do evaluation. You've helped start to demystify that and make it seem more approachable. Not only why we should be doing it, but some ideas on how. I've been looking at the chat as you've been speaking, and there's been some very interesting conversation about the fact that just because we use the term recovery, or just because we talk to people using services or to consumers or clients. They may not have a recovery orientation, or we may not. That may not fully measure how we're doing with recovery.

I think you both spoke to the fact that using polls and measures are one aspect of evaluating and addressing our practice, so I appreciate that.

I have a very practical question for both of you. Is there a cost to using these instruments? I'll start with you, Janice. I think you're on mute, Janice. You might need to unmute your phone.

Sorry about that.

That's okay.

The [inaudible] publicly available, free of cost. You can access all four versions of the tool, as well as scoring instructions, at our website at the Yale Program for Recovery and Community Health. I believe we're going to post that link in the chat box.

Absolutely. Yeah, that has been posted, and maybe Laurie can put it back in there again.

Yeah and Proper is available for free, also. It's posted, I believe, on the American Association, the community psychiatry, website at communitypsychiatry.org. I think, also, on the APA website along with the treatment -- the modules for the RTP.

Great. Thanks, both. [Wess], maybe I'll stick with you. We have a number of questions. I won't be able to get to all of them, but there was a question about, given our culture of Doctor knows best, that someone wrote, do you notice if there's a greater correspondence between the ratings that colleagues and psychiatrists give each other as compared to what clients rate? How the clients rate their psychiatrists.

It's interesting because we don't have a lot of data. We don't have a lot of experience with this yet. Obviously, when we are getting feedback from our supervisors, our colleagues, our coworkers, very often, they're not actually observing us directly. They rely, to a large extent, on their impressions of how we think, how we talk about the work that we do, how we interact with other people and. sometimes, what our clients tell them and some of their contacts about how they feel about their doc.

I think a lot of times the agreement is fairly close, but, again, it depends a little bit on how sensitive various people are to some of these items and how they think about them.

That's interesting. That's great. Thank you. Janice, one of the questions, again, a relatively practical question, was about whether -- The RSA, I think you spoke about it largely in terms of services and organizations, but the question was, "Can it be used to evaluate systems of care or managed care organizations, that sort of thing?"

Yeah, I saw that one pop up in the questions box. The tool as a whole is a tool that really is designed to assess behavioral health organizations. Having said that, I think there are probably items embedded within the recovery self-assessment tool that could be useful in those contexts. Larger systems of care, NCOs, and so forth. There's a very wide range of recovery oriented assessment instruments that are out there that I would encourage folks to take a look at. Some might be better suited for your organizations. There's things like the recovery enhancing environment scale developed by Priscilla Ridgway and colleagues. There's an interesting tool called the recovery knowledge inventory which, unlike the RSA, which assesses the agency orientation, the recovery knowledge inventory assesses the individual practitioners understanding of recovery. That one can have a lot more relevance regardless of context that you're working in because it's not dependent on the agency structure.

I believe, if I'm not mistaken, I think that that compendium of recovery tools may have been referenced in the newsletter that corresponded to this webinar. I would just encourage folks to take a peek and see what comes next for your organization.

Super. Thank you so much. The newsletter will be posted on our website if people haven't received it already, so people can access it. I'm sure that I could ask you many, many more questions, but I know this is the time, so I'm going to have to move on for now.

I would like to thank you both so, so very much for your knowledge and your willingness to present this, and to get us thinking about measurements and evaluation. We would, also, like to invite all of you who are watching to email us at recovery to practice. The email address is right here.

We are excited about some of the upcoming recovery to practice webinars. At the end of May and the beginning of June, we'll have three that are related to the theme of the role of community connections in recovery. Please join us for as many of those as you can, and keep an eye out in your email for the registration information.

As we said at the beginning, if you're interested in [inaudible] continuing education hours, please click on the link that's here on this slide where you'll be directed to a page with an evaluation and a quiz to complete to receive your certificate. If you're not interested in receiving those CEHs, you may download a certificate of participation as well as the presentation slides in the the Materials Download box near the bottom of your screen.

Please do also complete this feedback opportunity that will automatically load on your screen.

We really do value your feedback on that. On behalf of [SAMSA], I'd like to thank you all for taking time out of your day to attend today's webinar. Thank you.