Diversity, Equity, Inclusion & Belonging (DEIB) Best Practices in Addiction Treatment

STAGES OF CHANGE MODEL AND ORGANIZATIONAL ASSESSMENT TOOL

NATIONAL ASSOCIATION
OF
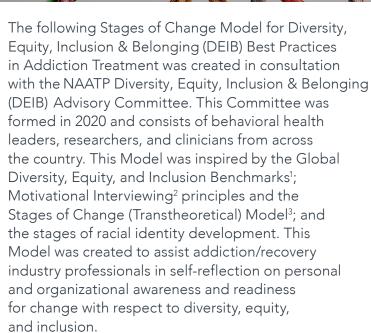**ADDICTION TREATMENT PROVIDERS**

VOICE | VISION | LEADERSHIP

We are a field in recovery. Many people working in the addiction field are in personal recovery from Substance Use Disorders (SUDs) and mental health issues, and they may draw upon their own experience to provide them with passion and dedication for helping others.

Despite the commitment of many thousands of ardent professionals, addiction continues to be a serious national social, economic, and public health crisis in the US that is not adequately addressed, leaving 90% of those who need help without services. We know that SUD is a chronic biopsychosocial-spiritual brain disease; we know that it is treatable, and we know that there exists vastly disparate access to treatment based on race and other social indicators. It is incumbent upon us, therefore, to stand up in the truth of that message and take action to help our field, and more of those who can be served by our work, to recover.

When we work with patients seeking our services, we know that an accurate and thorough initial assessment is key to creating an effective plan for service provision. In a parallel process, addiction treatment and recovery support providers can engage in self-exploration regarding our own readiness for change in implementation of practices that promote equity, justice, diversity, inclusion, and belonging in the addiction treatment industry. Addiction professionals often use Prochaska and DiClemente's Transtheoretical (Stages of Change) Model when working with clients with SUDs to explore their readiness for change. Just as we "meet the client where they are," we can do this with ourselves.

The following Stages of Change Model for Diversity, Equity, Inclusion & Belonging (DEIB) Best Practices in Addiction Treatment was created in consultation with the NAATP Diversity, Equity, Inclusion & Belonging (DEIB) Advisory Committee. This Committee was formed in 2020 and consists of behavioral health leaders, researchers, and clinicians from across the country. This Model was inspired by the Global Diversity, Equity, and Inclusion Benchmarks[1]; Motivational Interviewing[2] principles and the Stages of Change (Transtheoretical) Model[3]; and the stages of racial identity development. This Model was created to assist addiction/recovery industry professionals in self-reflection on personal and organizational awareness and readiness for change with respect to diversity, equity, and inclusion.

We cannot heal or help each other recover from discrimination, disparities, and inequities until we recognize the nature and impact of the problem and become ready to change.

Precontemplation

As with clients, identifying an individual or an organization as "Precontemplative" is not a value judgment. Rather, it means that the person or entity isn't equipped with a perspective on the need for and value of change in their lives and work. In this stage, with respect to implementing DEIB best practices, individuals and organizations may lack awareness that their current practice contributes to inequities or a decreased sense of belonging by diverse staff and clients. With the intent of treating everyone equally, a colorblind approach may be evident, resulting in harm caused by microaggressions in both organizational and clinical culture, milieu, treatment materials, company policies, public relations, and business development. This harm may or may not rise to the attention of leadership and may be addressed (or not) in staff and client day-to-day activities.

GOALS: Raise doubt and concern about current beliefs and practices, increase perception of problems with the current state, and practice harm reduction strategies.

Contemplation

Some recognition exists of privilege and oppression and that current behavior is problematic. Guilt or shame may be present. Racism and other forms of discrimination may be seen as occurring only in the past or currently present against the dominant group as well. An ambivalent, compliance-oriented mindset may be present, with minimal changes made in DEIB policies and practices in response to outside pressures or regulations.

GOALS: Explore ambivalence, identify reasons for change and risks of not changing, and increase confidence in the ability to change. As awareness grows, address guilt and shame through healing practices.

Preparation

We see the harms of structural racism on communities of color, along with other intersecting and compounding forms of structural oppression, such as anti-Indigeneity, ableism, heteropatriarchy, misogyny, and anti-immigrant animus. An awareness has developed of privilege, injustice, and the value of DEIB best practices, but we may look to others (e.g., people of color, transgender people) to confront racism, cissexism, and other forms of discrimination. Some systemic changes are being made with the belief that changing behavior will lead to a healthier organization.

GOALS: Set goals and develop a realistic plan to take steps toward change. As awareness continues to grow, continue healing practices and sublimate guilt and shame into energy for action and growth.

Action

Intentional actions to counter the oppression of historically marginalized communities. Some systemic DEIB changes have been implemented, showing initial positive results and outcomes.

GOALS: Make changes and monitor progress. Identify and use strategies to prevent relapse to previous behaviors. As awareness continues to develop, continue healing practices and use recognition of ongoing disparities for the energy to act, grow, and advocate for change with others.

Maintenance

Active pursuit of social justice. DEIB best practices are sustained for more than 6 months with the intention to constantly improve DEIB performance and strategies and prevent drift to earlier stages.

GOALS: Continuously pursue personal and professional agility and improvement as best practicesin DEIB change over time. Continue healing practices and help others through their process of change.

The DEIB Best Practices in Addiction Treatment Tool is largely based on the Diversity, Equity, and Inclusion Spectrum Tool (Meyer Memorial Trust, 2018)[4] and was modiied to be relevant to addiction treatment and recovery support providers. Values of 0 through 4 have been assigned to the stages of change to assist in identifying areas for improvement and monitoring progress. Because all organizations are different sizes, serve different communities, and have different resources, the approach to moving forward in DEIB best practices will differ across organizations.

	Organizational DEIB Commitment	Policies & Procedures	Leadership and Infrastructure	Training	Clinical Care	Community	Diversity	Equity	Inclusivity
Pre-Contemplation (0)	Does not see DEIB as relevant to its work, or does not have an interest in advancing DEIB work.	Does not have any DEIB-related organizational policies beyond non-discrimination policies.	Members of management or board have not taken leadership on DEIB issues.	Has not done any training related to DEIB, or staff completes trainings as required for compliance.	Treatment materials and modalities are not commonly adapted for different individuals.	Doesn't express interest in building stronger partnerships with communities facing disparities; may see it as an unrealistic or unimportant to the organization's mission.	Doesn't see diversification of leadership, board, and staff as a priority; may be paralyzed by the perceived challenges or view it as unattainable.	DEIB-related metrics* are not collected or considered in programs or in operational accountability mechanisms.	No explicit effort is made to create an inclusive atmosphere for diverse staff and patients.
Contemplation (1)	Recognizes the importance of DEIB to its work and is contemplating next steps.	Does not have, but is interested in developing, DEIB-related organizational policies.	A few members of management, staff, or board are leading internal DEIB discussions, but infrastructure to guide the organization's DEIB work is not established.	Is contemplating expanding organizational DEIB training; individual staff may have delivered some internal training.	Adaptations to treatment materials and modalities are made by some staff for diverse patients.	Values the idea of building partnerships with communities facing disparities, but may not know how or have relationships to draw upon.	Has had initial discussions about and values the idea of diversifying its leadership, board, and staff.	Does not collect DEIB-related metrics* in its programmatic or operational work, but views this as a future goal.	Values the idea of being an inclusive organization but tries to achieve this by encouraging diverse staff and patients to participate in the dominant culture or represent their own culture to educate others.
Preparation (2)	Recognizes the importance of DEIB to its work and is in the process of developing a shared DEIB vision and strategic plan.	May have some DEIB-related language in some organizational policies.	Individuals or small teams are leading internal DEIB discussions and consulting with leadership, but DEIB work has not been integrated into the organization as a whole.	Some staff, leaders, and board members have participated in DEIB-related training.	Culturally-responsive treatment materials and modalities are regularly integrated into treatment plans.	Is beginning to build partnerships with communities facing disparities but has not yet established accountability to and meaningful partnerships with these communities.	The organization attempts to diversify its leadership, board, and staff but may not know how to do it effectively or have strategies and systems in place; strategies may not result in growing diversity.	Collects some DEIB-related metrics* in its programmatic or operational work, but not in a systematic or comprehensive way.	There is an appreciation of the voice and perspective of diverse staff and patients, particularly in relation to the organization's DEIB work, but they are still expected to conform to the dominant culture or educate others. ▶

* DEIB-related metrics include:

1) Demographics of board, management, staff, and persons served, compared to the population of individuals in need of services;

2) Demographic analysis of initial contacts, call-to-admission ratio, admissions, AMA discharges, transfer/referral rates, and readmissions;

3) Demographic analysis of patient outcomes and consideration of social determinants of health;

4) Patient engagement/satisfaction surveys addressing respect for individual culture and identity, whether the care environment and services are culturally-responsive, and whether the care environment and services are trauma-responsive (empathic, safe, transparent, collaborative, empowering, and respectful of choice and preference);

5) Staff engagement/satisfaction surveys addressing the organization's inclusion practices in policies, services, and leadership, and whether the work and care environments and are culturally- and trauma-responsive."

	Organizational DEIB Commitment	Policies & Procedures	Leadership and Infrastructure	Training	Clinical Care	Community	Diversity	Equity	Inclusivity
Action (3)	Has developed a shared DEIB vision, and is working to align the organization's programs and operations with this vision. DEIB is incorporated into the strategic plan with measurable goals.	Has DEIB policies that include expected behavior regarding inclusivity in the work and clinical environments, as well as a process in place for patients and staff for grievances specific to inclusivity. Has an organizational DEIB plan but may be unclear how to fully operationalize it. An equity analysis is completed on policies & procedures.	Has internal committees or other formal structures focused on integrating DEIB into the organization's work. All levels of management, staff, and board are taking leadership on DEIB issues. An equity analysis is completed during the budgeting process.	All management, staff, and board are involved in DEIB training and capacity building. Training includes experiential and healing components and covers topics including implicit bias, privilege, and microaggressions.	Staff regularly receive training and supervision on implementing culturally-adapted or culture-specific treatment materials and modalities.	Actively works to build partnerships and trust with communities facing disparities; working to understand how to provide value and support to these communities.	Actively works to increase diversity of leadership, board, and staff, resulting in growing diversity; has begun to institute retention strategies for diverse patients. Demographics of staff, local community, and the larger community of individuals with the greatest need for service are compared, and plans are in place to better match service needs.	Collects and disaggregates comprehensive demographic data in programmatic and operational work but may not know how to integrate the information. Changes may be made to some clinical or operational practices based on this analysis.	The voice of diverse staff and patients is valued and integrated into the organization. Changes are made to treatment materials/modalities, and well as the care/work environment, in response to feedback from diverse patients and staff. The organization is in transition from a dominant culture to an inclusive/multicultural culture.
Maintenance (4)	Has integrated DEIB in organizational mission and vision statements which are actively being used to guide the organization's programs and operations. Progress toward goals is tracked and leaders, Board, and staff are accountable for meeting goals.	Has DEIB policies and an organizational plan with clear goals, strategies, and indicators of progress. DEIB policies are regularly updated based on equity analysis and with input from patients, staff, the community, and other stakeholders. All leaders and staff are clearly held accountable for policy adherence.	Work on DEIB issues is integrated into every aspect of organizational cultural and infrastructure. Leadership demonstrates accountability to patients, staff, and other stakeholders. Budgets reflect investment in improving inclusivity/belonging among staff and patients and in improving equity in access to services.	Fosters ongoing, comprehensive DEIB training, growth, healing, and leadership among management, staff, and board.	Culturally-adapted or culture-specific treatment materials and modalities are routinely integrated into treatment plans. Clinical staff and supervisors are evaluated on and accountable for culturally-responsive care.	Has strong, mutually beneficial, accountable, and equitable partnerships with diverse organizations and leaders from communities facing disparities. The organization collaborates with communities to assess community needs, and raise awareness of services in a culturally-responsive manner.	The demographic profile of the organization's staff and leadership approximates the profile not only of the local community, but also of the larger community of individuals with the greatest need for service. The organization has policies and strategies for strengthening and maintaining organizational diversity, and effective retention strategies are implemented.	Changes are consistently made in clinical programming, human resources practices, business development and outreach activities, and leadership as appropriate, in response to DEIB-related metrics*. Data reflect that the organization is removing barriers to opportunity and reducing disparity/disproportionality in access to services.	All staff and patients feel valued and all aspects of the organization reflect the voice, contributions and interests of a multicultural constituency; the organization has transitioned to an inclusive/multicultural culture and has created systems, policies, and practices to maintain this culture.

References

1. Molefi, YK, O'Mara, J, and Richter, A (2021). Global Diversity, Equity & Inclusion Benchmarks. www.centreforglobalinclusion.org.

2. Miller, WR, & Rollnick, S. (2013). Motivational interviewing: *Helping people change* (3rd edition). Guilford Press.

3. Prochaska, J, & DiClemente, C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.

4. Meyer Memorial Trust (2018). Diversity, Equity, and Inclusion Spectrum Tool. link to https://mmt.org/news/understanding-meyers-dei-spectrum-tool

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