This interview will be part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).

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The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration
Unifying science, education, and services to transform lives

The Recovery-Focused Transformation of an Urban Behavioral Health Care System

An Interview with Arthur C. Evans, PhD
By William L. White, MA

INTRODUCTION

Beginning with Dr. Benjamin Rush's eighteenth-century writings on chronic drunkenness as a medical disease, the City of Philadelphia has held an honored position in the history of addiction treatment and recovery in America. That history of innovation continues today in a bold vision of integrating mental health and addiction services within a conceptual framework of long-term recovery. Leading that innovation is Dr. Arthur Evans, Director of the Philadelphia Department of Behavioral Health and Mental Retardation Services. The following is an interview I conducted with Dr. Evans in November, 2006 on behalf of the Great Lakes Addiction Technology Transfer Center. In this wide-ranging interview, Dr. Evans eloquently describes the behavioral health system-transformation process that is underway in the City of Philadelphia. In my writings I have posed the question, "How would we treat addiction if we really believed that addiction was a chronic disorder?" Answers to that question are emerging in Philadelphia in a way that will influence the future of addiction treatment in America.

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GREAT LAKES ATTC: Could you summarize your professional background and the circumstances that brought you to Philadelphia?

DR. EVANS: I'm a clinical and community psychologist and have been working in the addictions field for the last 19 years, first as a practitioner and program manager, then in policy-level positions in the State of Connecticut. I served as the Director of Managed Care and then Deputy Commissioner for the Connecticut Department of Mental Health and Addiction Services. In that role, I was very much involved in strategic planning and leading system-transformation efforts in Connecticut. I was then invited to come to Philadelphia to fill a newly created position following the city's decision to combine all of its behavioral health services into an integrated system. I was recruited to continue building on the history of innovation in Philadelphia's behavioral health system.

GREAT LAKES ATTC: Provide an overview of how behavioral health services are organized in Philadelphia.

DR. EVANS: Pennsylvania has a county-based delivery system, with all dollars flowing through each single county authority. On the mental health side, our single authority is an Office of Mental Health, which receives all statewide grant dollars allocated for the city of Philadelphia and is one of three units within the Department of Behavioral Health/Mental Retardation services (DBH/MRS). The Office of Metal Health is responsible for services to primarily indigent individuals who have problems related to serious mental illness. There's also an Office of Addiction Services, which receives state dollars and federal grant dollars for people with addictive disorders. And then there is Community Behavioral Health (CBH), which is a private, non-profit, 501(c)(3) managed behavioral healthcare organization that is fully owned and run by the city. I'm the president of the Board of CBH, and the executive director of CBH reports to me. CBH administers behavioral health payments for practically all of the Medicaid populations that are served in the city. So those three entities allow us to manage practically all of the behavioral health dollars in Philadelphia as a single public system.

GREAT LAKES ATTC: How did the vision develop to redesign mental health and addiction services toward greater recovery orientation?

DR. EVANS: When I came into this position, the city had a fairly long history of innovation, particularly around how it has organized and administered behavioral health services. Through our initial discussions with multiple community constituencies, there was a desire to move our system of care toward greater recovery orientation, which was consistent with national policy directions as indicated by the New Freedom Commission Report and recent Institute of Medicine reports. What emerged from these discussions was a clear vision: *an integrated behavioral health care system for the City of Philadelphia that promotes recovery, resiliency, and self determination.*

GREAT LAKES ATTC: You made a decision early on to use the recovery orientation as the bridging concept between mental health and addiction services. How has this vision guided your work?

DR. EVANS: It is clear that many of the people we serve have co-occurring mental illness and emotional disorders. As we listened to the stories of people in recovery, it quickly became clear that we needed to find a way to serve these people more holistically. It was critical for us to have a vision of recovery that really incorporated both addiction and mental health, and an integrated vision through which we could plan and allocate funds for both mental health and

addiction services. Because of the unique structure of the Department of Behavioral Health in Philadelphia, we have been presented with an incredible opportunity to make this integration real at every level. Our goal is to move toward a unified framework of behavioral healthcare. Two early steps were important in this process. First, we brought together representatives from the mental health and addiction fields, including recovery advocates, people in recovery and family members, and providers of services, and we developed the following shared understanding of recovery:

> *Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices, and opportunities that promote people reaching their full potential as individuals and community members***.**

Second, we developed a set of nine core recovery values that would guide our system-transformation process in both mental health and addiction service settings. Those values were *hope, choice, self-direction/empowerment, peer culture/peer support/peer leadership, partnership, community inclusion/opportunities, spirituality, family inclusion and leadership, and a holistic/wellness approach.*

GREAT LAKES ATTC: You've described the ongoing system-transformation process as unfolding in three overlapping stages: aligning concepts, aligning practices, and aligning context. Could you describe those stages?

DR. EVANS: Our goal is systemic and lasting change in the design and delivery of behavioral healthcare services. As a result, we made a conscious effort to think about: 1) how we want thinking to change, 2) how we want people's behavior to change, and then 3) how we want to change the policy, fiscal, and administrative contexts to support the behavior and thinking that we ultimately would like to see in the system. All of our system-transformation activities keep these three areas of focus in mind. For example, if we focus only on trainings that introduce a particular area of behavioral change—let's say the increased use of motivational interviewing—but we haven't aligned our policies and funding decisions to support that shift, this behavioral change won't be able to be sustained over time. Alternatively, if we focused on trainings that promoted a certain philosophical viewpoint without giving people practical ways that their behaviors needed to change in order to reflect this new viewpoint, those trainings would not effectively support systems transformation. These three areas—concept, practice, and context—are interrelated and cyclical. Our ability to obtain conceptual clarity influences our ability to successfully operationalize our transformation values. The manner in which recovery-oriented practices are defined and implemented shapes the regulatory and fiscal support necessary for lasting change. Regulatory and fiscal policies in turn have an immediate impact on the kinds of services and supports we can develop for people seeking recovery.

GREAT LAKES ATTC: There are growing calls to transform behavioral health care agencies into truly "recovery-oriented systems of care." How did you convey to your service providers exactly how service practices would change within such systems of care?

DR. EVANS: We engaged service consumers and providers in dialogue about how practices would change, and in our published plan for system transformation we outlined twelve areas in which we expected services to change and outlined the direction of such changes. The chart below illustrates our summary of those changes within our *Blueprint for Change*.

***Service Engagement*:** Expand outreach services to reach people (individuals, families, communities) at earlier stages of problem development.

Service Access: Continue the rapid level of service access that has long-characterized some components of the Philadelphia behavioral health service system (e.g., substance abuse treatment services) and increase the ability to access services in other areas (e.g., psychiatric access, housing with community supports, etc.)

Recovering Person's Role: Emphasize the rights of people in recovery to participate in and direct service decisions, plan for services, and move toward self-management of their own recovery journeys in collaboration with the people who serve them.

Service Relationship: Shift the primary service relationship from an expert-patient model to a partnership/consultant model.

***Assessment*:** Move toward assessment procedures that are global (holistic), strengths-based (rather than pathology-based) and continual (rather than an intake activity).

Clinical Care: Move to clinical care services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent and trauma informed. These services recognize that excellent clinical care is critical but is only one aspect of service needed among others in a recovery-oriented system.

Service Retention: Enhance service retention rates (reducing rates of service consumer disengagement and rates of administrative discharge) by increasing the quality of clinical services and enhancing in-treatment recovery support services.

Locus of Service Delivery: Increase the delivery of community integrated, neighborhood- and home-based services and expand recovery support services in high-need areas. This enhances normalization and the effectiveness of skill teaching and skill retention, and decreases stigma.

Peer-based Recovery Support Services: Dramatically expand the availability of non-clinical, peer-based recovery support services and integrate professional and peer-based services.

Dose/Duration of Services: Provide doses of services across levels of care that are associated with positive recovery outcomes. The intent is that intensity of services will naturally decrease over time as recovery stability and quality increase, but that recovery checkups and, when needed, early re-intervention will continue for a considerable period of time. The system will develop innovative means for this connection (e.g., assertive phone follow up). Our vision is continuity of contact in a primary recovery-support relationship over time.

Post-treatment Checkups and Support: Shift the focus of service interventions from acute stabilization to sustained recovery management via post-treatment recovery check-ups. Support the use of Peer Specialists for post-treatment follow up, stage-appropriate recovery education, assertive linkage to recovery communities and, when needed, early re-intervention. Shift from passive aftercare to assertive approaches to continuing care.

Relationship to Community: Greater collaboration with indigenous recovery support organizations (e.g., faith community), more assertive linkages of clients to local communities of recovery, greater role in recovery education/celebration in larger community and greater role in recovery advocacy (e.g., issue of stigma and discrimination).

Source: *Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change,* Philadelphia Department of Behavioral Health and Mental Retardation Services

What we tried to achieve in our *Blueprint for Change* was to outline how the practices of our Department and our service providers would change through the system-transformation process, and how consumers and family members and other community resources could play important roles in this process.

GREAT LAKES ATTC: How did you plan the system-transformation process, and what constituencies did you involve in this process?

DR. EVANS: We think an inclusive, "big tent" approach is very important. From the very beginning, we engaged a variety of stakeholders, including people in recovery, providers, our staff, diverse community groups, and the faith community, because we had to find ways that the concept of recovery would resonate with all of those various constituencies. We created a Recovery Advisory Committee (RAC) that spent several months developing the consensus definition of recovery and core recovery values that all of those various groups could embrace. We continue to host regular community forums where people from across the city can come and share their thoughts and ideas about the system-transformation priorities. We believe that such partnering and ongoing input are critical for the long-term success of systems transformation.

GREAT LAKES ATTC: What are the early priorities that emerged out of that process?

DR. EVANS: For the next two years, we will be focusing our change efforts within seven priority areas: community inclusion/opportunity, holistic care, peer culture/peer support/peer leadership, family inclusion and leadership, partnership, extended recovery supports, and quality of care.

GREAT LAKES ATTC: In your presentations describing the system transformation, you have talked about the importance of parallel process. What do you mean by this?

DR. EVANS: What I mean by this is that the relationship we want to see between our direct-care providers and those they serve must be mirrored inside our department, both in the relationship between our department and the treatment providers and in our relationship with other community organizations. This realization has forced us to think about our own behavior and how it helps or hurts our system-transformation efforts. An early and ongoing priority for us was to make sure that the way we were doing business was consistent with the way we wanted our service providers to do business. For example, in planning new initiatives, we are involving the provider and recovering community in the early stages of thinking and development of ideas, rather than "telling them" what we want them to do. In the same way we are hoping that providers will tap the expertise of people in recovery, we are also trying to tap the expertise of providers in solving the problems that confront us both. Also, stressing the importance of dignity and respect in how we interact with one another has been a cornerstone of these efforts.

GREAT LAKES ATTC: How are you continuing to work at system transformation at the same time you have to maintain much of the system's functioning?

DR. EVANS: When you're running a billion-dollar organization, most of your energy and the organization's energy is focused on keeping the organization going, and relatively little of that energy is directed towards strategic planning, visioning, and taking the organization in a new direction. So first we had to build an infrastructure. We had to develop roles that allowed people to devote time to conceptualizing where we wanted to go, working on new initiatives, engaging various stakeholders, and developing the many products that were crucial to the system-transformation process. We did this by hiring a director of strategic planning, who would work in partnership with the director of policy and planning to develop and move system-change efforts forward. We created an internal steering group, the Systems Transformation Steering Committee, composed of representatives in key positions across the department. This group is also charged with developing and moving system-change initiatives forward. We have used national and local consultants to add expertise to the already existing skills of our staff and to support our major change initiatives. We developed specific targeted projects to implement our vision. Right now, for example, we are transforming our maintenance partial hospitalization system into a recovery-oriented, community-integrated system of services and supports. In order to do this, we are introducing all the transformation priorities into these transformed programs. We are working in partnership with people in recovery and providers in all aspects of the development of these programs. We are working with the State to break down regulatory and funding barriers to the provision of recovery-oriented services. This same process is happening in many new initiatives.

GREAT LAKES ATTC: Describe your use of workgroups to plan and implement change for particular service areas.

DR. EVANS: That's an example of where we had to behave in ways that were consistent with the recovery philosophy. One of the first things we did was to identify those areas where we thought it was important to have concentrated work—issues that we felt were critical to achieving a recovery orientation. Spirituality, for instance, is important to many people in recovery, and yet the linkages between the Department and the vast faith community in Philadelphia were weak. We developed our faith-based task force to work at developing these partnerships, which are envisioned to be reciprocal in nature. We bring resources to the table for the faith-based organizations, and they bring resources to us.

We know that, in a recovery-oriented environment, expert clinical care is critical. The Evidence-Based Practices (EBP) workgroup was developed to review the current state of the science and to develop recommendations for current EBPs, promising practices, and support structures for their implementation and installment in organizations. One outcome of our work in this area is the development of a new partnership with Dr. Aaron Beck and the Beck Center for Cognitive Therapy. This will have a direct impact on clinical care as we introduce cognitive therapy throughout our service system.

The Trauma Task Force is looking at the critical role that trauma plays in many addiction and mental health disorders, and is developing creative ways to incorporate trauma-informed services into our provider organizations.

The content of these workgroups is important, but the process for developing them is equally important. We staffed the workgroups by opening them up to everyone in the organization. I sent out an email that basically said, "We have a variety of workgroups. Anyone in the organization, regardless of your role, has the opportunity to be a part of the workgroups." Well, one of the interesting things we found out is that people who were in non-programmatic administrative and support positions signed up to help with these groups. We found out that many people in our organization were in recovery or had family members who were in recovery or struggling with addiction or mental health problems. They wanted to be a part of this service-improvement process, and they brought a very important perspective that the programmatic staff didn't always bring. The message their inclusion sent was that, if we truly believe in partnership at all levels, if we truly believe in the idea of people rising to their highest level of potential, we had to create opportunities like that internally, as a way of modeling what we wanted our providers to do. This engaged a whole layer of the organization who, quite frankly, had been underutilized in the past. It engaged them and got them really excited about the work we were doing.

This same process is happening at provider organizations across the city. As they catch the vision, or feel freer to pursue the vision they have been developing in the past few years, they are reaching out to new people within their organizations. They are engaging community partners, working with faith-based organizations in new ways, looking at the evidence for their clinical practices, and increasing their trauma awareness and capacity for intervention.

GREAT LAKES ATTC: You developed a very close relationship with the Pennsylvania Recovery Organization—Achieving Community Together (Pro-Act) and other recovery-advocacy organizations. How important do you think those relationships have been to the transformation process?

DR. EVANS: Engaging the recovery community, and engaging the recovery community in new ways, has been one of the most important things that we have done. Pro-Act has been terrific in the process. They have been out front in helping to put a face on recovery, something that we support tremendously. They have helped us engage the recovery community in a variety of activities, and they've been able to carry the message of recovery and the hope of recovery to communities that we may not have been able to reach as a department. They have pushed our thinking about what we should be doing as a department, both with our funded service organizations and with the larger community. It is hard to imagine having done this work without the partnership with Pro-Act.

GREAT LAKES ATTC: In relationship to the broader community, you made a decision early on to involve the faith community in this initiative. How did you come to that decision, and what has been the outcome of that involvement?

DR. EVANS: There are several reasons we felt it was important to involve the faith communities. First was our recognition that many people recover within the perspectives, beliefs, and contexts generated from their faith. As a result, we felt it was important to recognize the potential role of spirituality in the treatment and long-term recovery process. We also knew that there are many people who will not engage in treatment without the blessing of their faith communities. People often seek help initially from within their faith communities, and we wanted to build connections between these communities and our behavioral health service system. We felt the faith community, particularly the clergy, was in a position to help us achieve our goals, and at the

same time that we could be of service to them. We were particularly interested in the support that faith communities could provide to people during and following addiction treatment. We wanted to help those entities in the community that were there to support people coming out of prison and out of treatment, and to help them do that work on a long-term basis.

GREAT LAKES ATTC: How did you prepare the existing addiction treatment agencies for the changes that would be coming through the system-transformation process? There must have been considerable anxiety about what this would mean for everyone.

DR. EVANS: We did a number of things. First, we engaged them from the very beginning, articulated the vision of where we wanted to go, and invited them along on the journey.

We brought in top people from around the country, people like Bill White and Mike Hogan, to help articulate and legitimize our vision and to generate excitement about where we were going. We continue to involve the provider community in the major decisions we have made and are making as part of the whole transformation effort. For most major efforts we have cross-system workgroups that involve providers, people in recovery, and family members, as well as DBH staff. We've tried to be very transparent about our decision-making. Finally, we've tried to make sure that what we are promoting is clearly reflected in the Requests For Proposals for funding that we issue. We have tried to be consistent in our messaging and catch ourselves when we are doing things out of old habits that violated those core messages.

GREAT LAKES ATTC: Do you think that the fundamental relationship with the provider community has changed through this process?

DR. EVANS: I think that they are becoming more trusting of and more open with us. We are trying to move away from a policing role—the "gotcha mentality" that we in government can drift into. We are trying to move toward a partnership model that emphasizes our need to work together toward a shared recovery vision. Through developing workgroups that involve all stakeholders on different topics, we are tapping into the expertise of the provider community as we plan and develop new initiatives, practices, and vision. Our addictions group is currently involved in a process that involves all stakeholders in planning the next steps in transforming this segment of the system.

GREAT LAKES ATTC: What are some of the changes that you've seen already through the system-transformation process?

DR. EVANS: The thing I get the most satisfaction from is the fact that people have a voice now who historically have not had a voice within our system. Foremost among these are people in recovery and their family members who are not a part of the "professional" advocacy groups and had not historically participated in the Department's planning efforts. We have hired people in recovery in the Department to help us in this transformation. We are training and mentoring them to assume leadership roles in the future. We recognize that, while many organizations have people in recovery on staff or on boards, it takes additional support and training to have them assume true leadership roles. We are committed to this process.

We have also opened ourselves to input from the larger non-professional community in ways that are unprecedented. These are just people in the community, including faith leaders and

leaders of grassroots community-based organizations, who now are engaged with us in very important ways. There are also several other things that come to mind.

We have committed to train and hire 100 peer specialists in the system over the next year. These are people who have mental illness and/or co-occurring disorders who have moved to a place in their recovery where they are ready to "reach back a hand" to someone else. Hiring these trained people into our provider organizations will be a huge step forward in advancing the voice and leadership of people in recovery.

We are moving our "monitoring process" to one which is less focused on adherence to regulation and more focused on recovery and recovery outcomes. We're redoing our evaluation process with a focus on recovery outcomes, as opposed to traditional process measures. We are developing funding models that support recovery-oriented services and incentivize recovery outcomes. We're looking at how to create funding mechanisms where dollars follow the client. We're looking at funding mechanisms that provide people with a menu of services, as opposed to site-based services where people don't have those kinds of options.

GREAT LAKES ATTC: You've taken people inside your organization who for years have seen themselves in a policing function and transformed them into technical consultants and partners with agencies. That is a radical change in the monitoring process.

DR. EVANS: That is a huge change that we are still working on. An example of progress that we are making in this area is with our monitoring and credentialing process. Providers have often complained that this process is too focused on minor details (e.g., a missing signature), rather than on the bigger picture of quality of care. Recently I have had a number of providers share with me that they had a great credentialing visit—that it was very helpful. This is something we'd never heard before. This is a credit to our staff, who are really focusing on quality and making a variety of important changes to move the system forward and improve care. Providers are starting to see us as collaborators in this process—as people who are trying to help them provide a better service. We've still got a long way to go, but we're clearly making progress.

GREAT LAKES ATTC: As you look back over this process, are there any lessons that you think you would share with other cities or states wanting to pursue a similar system-transformation process?

DR. EVANS: I can't say enough about the issue of parallel process that we touched on earlier. Consistency—walking the talk—is very important. You can't have a singular external focus of telling the providers what they need to do in order to be more recovery oriented. It has to be, "What do we collectively need to do to conduct our business in a way that is consistent with these values? And then how do we help and partner with our providers and consumers and other stakeholders to make this transformation happen?" To me, the most important aspect of this is having a mindset that is collaborative, that is supportive, and that is consistent with the values of recovery. After that, there are a number of things we've learned. First of all, transparency is very important. You can't promote a recovery-oriented system and then make decisions about how you're going to fund and who you're going to fund with opaque processes that people don't understand. That doesn't work. I think the other thing that we've learned is: communication, communication, communication. You have to keep putting the message out, letting people know what you're doing and why you're doing it. I think it's also important to give people practical examples of what you want them to do. So you're not only articulating that a

recovery orientation is important, but you're also providing people with opportunities to get training and support around how they're going to change their practice.

Another key lesson is the role that relapse plays in this systems transformation work. This is another example of our parallel process. Providers, people in recovery, and families are all used to doing things one way, and the pull back to the familiar is always there. "Relapses" of many kinds will happen. We are learning to plan for them, to learn from them, and hopefully to build in supports to lessen their occurrence.

GREAT LAKES ATTC: You've made an incredible investment in training through this process, both local training and bringing outside people in for training. Could you comment on that?

DR. EVANS: We've had to do that. The training that most behavioral health professionals get offers no consistent recovery orientation. You can't assume people have been trained from this perspective, so it must become part of everyone's orientation and training within the field. We felt that we needed to put a significant amount of resources into training, to help people have a different way of thinking about the work, but also help them have a different way of behaving. The trainings are designed to give people different options in terms of how they design and deliver high-quality services. We also made an important strategic decision about the nature of this training. People in recovery, providers, and staff from the Department are trained together. This format has modeled the kind of partnerships we are working to develop and has definitely increased the impact of the training. Training in this way is another example of the parallel process.

In the next 12-18 months we are going to build on this basic training through providing training that advances, not just our collective understanding of recovery, but also the implementation of recovery-oriented practice across the behavioral health system.

GREAT LAKES ATTC: As you look back over this process, what are some of the areas of system transformation that you feel you've had some of the greatest success in?

DR. EVANS: I think we have a considerable amount of buy-in from multiple constituencies at this point in the process. We try to keep our ear to the ground in terms of what people are really saying, and we create opportunities for people to tell us what they're really thinking, through focus groups and other mechanisms. We now have almost universal acceptance of our core ideas by our stakeholders. I think that's huge.

One other area that really excites me is what I see happening among the communities of people in recovery. We have people in recovery now working as consultants within DBH on major projects. There are people involved in change-management teams at provider organizations. There are people sharing their recovery stories in many public venues; and there is a new energy, enthusiasm, and emerging leadership capacity within that community. This is critical in terms of moving us toward a "consumer-directed" system.

We also are developing new initiatives that are true partnerships. We recently funded several prevention initiatives but required that the applicants for those funds demonstrate partnerships between providers and local grassroots organizations. We are providing seed-grant funding for enhancement of programs over the next year to providers who are willing to commit to moving our system-transformation priorities forward in innovative ways.

All these seemingly separate initiatives create a synergy of vision, energy, and momentum that will support moving this transformation forward.

GREAT LAKES ATTC: One of the obstacles that people often cite in discussions of moving toward greater recovery orientation and shifting from models of acute care to sustained recovery management is the question of financing. Do you have any thoughts about where service financing models will go in the coming years to support this recovery orientation?

DR. EVANS: We are going to need different kinds of funding models, because many of the things that support recovery are not what we are reimbursing in the fee-for-service rates through which we currently pay service providers. We're going to need to move to more risk-based financing models that give people more flexibility in how to use the dollars that they receive and place the emphasis more on service outcomes and less on units of service delivery. The other thing we need to think about is how we can support giving people a menu of options, and how providers can offer those options in ways that are financially viable. We're attempting to do that with a major redesign of our partial hospital programs and our day-treatment programs. We're attempting a radical redesign based on the notion of giving people a menu of choices, having fewer site-based services, and providing more services in the community. We're working with the state to develop a financing model through Medicaid that will allow us to do that. We have to invest energy, time, resources, and commitment to work on those issues.

GREAT LAKES ATTC: Have federal programs and regulatory guidelines helped or hindered the transformation process in Philadelphia?

DR. EVANS: Medicaid policies have been the most difficult. With State grant dollars, we have more flexibility to purchase services that are more supportive of people's long-term recovery. The biggest impediment for us is the medical necessity criterion that is required through Medicaid, and how narrowly that's defined. If I were to identify one barrier, that would be it.

There could be many other examples, but another one that impacts us daily is the division between mental health and addictions funding and regulations. This division stands in the way of a truly unified behavioral health system organized around the needs of the person in recovery.

Another is Medicaid's perspective that "treatment services" are best provided on site, when in actuality people's lives happen in their communities. This presents an obstacle to providing resources to support true learning in people's natural environments.

Both of these barriers are being worked on now with key policy makers at the State.

But it's not just external obstacles. Our own regulations have sometimes been an obstacle. We're constantly fighting them. We can be our worst enemy at times, by doing things because of tradition and history. We are involved in an internal process to continue to move toward flexibility and a base of regulations that promotes recovery and support for the person's recovery plan. One project that is assisting with this is our Unit Recovery Planning Initiative. Each unit within the Department is going through a process to explore the implications that our system-transformation priorities have on their daily work and decision making. As a system, we have spent a significant amount of time developing a shared vision. Now internally we are

examining what that vision means for our internal practices, policies, and fiscal strategies. Consistent with the collaborative and inclusive approach that we have taken thus far, each member of each unit is a part of this process. Through engaging in this work, staff are developing an increased sense of ownership in the transformation. They are also identifying the tension between our current practices and our envisioned system of care, and as such helping us prioritize our focus.

GREAT LAKES ATTC: How are you planning to evaluate the system-transformation processes that are underway?

DR. EVANS: We're going to do a number of things. One of them is that we've established a recovery baseline assessment of our whole system. We basically required all of our providers to complete a recovery assessment that collected information about the perception of the recovery orientation of each program from the viewpoint of the management staff, the director, the staff, and service consumers and their families. We scored them and rated them, and we will reassess the system after a year or so to see how these key dimensions have changed. We are doing ethnographic studies of the processes we have used to implement the change process. And we are also looking at recovery outcome measures at individual, program, and system levels.

GREAT LAKES ATTC: What do you see as the next major steps in the system-transformation process in Philadelphia?

DR. EVANS: One of the exciting but challenging things about this process is that it has so many facets. I think there are several key things we need to focus on in this next stage. One critical area is continuing to build on the momentum that we created thus far around increasing, not only the involvement, but also the leadership of people in recovery in the system. As such we will continue to support people in recovery in achieving and maintaining diverse leadership roles and having opportunities to participate in policy decisions going forward. To advance this goal, we are currently exploring a partnership with a local community college to develop a leadership program for people in recovery that will lead to an Associates degree. We will also be exploring the development of more consumer-operated services.

A second major area that I think we have to continue focusing on is changing our own internal policies to be more consistent with a recovery orientation. I think we still have some work to do internally to be an organization that conducts its business within a recovery-focused framework. In order for this transformation to take root and lead to sustained change, we are going to have to be even more consistent in walking our talk and creating policies that will support the transformation. We have begun this next phase in partnership with providers and people in recovery. One of our system-transformation priorities, for instance, is community integration. As providers have begun to change their practices to facilitate increased opportunities for people to become fully integrated into their communities, they have expressed concerns about balancing consumer choice with their professional assessment of an individual's readiness to engage in certain activities. They want to know, when there is a discrepancy between the two, what should they do? They have also asked about how their liability as providers is factored into all decision making. To address tensions such as this, we are developing ad hoc workgroups such as our risk assessment workgroup. This consists of a diverse group of stakeholders who are exploring together what risk assessment should look like in a recovery-

oriented system of care, and what monitoring policies and practices need to be changed within our department to support the providers' movement in this direction.

In addition to tackling some of the tensions that emerge as we increasingly strive to operationalize and implement recovery-oriented care, we are also seeking to develop demonstration projects which can be models of recovery-oriented care for the rest of the system. Right now we are in a competitive application process to award mini grants to providers and community-based organizations. Innovative projects that result from this and other initiatives will be highlighted and celebrated at a one-day conference early next year. We believe that a critical part of this phase of the transformation process will be creating opportunities for the development of a learning community where our department, people in recovery, family members, and providers can come together to share lessons learned and celebrate successes.

This next phase will also involve an increased focus on enhancing naturally occurring recovery supports in the broader community. We have people in recovery coming to us right now wanting to start mutual-help groups that don't currently exist in their neighborhoods. We are developing a training program for these leaders on how to develop, implement, and sustain mutual-support groups. These groups will be in the community, drawing from the community and giving back to the community. We are also increasing our focus on supporting grassroots community-based organizations and faith-based organizations where many people in recovery turn for help, and ensuring that linkages between this informal "treatment" system and the formal treatment system are strengthened.

Finally, in this next phase of the transformation, we are going to increase our focus on delivering more services and supports that are evidence based. The people we serve deserve the best, and we need to get tooled up to deliver it.

We have much to do, but we are very excited about these new directions that the stakeholders in the system have chosen.