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Pioneer Series

The Recovery-focused Transformation of Addiction Treatment: An Interview with Arthur C. Evans, Jr., PhD

Dr. Arthur Evans, Jr., currently serves as Director of the Philadelphia Department of Behavioral Health where he has guided the recovery-focused transformation of Philadelphia's behavioral health care system. Through that process, the emerging "Philadelphia Model" has become a leading landmark in national and international efforts to transform addiction treatment into a recovery-oriented system of care. Dr. Evans brings to this role a distinct blend of vision, passion, intelligence, competence and joy. For the past five years, I have witnessed him leaving people in each room he enters more inspired, more involved and more willing to work with one another. In this wide-ranging interview conducted in the fall of 2010 Dr. Evans reflects on his career, his pioneering work in Connecticut and Philadelphia and his thoughts about the future of addiction treatment and recovery in America.

Entry into the Field

Bill White: Dr. Evans, thank you for taking this time to talk with addiction professionals across the United States. You completed your undergraduate and Master's work in experimental psychology at Florida Atlanta University and your doctoral work in clinical and community psychology at the University of Maryland. Had you decided during that preparatory work to specialize in the treatment of psychiatric and addictive illnesses?

Dr. Arthur Evans: I had. I went to Florida Atlantic University as an undergraduate with the expectation that I would finish my Bachelor's degree there, perhaps a Master's, and then go into a clinical psychology program to get a PhD in clinical psychology. What was interesting about my experience at Florida Atlantic was that it was an experimental psychology program. That program was all researchers, with the exception of one clinical psychologist who was not even a full-time person. I became well grounded

in the scientific side of the field there, but as I was finishing my Master's in experimental psychology, I decided I really wanted to focus my life on helping as many people as I could as a psychologist.

Bill White: I'm intrigued that your combination at University of Maryland in both clinical and community psychology so informed your later work. Was that by intention?

Dr. Evans: It wasn't. I didn't know what a community psychologist was when I went to Maryland. I applied to Maryland because it had an APA-approved clinical psychology program. When I got there, they had both clinical and community psychology programs. I got the typical clinical training that clinical psychologists get, but I also got training in community psychology. I had courses like Ecological Assessment, Program Evaluation, and courses that looked at people in their social contexts—courses that talked about systems, and communities, and neighborhoods. So, it was a level of abstraction that was higher than just the individual. That's been very important to my thinking about what it means to treat people with behavioral health problems. A lot of how we have approached recovery management in Philadelphia has been shaped by and informed by an ecological perspective, a systems perspective, a strengths/challenges perspective--all of which are rooted in my community psychology training.

Bill White: When you left Maryland, you went to New Haven, Connecticut. I'm interested in how you would describe your early work in New Haven and how that work informed some of your later work transforming behavioral healthcare in the United States.

Dr. Evans: When I left Maryland, I went to Yale University's School of Medicine for my internship. At the time, there were only a few APA-accredited internship programs in the country where you could get community psychology experience as well as clinical experience. Yale was one of those programs, and my experience there was very important to my career. During my internship, I saw children, I saw families, and I saw individuals who had serious mental illness. I also worked in a prevention-focused project with youth in schools, did program evaluations and worked on a suicide prevention hotline. That mix of clinical work with individuals and working with people who were thinking more about population health and how to intervene at the population level through prevention and early intervention programs was invaluable to me. If you look at how we have

done recovery management in Philadelphia, you will see this mixed emphasis on excellent clinical care and broad interventions aimed at enhancing community health. I also knew from my early Maryland and Yale experiences that I wanted to work and support people who were under served, particularly people from ethnic and racial minority populations.

Bill White: : In 1998, you took over the position of Director of Managed Care for the Connecticut Department of Mental Health and Addiction Services (DMHAS) and later served as Deputy Director of DMHAS with Dr. Tom Kirk. Together, you launched the first state-level recovery-focused systems transformation process in the country. Could you describe that process?

Dr. Evans: I have to first give Tom Kirk a tremendous amount of credit. As I stand here today and look back, a lot of things that we take for granted now about a recovery orientation within behavioral health care simply did not exist ten years ago. When Tom said, "We're going to move our service system," which was both a mental health and addiction treatment system, "to a recovery orientation," this was a radically different approach than prevailing practices in both systems. It took a lot of vision and courage for him to take on this kind of systems transformation process. This was before the New Freedom Commission Report, IOM reports and many subsequent research reports that now support this new direction. There was nothing other than the early work of Courtney Harding and some of your writings to guide us. I don't think you can overstate the importance of Tom's vision to move Connecticut and the whole country toward this recovery framework.

Bill White: Were you immediately drawn to this new approach?

Dr. Evans: For me, it just made sense and was so consistent with my philosophy and my own training. What I didn't anticipate at the time when we had those first conversations is how much of a challenge it was going to be to try to move a system, a traditional system, to one that really embraced recovery as an organizing framework. I remember the first meeting with the leadership of one of the large community mental health centers in Connecticut. I remember asking the question, "How are your services recovery oriented?" The reaction I got was as if we had two heads—like, "What are these guys talking about?" They responded, "First of all, we do mental health services here. People don't recover." The undertone was, "You addiction guys don't know what you're talking about." When I left

Connecticut—this was probably four years later—that particular program was by far the most advanced recovery-oriented program in our system mainly because of the leadership there. I really felt good about how, over time, even people who pushed back initially came to embrace the philosophy and really push forward with many service innovations.

Bill White: Much of your writing during this period was focused on the implementation of evidence-based practices and developing cultural competence in the treatment of behavioral health disorders. How did this early focus inform your later work?

Dr. Evans: One of the things that I have tried to do in my career is to not get trapped into silos of thinking or practice. To me, it makes perfect sense that a recovery-oriented system has to be evidence-based to the extent possible. My belief is that if we're going to give people the best chance of recovery, we have to bring the best knowledge and the best practices that have been proven to have the greatest effects. So, from very early on, I thought it was important to integrate evidence-based practices as a fundamental part of a recovery-orientation. And I should say that, in the early days, that was not the typical way that people thought about recovery-oriented care. In fact, there was a camp that said evidence-based practices are antithetical to a recovery orientation—that only providing such practices limits peoples' choices.

Similarly, I thought it was important to incorporate the idea of cultural competence and the reduction of health disparities. My rationale was that if a system is going to be effective in helping people recover, then it has to work for everyone. So, for me, it made a lot of sense that cultural competence and thinking about a person's cultural background had to be a part of the mix of a recovery-oriented system. In the early days, these were seen as disparate concepts. We had to work hard and be very intentional in affirming that cultural competence was not just complimentary, but an essential quality of recovery-oriented systems of care. It's the same with trauma. A truly recovery-oriented system of care individualizes treatment. That means you have to think about, "Does the person have a trauma history? Does the person have a co-occurring condition? What's the person's cultural background?" What are those things that we know from the scientific literature and those things that we know from our clinical experience that are important to recovery outcomes. So, integrating what were once thought to be separate initiatives was very intentional on our part.

I was very concerned that we avoid the recovery movement initiative in Connecticut being seen as a fringe issue only of interest to people in recovery and that the initiative would become marginalized. I wanted people who saw this whole recovery thing as sort of fluff but not real clinical work to understand that in actuality it would require a heightened level of clinical sophistication. I wanted to make sure that whatever we were doing were things that were going to last. A lot of the reaction we got early on was, "This is the flavor of the month. It will come and go like other fads." We worked very hard in Connecticut to make sure it was not just a superficial change in rhetoric.

Bill White: What do you think were among the most important first steps in the Connecticut transformation process?

Dr. Evans: I think that Tom Kirk made two very important decisions early on. The first thing he did was go to people who were in recovery from mental illness and addiction. He went to the mental health and addiction recovery advocacy groups in Connecticut and asked them to come up with the values and philosophy and perspective that would be the foundation for the work that we were going to do. In retrospect, I think that that was really brilliant and gave us a foundation that was built by people who were in recovery and that has lasted to the present. The other thing that Tom did, which I didn't appreciate at the time, was he really shifted my duties as Deputy. Historically, the Deputy in the department had sort of operational responsibilities for the system. When I came in, he basically took away all of the operational responsibilities and asked me to lead the transformation of the system. So, my staff became a think tank within the organization. This was enormously important because the work is so complex. It takes concentrated efforts that I don't think we ever could have pulled off if there were not staff devoted to facilitating this change process.

Systems Transformation in Philadelphia

Bill White: In 2004, you came to the city of Philadelphia to head the Department of Behavioral Health and Mental Retardation Services. How did that opportunity arise?

Dr. Evans: I was in Connecticut minding my own business in what I considered the best behavioral health job in the country within one of the best behavioral health systems in the country. Then I received a call

inquiring about my potential interest in heading Philadelphia's behavioral health care system. Philadelphia, which was doing some really interesting and important work around the financing of behavioral healthcare services and the administration of services, was looking for someone to elevate the quality of clinical care within the service system. Over a period of several months of discussion, I made the decision that this would be an interesting place to apply the lessons I had learned in Connecticut to a larger system. So, I made the jump, and now I still think I have the best behavioral health job in the country.

Bill White: How did the systems transformation process begin during your early tenure in Philadelphia during 2004 and 2005?

Dr. Evans: The first thing I did was acknowledge the great work that was already underway in Philadelphia and engage people at all levels in how we could further elevate the quality of treatment. There had been a strategic planning process underway before I arrived, but there was not a focused effort to increase the system's recovery orientation. One of the key strategies that we used early on was to bring in people nationally to talk about recovery, including yourself and Mike Hogan. They articulated why this recovery orientation was important and how service practices changed within this orientation. I also personally spent a lot of time talking to treatment providers, advocacy groups, and all kinds of other community groups.

We also did dozens of focus groups with people from all parts of the system including people in recovery, family members, direct service staff, supervisors and executive directors of treatment organizations and advocacy groups. In these focus groups, we first explored what changes to the existing system were important to these stakeholders from their respective vantage points. We asked people in recovery, for instance, what types of services and supports helped or hindered their recovery. We also talked with people about the changes that we wanted to make. Through these focus groups and community meetings we began to develop a shared sense of urgency about the need to continue improving the existing service system.

As a result, we started developing papers and PowerPoint presentations to educate people and capture the growing consensus on future directions. We did a number of conferences to begin exposing people to the ideas and we created opportunities for people to have a chance to talk about what they thought the concepts meant and what that might look like in urban Philadelphia and how that might be different than what other places had

done. And we established a recovery advisory committee to guide the systems transformation process.

One of the interesting things is that, in Connecticut, from the time that we started the work of bringing people together to the time we had consensus around a definition of recovery was about a year. When I came here four or five years later, the state had a definition of recovery and there were lots of definitions from all over the country. It still took Philadelphia about a year to develop and reach consensus around a definition. For me, that was a really important lesson. To do the kind of systems change on the scale that we've tried to do it here and in Connecticut, people have to not only understand the concepts; they have to internalize the concepts, and that just takes time. It takes people having the chance to reflect and talk with each other. Only when this conceptual alignment occurs can the larger process of systems transformation move forward.

Bill White: A lot of people would think of a leader at your level spending a lot of time exerting your influencing through speaking, and yet observing you these past years, I'm struck by how much time you spend asking questions and probing and listening. How important is the listening function to what you've achieved?

Dr. Evans: I think it's absolutely essential. I try to pride myself on being bright enough to know how much I don't know. I do try to spend a lot of time just listening to people and talking to people without assuming that I or my agency has all the answers. There's a saying that I have, which is, "Inherent in every community is the wisdom to solve its own problems." I really believe that. I don't care how challenged a community might be, I don't care how it might look on the outside. I think that there are always people within a community whose wisdom can be tapped and mobilized. People know a lot more than systems often give them credit for. Stopping long enough to ask and listen important.

Bill White: It would have been easy to simply take what had been done in Connecticut and to impose it on Philadelphia, but you understood that the process is even more important than the recovery definition and visions statement that comes out of it.

Dr. Evans: I think that that's very true. The process is very important. Two concepts underscore this. The first I borrowed from the scientific world where I found the idea of fractal which means that an object is a made up of

a self-replicating image. So if the object is a triangle at the meta level, if you look at the micro level, it's made up of smaller triangles. So, the process at a macro level needs to be mirrored in what is going on at the micro level. The second related clinical concept is that of parallel process—the idea that what goes on in the therapist-client relationship and what goes on in clinical supervision and larger organizational processes mirror one another. I think for me, those two concepts really are at the forefront of my thinking about systems change. We can't say to providers, "We want you to work with people in a collaborative way, to be respectful, to listen, to have more of an equal relationship as opposed to a hierarchical relationship" if we don't in turn exemplify that in our relationships with providers.

Bill White: By 2007 and 2008, people were beginning to refer to the Philadelphia Model of recovery management and building recovery-oriented systems of care. What do you see as the most important elements of such a model?

Dr. Evans: There are three or four things that in my mind are really central to the approach that we've taken that are different than the approach taken in other places. First, we have tried to create a transformation process that is both a science and an art. On the one hand, you'll hear me talk about the importance of research, data and rigor in evaluating performance outcomes. And on the other hand, you'll hear me also talk about the importance of the relational aspects of systems transformation—at all levels. To me, both of these dimensions are important and not at odds with one another. I think that this blend of the rational and intuitive comes out of my musical training. I think to be a musician, you have to be a good mathematician because you have to keep time and read notes and such, and yet there is this deep intuitive side to music, and when these are put together the whole is greater than the sum of the parts. My approach to thinking about systems is very similar in that these various ways of knowing must both be respected and blended.

I think another thing is to distinguish the potential depths of change involved in what people are calling recovery-oriented systems of care (ROSC). In our writings about ROSC, we have described additive, selective, and transformational approaches to ROSC. In Philadelphia, we think that ROSC requires a transformative approach in which the core governing concepts, core service practices and the contexts (policies, funding mechanisms, regulatory guidelines, etc.) must all be aligned to support long-term recovery for individuals and families, as well as

neighborhoods and the community as a whole. In our approach, everything in the system is on the table, and you have to change all of those things from the highest level in the system to the lowest level in the system to assure their congruence with the recovery vision.

We also place emphasis on working in a social and community context. A lot of work focuses on recovery support as a way of making a system recovery-oriented. I think that that doesn't go far enough. You have to think about treatment, and you have to think about the broader community context in which people live. One of the things that we have really emphasized is that it doesn't make sense to help people initiate recovery and then put them back into communities that fail to support their recovery. It doesn't make sense to me to have a system of excellent care when people don't know how to access that care because we don't have a relationship with people in the larger communities, or people in the community don't know where to go when they need help or don't trust the people who are offering the help.

Part of what we are trying to do in Philadelphia is create a supportive community in which recovery can flourish. That includes but goes beyond breaking down barriers that people may have in wanting to come into treatment. It involves challenging stereotypes of people in recovery by building relationships between people in recovery and the larger community. We envision a world in which recovering people are warmly welcomed into the neighborhoods, schools, workplaces, churches and other social venues. One of the ways we facilitate this process of community inclusion is through mini-grants to community coalitions for projects that will help recovering people and their families experience a full life in the community. It's important to have treatment resources but it is also important to have these broader and more enduring supports in the community.

Bill White: Very early on, you engaged the faith community as a recovery support resource. How has that collaboration evolved over the past five years?

Dr. Evans: It has not evolved as much as I would have liked due to several personnel changes in the leadership of this initiative, but I think our thinking has become more sophisticated as we've done the work. We are now talking about several components of this work. One is the need to enhance providers' understanding that many of the people who walk through their doors see themselves as spiritual beings and are often part of a faith community. Many of these individuals see and understand the world and

their behavioral health condition through the lens of their faith. If we're going to be effective as a treatment system in working with those individuals, we need to understand that lens and understand the role of faith as a catalyst and ally in the long-term recovery process. We need to be respectful of diverse faiths and engage faith communities as allies for people who choose spiritual and religious pathways of recovery. So, part of the work has been to bring that perspective to the treatment world, which frankly, is not the standard way that professionals have viewed faith and its potential role in treatment. Most of us were trained to not talk about a person's faith within the context of treatment. The reality is that people bring that in; we ought to understand it and work with it.

The other thing we have come to understand is that there are people in faith communities who are dealing with family members or friends who have behavioral health conditions. Often, members of these faith communities do not have the expertise to help address those behavioral health conditions nor do they know where to get help for such conditions.

We also think it's important that the faith community understands addiction and mental illness because recovering people often seek solace within these faith communities. Their recoveries may be greatly influenced by how well they are received when they reach out to such communities. We want to make sure that communities of faith understand that people can recover, do recover, and that the faith community can play a big part in such recoveries.

We are also discovering members of the faith community who want to provide specialized recovery support services, and for those individuals, we want to work with them and help them develop workable models of recovery support.

Bill: You have placed the special emphasis on the mobilization of the recovery community and on peer leadership development. Could you describe some of the activities in this area?

Dr. Evans: I think that that has been the single most important thing that we've done in Philadelphia, and the thing that I feel especially proud of. When we started this work, there were very few people—probably less than 10 people, outside of the professional advocacy community,—who would publicly identify themselves as people in recovery and felt comfortable sharing their experiences of recovery in public settings. It is not an exaggeration today to say that there are thousands of people who are standing up to put a face and voice on recovery. PRO-ACT, on the

addiction side, has thrived as a recovery advocacy organization and deserves a lot of credit for this recovery community mobilization that we have experienced. We met early on with them and have supported all kinds of leadership development activities and opportunities for service aimed at people in recovery. This has made a huge difference in people's lives.

Bill White: One of the things that you did early on was increase the recovery representation within your own organization. I'm wondering how the organizational culture began to change as recovering people came in to DBH/MRS.

Dr. Evans: The interesting thing was that there were a lot of recovering people in the organization already, but no one knew it. During our journey through this process, there have been a number of "aha" moments. Let me describe an early one. When I first decided we were going to do recovery transformation, I sent out an email to everyone on our staff—about 600 people across the entire agency—requesting volunteers to participate in key workgroups that were going to help guide the process. An interesting thing happened. A lot of people who volunteered were not the people we expected, such as people from IT and members of our clerical staff. Well, it turns out that a lot of those people were in recovery or were family members of persons in recovery. This recognition of our own recovering people was the beginning of our celebration of recovery. We began to create new traditions where key trainings and conferences involved a person in recovery telling their story. It was a way of saying, no matter what the agenda, "This is what this is all about." Additional people in recovery were also hired to be a part of the strategic planning unit, which was charged with guiding the recovery transformation process. In this way, we ensured that the perspectives and voices of people in recovery were central in everything that we did related to our recovery transformation process.

We have tried to celebrate recovery within our own organization. In fact, before the Recovery Walk, one of the things that Sadé Ali did—our Deputy Director—was ask people to register how many years they had been in recovery. It turns out we have more than 1,000 years of recovery within the organization. Openly acknowledging that has created an important change in our organizational culture. One of the things that we take pride in is that we make no major policy decisions or financial decisions without people in recovery in the room. So, everyone knows that if we're doing an RFP or any kind of procurement that we make sure that there are people, not only staff who are in recovery, but people who are recent service users of

our system in the room to help make those decisions. I think it's been another way of signaling, both internally and externally, that recovery voices are enormously important in what we do.

Bill White: I had the privilege of observing Philadelphia Mayor Michael Nutter address more than 1,000 people at the First Recovery Conference, more than half of whom were in recovery. Was that a pivotal moment in the history of the Philadelphia systems transformation process?

Dr. Evans: I think so. To Philadelphia's credit, both Mayor Street and Mayor Nutter have been very supportive of the recovery transformation. Mayor Nutter has been exceptional in his support of what we do. He gets it at a real intuitive level, which I think is really exciting for people. When he came and spoke to the professional and recovery communities for the first time, it signaled to the recovery community and to the treatment community that this is a mayor who gets it and who is supportive of what we're trying to do. It was a great point of validation for everyone and acknowledged to the larger community the importance of what we are doing.

Bill White: There was a period of time after you came when the Mayor asked you to take over as acting Commissioner of Human Services for the city of Philadelphia. How did that experience influence the work you had begun with systems transformation?

Dr. Evans: I had actually been in the city only for about 18 months when I was asked to also manage the child welfare agency during a crisis. During the first six months, I had little time to devote to behavioral health, and my fear was that much of our early progress might be lost. But when I came back to my full-time position at DBHMRS a year and a half later full-time, I was very pleasantly surprised by how much of the work had proceeded. In retrospect, I believe the key to this was that I developed competent leaders who were continuing to guide the process. Transformational change requires a different style of leadership. Rather than top-down leadership styles, it requires that potential leaders are identified and mobilized at all levels of the organization. By the time I went to the Department of Human Services, there were numerous recovery champions both within the Department and in the broader community who had a clear vision for the system and the passion and ability to bring about significant change. I think that this is one of the hallmarks of a successful transformation process. The process cannot be sustained if it rests only with one person.

Transformational change requires that leaders share their expertise, motivate and empower others to be innovative and become change agents within their realm of influence. I had key leaders in place at DBHMRS who were some of these critical change agents and who continued to guide the process. These included Dr. Ijeoma Achara, Roland Lamb and Tom O'Hara.

We also asked each unit to develop their own unit recovery plan—what initiatives they were going to take to move the transformation process forward. The unit recovery plans allowed work to proceed at the frontlines of organizational activity. The plans also helped people really get what the transformation process was all about and its implications for their role in the organization and the community.

Bill White: Could you describe more about the benefits of these unit recovery plans?

Dr. Evans: There have been a lot of counter-intuitive lessons learned from the unit recovery planning process. If you had 10 resulting initiatives and you looked at those 10 initiatives and made predictions on which ones would yield the greatest and least returns, the predictions will often be wrong. I would have thought when we started developing unit plans that we get the biggest bang from the units that were most directly involved with our providers and that we'd get the best ideas from people who were clinicians and people who had programmatic backgrounds. And yet we got some of the most interesting projects and some of the most innovative thinking from people who were non-clinicians, people who were working in IT and finance or other administrative areas. What that told us was that what we're trying to do and the concepts that we are conveying have implications for people across the organization and in ways that are not always apparent and that it is critical to engage and listen to people at all levels. Creating a recovery-oriented system of care really has implications for everyone in the system.

Bill White: Having to lead transformation in the midst of such crises really reinforces that transformation is a lot more like jazz than scored music. There are all these unanticipated things that have to get incorporated into the process.

Dr. Evans: Absolutely. If you asked me today, I might say, "Here's the area that we're really going to emphasize and really make an impact in terms of our transformation, and here are the areas that we're probably going to wait on," but we're not always right. We have these wonderful surprises from

areas in which we are not focusing that just take off as a result of personal initiative or an unexpected event. I do think jazz is a good metaphor for this process. There's not a script as much as we might desire one. If you understand that and are comfortable with that creative process, transformation can be a personally and professionally exhilarating and meaningful process.

Bill White: There had to be considerable resistance to the transformation process early on, given the breadth and depth of the changes that you were talking about. What was the nature of some of that resistance and how it was managed?

Dr. Evans: We first encountered a phenomenon called the "We bes and the you bes." It's "We will be here; you will be gone." There was a sense that, "You're appointed here now, but this is going to go away." That was the same dynamic that we had in Connecticut also. People thought that in a couple years, we'd be on to something else. There was an early period in which people wanted to marginalize recovery as this soft philosophical shift that had little relevance to service practices. There was pushback from some professional disciplines who felt they were losing status, and, of course, there were a tremendous number of turf issues. Systems transformation requires people to give up some control. It requires people to do things differently. And it requires some loss of professional turf. There was also from not all, but from some of the provider community the response, "We've been doing this work for decades. We know what we're doing. Are you telling us what we've been doing is wrong?!" We go out of our way to say, "This is not about people doing something wrong and we're here to tell you the right way to do it. This is about the evolution of the field. Our thinking evolves. We learn more. As we learn more, we ought to incorporate our best thinking and learning into what we're doing.

Having said this, I think to the city's credit we had much less resistance and active pushback than has occurred in many places. I attribute that to the partnership relationship we developed with our key constituencies and to the collective commitment to improve the scope and quality of treatment and recovery support.

Bill: I've been struck by the extent to which you pushed your staff to filter all their relationships inside and outside through these values of respect, partnership, and transparency.

Dr. Evans: I think the issue of transparency is very important because frankly, I've been a provider, so I get this. I think that there's always some suspicion of government and of the payor, that they've got something up their sleeve and that there's something that they're not really telling us. I think over time, by simply just putting it out there and saying to people, "We're going to tell you as much as we possibly can as much as we know as we know it or when we can tell you." Sticking to that as a strategy has gone a long way in building partnership. I'll be the first to say that we haven't always done that. There are times when we violate our own principles and we violate our own values around this stuff, and I'm quite sure that we're going to have continued examples of that. But I think today that is more the exception than the rule.

Bill White: One of the things that I hear from state and city behavioral health leaders is that they're challenged by the demands to maintain the system of care at the same time they're trying to transform it. One of the questions they always raise is: how do you get the resources and where do you get the energy to sustain that kind of a process? What are your thoughts on that?

Dr. Evans: That's a good question. This issue came up in Connecticut and in Philadelphia because in both places we've faced financial crises. We had budget cuts or we had less latitude to do things because of the fiscal environment. A couple of thoughts: number one is that I think it's actually easier to make change when you have those kinds of fiscal constraints. I think it's really important for leaders to use those opportunities to make the changes that would be more difficult make when times are good and budgets are flush. I reject the idea that the only way you can do recovery transformation is with additional resources. My position is if your budget is $100,000, then you have $100,000 to work with in terms of recovery-oriented services. If your budget is a billion dollars, then you have a billion dollars at your disposal to make your system recovery-oriented. So, the trick is not to see the work as being "What do I need to add in order to do the work?" The work really is about "How do I take what I have and transform that into something different?" In Connecticut, I didn't have a budget. We had a very, very small budget for training and consultation and technical assistance, a very small budget. And we were able to do that work. That work continues today 10 years later. So, I don't buy the idea that you can't do this work without additional resources, and in fact, again, I think when

you don't have a lot of resources, that is exactly the time to do this kind of work.

Number two, it's really important, and again this is a lesson from Tom Kirk, that you have people dedicated to lead the transformation process. You cannot drive the train and change the tires of the train at the same time. You gotta get somebody else to work on the train while someone else is driving it. Creating that internal think tank and leadership team is critical. The person who leads that work for us has always been a person that reported directly to me and now is actually a deputy director in the department. That shows you the level at which I believe the work has to be done.

Bill White: Another ingredient that I would identify as critical to systems transformation is the kind of leadership that Tom Kirk and you brought to Connecticut and that you've brought to Philadelphia. You both brought a high level of energy and excitement and created lots of rituals where people could celebrate the successes and progress that was being made.

Dr. Evans: I do think that that's important. I have tried to send a consistent message throughout all of our activities: people do recover and that's what all of our work is about. The goal is a person in recovery who is getting their life back, who has a meaningful life in the community. That's what we want to celebrate. That's what we want to keep lifting up to our provider system and to the broader community.

Bill White: How do recovery-oriented systems transformations change the role of frontline addiction professionals and other service professionals?

Dr. Evans: I think these roles change in two or three fundamental ways. First, is how one thinks about the work, the underlying clinical philosophy which is focused on a long-term recovery management strategy, as opposed to focusing on the person within a particular level of care. Even if you're in acute services, you ought to be thinking about "What is my role in helping this person on their path to long-term recovery?" In essence, frontline addiction professionals expand their focus from helping people to initiate their recovery, achieve abstinence or reduce their symptoms to providing people with all of the services, supports and community connections that they will need to help them to sustain their recovery and build a full life in the community.

Secondly, I think it changes how one sees their own role. Rather than viewing themselves as the expert who is responsible for directing the treatment process, in a recovery management approach the service relationships change so that frontline professionals see themselves as partnering and collaborating with the people that they serve. There is recognition that the person has expertise about their goals, needs, preferences and what has or has not worked in the past, while the professional has clinical expertise. Together they engage in shared decision making. This requires a shift in power. Rather than the professional independently calling the shots, power is shared and professionals respect that the person being served has the right and the ability to participate in making critical decisions that affect their lives.

Thirdly, I think this move to recovery management demands the highest possible skill level that one can obtain. One of the things that's interesting to me is that people sometimes push back against the idea of recovery-oriented care in the belief that by giving people choice and a lead role in their own recovery that you're basically turning over the clinical services to the client. And in some ways, that's true, but in another way, it requires more skill than a more traditional approach where there is not this great emphasis on sustained engagement and collaboration. I think to be a part of a recovery-oriented system of care, you really have to bring—to use a colloquial—your "A game," and that means you need to be versed in what's the best evidence-based practices. You need to be versed in the issues that get in the way of people's recovery like trauma and co-occurring conditions. You need to be skilled and adaptable at understanding the diverse cultural contexts in which recovery must be nested. You need to be willing and understand the role of spirituality and faith in people's recovery process. You have to understand and be knowledgeable about and fluent in the growing diversity of recovery pathways and support groups. The needed skill level is much higher and more demanding in a recovery-oriented system of care.

Bill: You've recently invested a lot of time and resources in Philadelphia developing practice guidelines. Was this your way of bringing systems transformation to that frontline relationship?

Dr. Evans: I think this work is very conceptual, but at the end of the day, we have to affect frontline service relationships and practices. We have to take these concepts and translate them into actual action through service practices. The practice guidelines provided us an opportunity to translate

these concepts and this way of working into practical things that people can do across a variety of different levels of care and across a variety of populations. The guidelines were written to encapsulate all of the work that we've been doing up to this point and put it into a format that articulates clear expectations for service providers. For example, one of the domains addresses the need for assertive outreach and engagement which we are trying to enhance in our system. The guideline articulates the critical competencies within this domain. It says, "Here are the kinds of things that this means. It means you need to understand the community resources. It means you need to connect with indigenous helpers in your community. It means that even if you are an inpatient or outpatient provider, you need to have a strategy for leaving your four walls and going into the community to reach people before and after such treatment. The practice guidelines take the concepts and put them into action.

Bill White: When you first began the systems transformation process in Philadelphia, were there any early experiences that really confirmed for you that you were moving in the right direction with this process?

Dr. Evans: The most powerful thing is what people who experience recovery-oriented care say, particularly those with a past history of more traditional treatment. I was most moved when I began to hear people say, "I've been going through programs for years, but now I'm finally starting MY recovery." Or "This is the first time I felt like my needs and my wishes were really listened to." Or "This is the first time I got sustained support after I left treatment." When I began hearing those kinds of remarks, I knew we were moving in the right direction and needed to keep going forward.

Bill: More than 11,000 people marched in the city of Philadelphia in the National Recovery Hub event. Did you ever imagine you would see that many recovering people and their families marching in Philadelphia?

Dr. Evans: I could not have imagined that when we started the work here, particularly when you think that the first recovery walk here drew some 150 people. To go from that to 11,000 people in 2010 is quite remarkable and I think it says a lot about the city of Philadelphia and what we have tried to accomplish here with our recovery transformation process. We were honored to host the national Recovery Walk, but we were even more honored to have done so in a community that really gets what we are trying to do here. Philadelphia is moving from a focus on problems to a focus on

solutions and our recovery events are living proof of the reality of such solutions. People have really stepped up, and it's been great.

Bill White: What are some of the mechanisms you put in place to evaluate the effects of the systems transformation process in Philadelphia?

Dr. Evans: We've done several things. First, we created consumer satisfaction teams who go to our funded programs and speak directly to participants about their experiences in treatment. We are assessing the recovery orientation of our programs through the eyes of our most important constituents. We want to know if people are feeling respected, being helped, getting the range of services they need, and offered choices? The consumer satisfaction teams also get information from service providers on changing needs of clients and obstacles to long-term recovery. These are supplemented by regular focus groups we do throughout the system to gage the direction and pace of the change process. We also used systems data to evaluate how we're doing. We look at a number of systems level indicators such as recidivism and continuity of care. And we also do special studies from time to time with our academic partners to look at specific programs. We're currently working with the University of Pennsylvania on evaluating telephonic aftercare.

Bill White: You are also creating a report card for the system as a whole and for individual programs.

Dr. Evans: Yes, we are doing provider profiling using our utilization and claims data. We are piloting this with our residential rehabilitation programs and ultimately we will develop profiles for providers in all of the levels of care. We're starting with residential providers because they are a big important part of our service system, and that allows us to both evaluate how a particular provider is doing on things that we have deemed as important, and it also allows us to evaluate or look at that provider in relation to other providers, and so we rank them as well as come up with a profile of how they're doing on key recovery-oriented indicators.

Bill White: Philadelphia is going to be the first major community in the United States to measure recovery prevalence by zip code. How important do you think that kind of data is to the future of recovery transformation processes?

Dr. Evans: I think it's very important because we have historically not known the prevalence of recovery at a national, state or community levels. The ultimate test of a recovery-oriented system of care is contraction of the problem and expansion of the lived solution. We need to be able to measure changes in recovery prevalence over time at the community level. This data is going to be very helpful to us.

Bill White: It should be able to help you be much more precise in targeting services to particular neighborhoods.

Dr. Evans: Yes, this geomapping, or what we call recovery resource mapping, will allow us to compare the density of need based on problem indicator data and to look at recovery prevalence and by recovery support resources all by zip code. This will provide a planning tool to make sure we are getting resources precisely where they are needed and will also allow us to evaluate the community-level effects of our various initiatives. This will allow us to develop different strategies for those communities that have less recovery capital from those communities where we may have made greater progress.

Bill White: You've had visitors from across the country and around the world visit Philadelphia to study the transformation process. What do these visitors tell you they find most striking from their visits there?

Dr. Evans: I think they are most struck by the scope and breadth of what we're doing. I think all the things that we're doing are really important to a recovery-oriented system of care. So when visitors arrive, they will see a system that is pushing evidence-based practices, looking at the issues of trauma, looking at the integrated treatment of co-occurring disorders. They will see a system that is working in the community with indigenous community helpers and doing recovery murals as a strategy to engage the community. They'll see an LGBT initiative because that's a community that we're trying to reach. They'll see a community that has strategies for engaging various immigrant and minority communities, including the Asian and West African communities. They'll see a wide span of initiatives all focused on maximizing people's ability to recover. I think the other thing that is striking, particularly to our visitors from Asian and European countries is the emphasis that we place on peer services and peer culture and

the strong voice people in recovery have in the system, both within the treatment programs and within my department.

Bill White: Has the national and international attention that's come to you been a diversion or an aid to the transformation process?

Dr. Evans: I think it's been helpful to us. Having a growing audience to which we must articulate the whys and hows of systems transformation has sharpened and expanded our thinking. There are a lot of things that we do and have done intuitively. When we have visitors, we have to stop and think about what we're doing and why we're doing it. This has provided a discipline that we might not have otherwise had.

Bill: This sudden interest in recovery management and recovery-oriented systems of care raises questions of whether these really constitute profound sustainable change or will turn out to be what you earlier referred to as a "flavor of the month." How have you avoided that kind of transient flavor of the month phenomenon?

Dr. Evans: The successful strategies in both Connecticut and Philadelphia have included a sustained commitment to RM and ROSC by top leadership and the integration of all new initiatives within the RM and ROSC frameworks. That means that managed behavioral health care, evidence-based practices, cultural competence and health care disparities, trauma-informed care, treatment of co-occurring disorders, homeless initiatives, service integration initiatives, health care reform—everything has to be integrated within rather than seen separately from RM and ROSC. This is our way of saying, "This isn't going anywhere; it is the future."

Bill White: Is there an Achilles heel or particular types of vulnerabilities that will make it very difficult for some states and cities to successfully replicate what you have been able to achieve in Connecticut and Philadelphia?

Dr. Evans: We don't have a good database of implementation lessons learned through these processes. Your work has been enormously helpful to our system and the field in general because you have begun to document and to write about these transformation processes, but once you go beyond your work, there's little else documenting the lessons learned from systems transformation initiatives. I think the failure to capture that collective

experience is a big Achilles heel. For those of us who are in policy positions or are in government administrating large systems of care, most of our effort is spent keeping the system functioning. We don't spend enough time stepping back, reflecting on the work we are doing, and documenting what we've learned. That failure is forcing communities to reinvent the wheel as they begin their own transformation attempts. That is unfortunate.

I think the other Achilles heel is developing outcome measures that allow us to articulate with data what we mean by recovery-oriented care and the indicators by which such care should be evaluated. We are trying very hard to develop such measures and to use them for systems evaluation and to guide the future or transformation efforts and to link our efforts to what is unfolding in the broader healthcare arena.

Bill White: I would add one additional point and that is the stability of leadership needed at multiple levels of the community to sustain ROSC transformation efforts—stability I think has been critical to what has been achieved in Connecticut and Philadelphia.

Dr. Evans: Let me speak to one issue that is of great concern to me. One of the great vulnerabilities of the addictions field, and the broader behavioral health care field, is its aging leadership. Even in my own agency, I am going to lose half of my executive team to retirement in the next three years. That is an enormous brain drain on an organization and a field. It's good that we will bring in new and younger people with fresh ideas, but we are at risk of losing a lot of valuable institutional knowledge. We need immediate efforts aimed at leadership development and succession planning to carry the field forward, to sustain ROSC transformation efforts already underway and to generate the new leaders that will guide tomorrow's ROSC transformation efforts. And we need that leadership at all levels of the system.

Bill White: When you were recently asked about the next stage of system transformation in Philadelphia, you responded with the phrase "wider and deeper." Could you share with our readers what you meant by that?

Dr. Evans: By "wider" I mean that we must extend the transformation effort beyond the core of the treatment system. We must scan the environment to see who was left out or not fully engaged in earlier stages of the transformation process. We are beginning to ask: What are the specific implications of RM and ROSC to children and adolescent services? What will this look like in our criminal justice programs? What does enhanced

recovery orientation mean for methadone maintenance and other medication-assisted treatment? We have focused on some specific levels of care, particular parts of our provider community, particular client populations. Wider means that we are now extending the reach of the transformation process, applying lessons learned to date and learning new lessons as we go.

I think "deeper" means that we move from a shift in philosophies of care to changing frontline service practices and on to the lives of people in need of recovery. We think of this as taking systems transformation from the policy level to "the corner." It means we go from superficial changes to changes that make profound differences in people's lives. Deeper means that we institutionalize the change in such a way that it doesn't matter who comes and goes, the change is going to last.

Bill White: When you went broader in Philadelphia with the transformation process you found yourself needing to connect the concepts of recovery and resilience and self-determination. Could you comment on that?

Dr. Evans: I've always seen prevention as an essential part of a recovery-oriented system of care. I don't think we've articulated that as strongly as we could, but it's essential. In a recovery-oriented system, what you are really doing is changing more than a treatment system. You are changing an entire community. And what you do to change a community so that recovery can flourish encompasses the same things you do to enhance community health to reduce the incidence and prevalence of alcohol and other drug problems. People don't recover in treatment programs. They recover in a community, and that's why so much of our focus is on the community itself. Primary prevention and early intervention are not afterthoughts—superficial appendages to the system; they are a fundamental part of a recovery-oriented system of care.

Bill White: There seems to be a larger vision emerging in Philadelphia around the question: How do we move beyond the focus on the care of individuals (adults, adolescents, children each treated as a discrete unit of care) to the development of sophisticated, family- and community-focused strategies aimed at breaking intergenerational cycles of alcohol and drug and related problems.

Dr. Evans: Yes, this ecological perspective is emerging as a fundamental element of the Philadelphia model. We stress that we can't just work with

the individual, but instead have to work with the family, extended family and community to create a kind of healing sanctuary that can break such cycles. We have to have intervention strategies for all three levels of analysis: for the individual level of analysis, for the family system, and for the community and broader social system. As we move forward, we must design, evaluate and continually improve such interventions.

Bill White: Dr. Evans, you have also begun to talk about this notion of community recovery, that we may need processes that help whole communities heal from the effects of addiction and other behavioral health problems.

Dr. Evans: When I think of community recovery, I think of what we're doing with the mural arts program here in Philadelphia to create a series of murals. For each mural, we go into a particular neighborhood community and meet with people to develop a theme for the planned mural. It could be "Second Chance," or "Recovery," or "Protecting Our Children," but some theme related to behavioral health. This work has been funded by the Robert Wood Johnson Foundation and has illustrates the kind of community-level interventions we have attempted. The process of planning and creating each mural is designed to exert a positive and enduring influence on the neighborhood—an influence designed to elevate local recovery capital. Each mural project involves a three-year involvement with the neighborhood to sustain the local mobilization that occurs through the mural development process. So, if people say to us in these extended conversations that part of the neighborhood problem is too many abandoned buildings, we help them engage partners to answer the question, "What can we do in this community to address that issue?" Over time, what we're doing is beginning to strengthen the health and fabric of the community itself. It's really exciting work, but there is no roadmap for this—only a commitment to sustain the conversations and the commitment to elevate community health.

Career Reflections

Bill White: When you look over the course of your career, who are some of the people who've most influenced your views about addiction, treatment and recovery?

Dr. Evans: Well, there have been a lot of people. Bob Steele, my dissertation advisor at the University of Maryland, helped me understand

policy development within an ecological perspective. Esther Armmand, who hired me as clinical director of the first freestanding medical detox program in New Haven, Connecticut when I was just out of graduate school, taught me a great deal about addiction and the importance of respect and flexibility in working with individuals and their families. She also helped me understand how a program had to fit within larger systems of care and within the larger community. Tom Kirk was very important in my development in giving me the opportunity to serve as his Deputy Director and in helping shape my philosophy about ROSC. I also learned a lot from Tom about the importance of vision and the need for courage to sometimes swim against the political tides in the pursuit of service excellence. Other significant influences include people I have worked with and who have worked for me, including yourself, Wayne Dailey, Sadé Ali, Dr. Ijeoma Achara-Abrahams and Dr. Larry Davidson from Yale. And then there are the multitude of people in recovery who have profoundly influenced my views about treatment and recovery.

Bill White: What do you feel best about as you look back over your career to date?

Dr. Evans: I think the models that have been created in Connecticut and Philadelphia. The first job I had in government was bringing managed behavioral health care to the public sector in Connecticut. This was in the late '90s when managed care really had a bad name due to private sector companies that had done a poor job of it. I had the privilege to lead this effort and feel very proud of its success, particularly since so many people expected it to fail. What we did with that really made a difference in the lives of the people that we were serving. That led to leading the larger transformation effort in Connecticut with Tom Kirk. Connecticut continues to be viewed nationally and internationally as a model for recovery-oriented systems of care.

I certainly feel good about the work that we've done here in Philadelphia over the past six years. The amount of progress that people and organizations have made here in a relatively short period of time continues to amaze me. I think it speaks well of the people in the city and the commitment that people at all levels have made to the work we are doing. My work here has been deeply gratifying.

Bill White: As a final question, how can addiction professionals around the country help lead and support the kind of change processes that have been underway in Philadelphia?

Dr. Evans: Well, I think we all have to become students of this movement to create recovery-oriented systems of care and to recognize the difference between superficial changes in rhetoric and true systems transformation. Addiction professionals can embrace this recovery vision and become part of the movement to align clinical practices with this vision. They can also participate in some of the larger systems change efforts by volunteering to sit on committees and various work groups and by actively participating in local recovery celebration events. Perhaps the most important thing addiction professionals can do is to listen to people who are in recovery, the people who are the true beneficiaries of this work. That level of professional humility and that willingness to enter into a process of long-term recovery support will help us move forward all over the country.

Bill White: Dr. Evans, thank you for spending this time with us.