The Role of Partnership in Recovery-Oriented Systems of Care: The Philadelphia Experience

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Abstract

Considerable effort is underway in the United States to transform behavioral health care toward the goal of supporting the long-term recovery of individuals and families. Achieving this goal requires new organizational partnerships, refined strategies of collaboration, fresh approaches to policy and clinical decision-making, and a fundamental restructuring of relationships throughout the system of care. This paper describes the role such partnership processes are playing in transforming addiction treatment in the City of Philadelphia into a recovery-oriented system of care.

Key Words: Systems transformation, partnership, collaboration, consumer council, faith communities, communities of recovery

Introduction

The addiction and mental health service fields are undergoing recovery-oriented systems transformation efforts at national, state, and local levels (Anthony, 1993; White, 2005, 2008a, 2008b). Recovery-focused systems transformation is the process through which behavioral health organizations shift their historical focus on acute or palliative care (serial episodes of brief biopsychosocial stabilization or sustained amelioration of personal pathology and its related social costs) toward support for long-term recovery and enhanced quality of personal/family life in recovery. Systems transformation initiatives are dramatically changing service goals and philosophies, funding and regulatory policies, service practices, constituency relationships, and approaches to performance measurement and monitoring (White, 2007a). These efforts are marked by:

- Unprecedented levels of participation of recovering people and their families at all levels of system decision-making
- Increased integration of addiction treatment, mental health, and primary health care
- Integration of professionally-directed clinical services and peer-based recovery support services
- New organizational partners (recovery community organizations, recovery homes, recovery schools, recovery industries, recovery ministries/churches)
- Assertive approaches to sustained recovery management (Anthony, 2000; White, Boyle, & Loveland, 2003, 2004; Davidson & White, 2007; Gagne, White, & Anthony, 2007).

In the City of Philadelphia, a recovery-focused systems transformation process began in 2004 under the leadership of Dr. Arthur Evans, who had helped initiate a similar

process in the State of Connecticut. Earlier papers and presentations detailing the goals, strategies, and preliminary outcomes of this "recovery revolution in Philadelphia" address a most basic question: Why would a large behavioral health care system need transforming when it already has its own well-resourced managed behavioral health care organization (over $1 billion a year in revenues), 64 addiction treatment providers operating 182 distinct programs, and a community network of more than 250 recovery homes and more than 800 weekly recovery support group meetings (Evans, 2007; Evans & Beigel, 2006; White, 2007b).

The answer to that question for Philadelphia (and for the rest of the country) is that these valuable resources are simply not enough. Their inadequacy is not rooted in a lack of resources to provide a greater volume of the same services to more clients. It is instead rooted in the basic design of modern addiction treatment. Long-term recovery from addiction can be conceptualized in four broad stages: 1) pre-recovery identification, engagement, and destabilization of addiction; 2) recovery initiation (acute biopsychosocial stabilization); 3) transition from recovery initiation to stable recovery management; and 4) enhanced quality of personal and family life over the course of long-term recovery. At present, addiction treatment in Philadelphia and in the United States devotes nearly all of its resources to the second of these four stages. The treatment system as currently designed facilitates recovery initiation more effectively and more safely than has ever been done in history. What it fails to do as a system of care is voluntarily attract individuals early in their addiction careers, systemically support the transition from recovery initiation to recovery maintenance, and enhance global functioning, citizenship, and life meaning and purpose in long-term recovery. Without significant recovery supports across all four of these stages, addiction treatment as currently designed and delivered fails to assure recovery sustainability for the majority of its clients.

Earlier publications have discussed the why (analysis of systems performance data) and what (needed changes in practice) of the systems transformation efforts that are addressing these design deficits (For a summary, see White, 2008b). This latest work is part of a series of papers focused on the how of systems transformation (also see White, 2008a). This first paper focuses on one particular dimension of the systems transformation process: the strategies used to restructure system relationships and the lessons learned in Philadelphia about this crucial aspect of recovery-focused systems transformation. Here are our reflections and suggestions for others leading such transformation processes.

Chameleons Change, Caterpillars Transform

Recovery-focused systems transformations involve more than minor refinements to existing models of addiction treatment. Such transformations require a fundamental reconstruction of service concepts, practices, and policies. They start with the realization that no one person, episode of care, system of care, or governmental entity has the resources to support long-term individual and family recoveries for all who need it. Partnerships are fundamental to achieving transformation. We have used the metaphor of the chameleon and the caterpillar to underscore that systems transformation must involve a deep and enduring change in the character and identity of addiction treatment and all of

the relationships involved in it rather than superficial commitment to new rhetoric and a few new service appendages.

Listen to Multiple Constituencies

The first step in systems transformation is purposefully listening to system stakeholders, beginning with its most important constituents—the individuals and families served and individuals and families who need but have not received services. New leadership of the behavioral health care system in Philadelphia provided a natural opportunity to conduct focus groups to rigorously evaluate the system of care as it existed in 2004. In addition to current and potential service consumers and their families, structured efforts were made to listen to the perceived needs and concerns of those who had worked within the component parts of the Philadelphia behavioral health care system, including staff from key federal and state agencies, representatives from all the existing behavioral health care departments, contracted service providers, recovery advocacy groups, recovery community institutions, leaders from local community centers and the faith communities, and allied service agencies. There were also discussions with the Mayor and other political leaders in the City of Philadelphia about how behavioral health services related to broader community problems, e.g., homelessness, violence, AIDS, and to particular neighborhood development goals.

The City of Philadelphia, like most cities, has a specialized system of addiction treatment, a larger network of allied health and human service agencies, and an even larger network of informal recovery support services (e.g., recovery mutual aid societies, recovery advocacy and support organizations, recovery homes, recovery ministries, etc.). As we listened to individuals representing these three worlds, they portrayed isolated islands connected by drawbridges that remained permanently up, isolating each world from the other. The challenge as it came to be conceived was to connect and align these resources to support long-term recovery for individuals, families, and neighborhoods. What became apparent was that systems transformation must involve not a renewal of addiction treatment as a system of care, but the integration of a renewed addiction treatment into a much larger arena of recovery support. These insights altered the collective vision of the future of addiction treatment and recovery support as well as how system stakeholders viewed each other.

It was not enough to increase the listening stance of DBH/MRS; the challenge was for all of these parties to come together as a listening/learning system of care. That meant that everyone in the system had to increase their listening and learning capacity. The use of skilled facilitators and agendas with structured decision-making steps turned meetings that had been futile exercises in serial speechmaking by the dominant few into discussions in which everyone had an opportunity to speak and where consensus was achieved or key areas of disagreement and choice were identified for further exploration. This listening exercise was extended through the design and delivery of highly participatory, system-wide core recovery trainings. These training sessions provide opportunities for service planners and providers to interact with individuals and families in recovery and to deepen their understanding of the challenges and opportunities encountered in long-term recovery. As of November 2008, 64 Recovery Foundations Training sessions have been conducted for more than 1,600 participants.

Conduct an Inventory of System Relationships

This listening process came to be thought of as a "searching and fearless" inventory[1] of the existing system of care and of system relationships. Everyone, regardless of their role or tenure within the system, was asked to candidly share their experience within Philadelphia's behavioral health care system. The stance of all those assigned to conduct these listening exercises was not to defend, rationalize, project blame, or even to correct misinformation. It was to listen, record information provided as accurately as possible, and invite those speaking to enter into a different type of future relationship with the Department of Behavioral Health and Mental Retardation Services (DBH/MRS). That process began in earnest in 2004 and has continued to the present through formal mechanisms that included continued focus groups (with multiple constituency groups), town meetings, meetings with recovery advocacy groups, consumer surveys, and the use of advisory boards and ad hoc committees.

Through this process, people at all levels began to see that the system itself was wounded and was in need of recovery (see below for elaboration of this point). A distinctive aspect of this evaluative process was the early involvement of recovering people in planning this process through two mechanisms. A Recovery Advisory Committee (RAC) was established that developed a recovery definition, a statement of core recovery values, and a vision document that guided behavioral health systems transformation (see discussion below). The RAC also generated critical input into system change priorities and helped plan peer leadership development initiatives. A second mechanism that assured broad participation in the early needs assessment process was the use of surveys of people in recovery regarding recovery-related needs in Philadelphia. The use of written surveys helped capture information from people who were hesitant to speak in the focus groups.

Create a Vision of Change

The listening exercise must be followed by an honest disclosure of system strengths and weaknesses and an inspiring vision of systems renewal or transformation. This occurred in Philadelphia via a series of meetings in which new leadership 1) acknowledged system problems and potentials as perceived by all stakeholders, 2) made a commitment for changing those problems, and 3) invited all stakeholders to participate in mapping out a process of systems transformation. Both local and outside consultants were utilized to create a vision of how core ideas, service practices, and stakeholder relationships would change within a recovery-oriented behavioral health care system.

A number of advisory structures were established, including a Recovery Advisory Committee and a number of ad hoc committees that evolved into the Advisory Board of the Office of Addiction Services. These groups helped crystallize and disseminate the emerging vision of the systems transformation process.

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[1] The process was viewed as analogous to Alcoholics Anonymous' Fourth and Fifth Steps*: 4. Made a searching and fearless moral inventory of ourselves. 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.*

Vision: *An integrated behavioral health care system that promotes recovery, resiliency, and self-determination.*

Mission Statement: *To support people in an environment of recovery, with a focus on prevention, wellness, and self determination to facilitate realizing goals and attaining the highest quality of life possible. We will work with consumers/clients, families, and providers to assure that services are accessible, effective, appropriate, and of high quality. We are committed to develop a system of care that is data driven, employs evidenced-based practices, increases cultural competence, and eliminates health care disparities. This integrated system of care will attend to individual needs and preferences and function in collaboration with a broad range of stakeholders.*

This stage involved raising consciousness about recovery, eliciting commitment to a sustained transformation process, and addressing insecurities about the change process and how it would affect individuals and institutions. Budding partnerships were strengthened as key individuals and organizations were involved in planning, hosting, and evaluating the town meetings and conferences that conveyed this new vision.

The shared vision was based on an understanding of mutual limitations and collective strength. The central message mirrors the experience of many in personal recovery: "We can achieve together what we could not achieve alone."

Develop Consensus on the Need to Move from Power to Partnership (Building a Community of Recovery)

Through those early listening exercises, it is important to develop a deep understanding of why prevailing relationship patterns within the system of care must be changed. In Philadelphia, review of feedback from the meetings and focus groups revealed a striking image of relationships throughout the behavioral health care system. Power-based relationships that were governed by real or implied threat and control pervaded the system from top to bottom. Whether viewing relationships between federal and state agencies, state and local agencies, agency leadership and direct service workers, or the relationships between direct service workers and clients and families, focus groups revealed an underlying tone of paternalism, disrespect, and, at times, outright contempt.

The theme that emerged was one of a need to control. Clients are controlled by counselors, who are controlled by supervisors, administrators, and boards, who are controlled by state, federal, and private funding and regulatory agencies, who are controlled by the larger political entities to which they are accountable. Competition, conflict, and struggles for status, power, and resources too often colored relationships. With the multiple interests involved, it is easy to see how the focus on the needs of individuals and families can get lost. The restructuring of relationships to emphasize service consumers at the top of this hierarchy or more ideally, to flatten this hierarchy, is a major goal of systems transformation.

Other issues that emerged in focus groups were distrust and "game playing." From clients to macro system administrators, the system consisted of closed tiers with those in each tier viewing the tiers above and below through a perceptual lens of deficits

and an attitude of condescension. Such relationships may be inherent within hierarchical systems, but this seems to be magnified in systems dealing with highly stigmatized issues and groups of people. The distrust and disrespect that pervades intrasystem behavioral health care relationships may well reflect the internalization and institutionalization of the social stigma attached to addiction and mental illness. The question raised in the Philadelphia transformation process was how to best move from this atmosphere of power-based relationships toward one marked by deep and sustained respect and collaboration.

As discussions between representatives of DBH/MRS and other system representatives continued and relationships moved beyond role-scripted communications, there was growing consensus that a new recovery-focused philosophy was needed not only for clients and families but for the system as a whole. Several emerging tenets of that philosophy emerged, including the following core ideas:

- We are all wounded (imperfect).
- Both the elements of the service system and the service system as a whole are wounded (imperfect).
- The service system and its practitioners have taken on some of the characteristics of the disorders they are expected to treat, e.g., denial, projection of blame, grandiosity, self-centeredness, preoccupation with power and control, and manipulation.
- We all need to recover—individually and as a system of care.
- We need to recover together.

These points provide a means of escaping the "we-they" polarizations that split communities, professional fields, and organizations into warring camps. They provide an esteem-salvaging answer to the central question underlying resistance to change: "Are you saying that everything I've been doing is wrong?" They create a "we" position from which everyone can acknowledge that the support provided in the past had value but, when provided in isolation, was often ill-timed and sustained for far too short a period of time. These points also helped create a learning community capable of taking the risks inherent in successful transformation. They also openly acknowledge that stakes are high, that hope has been raised, that we are all now invested, and that the costs of failure are very high.

Develop New Values to Guide System Relationships

To facilitate the healing and renewal of the Philadelphia behavioral health care system, DBH/MRS leadership increased relationship-building activities across the boundaries of system components and sought to model key values that would lead to more supportive relationships between system constituents. The values displayed below were those it was felt DBH/MRS had to exemplify in order to change relationships throughout the behavioral health care system.

Values Guiding Partnership Development in the Systems Transformation Process
Hope: Sustained recovery and its rewards are possible for individuals, families,

neighborhoods, and communities.

Respect: Treat all system stakeholders with courtesy and appreciation of their unique strengths and contributions; negotiate rather than dictate; gain trust by giving trust.

Strength: Build on existing assets, emphasizing past traditions of commitment, innovation, and excellence; recognize and celebrate transformation efforts.

Transparency: Make the criteria upon which decisions are made and the decision-making process visible to all people affected by the decision, e.g., from backroom decision-making to picture window decision-making.

Inclusion: Involve the people who will be affected by a decision in the decision-making process; cultivate mutual learning, interdependence, and reciprocity of support.

Fidelity: Make only promises you can keep; keep the promises you make.

Honesty and Candor: Tell the truth; when wrong, promptly admit it and make amends, e.g., "I made a mistake; it is my responsibility to correct it; I will correct it."

Forgiveness: Expiate and let go of past; expect some regression to old styles of interacting, promptly acknowledge such regression and correct it.

Consistency and Endurance: Stay on message and sustain the effort; transformation, like recovery, is not an event but a prolonged process.

Throughout the systems transformation process in Philadelphia, people were invited to step forward and were provided forums to tell their recovery stories—stories that told how things were, what had happened to change their lives, and what their lives are like now. We tried to emulate that storytelling style by creating a parallel story of how things were for the service system (a rigorously honest account of system assets and aberrations), what happened to spark positive change in the system, and what things are like now. We sought to create a story of how wounded systems can begin a recovery process that parallels the recovery processes of those they serve.

Begin the Transformation and Partnership Process Internally

The Philadelphia behavioral health system has rapidly evolved since the closing of the Pennsylvania state hospital system. Prior to 2004, Philadelphia's behavioral health services were provided through the administrative umbrella of the Office of Behavioral Health and Mental Retardation (OBH) via four distinct organizational units: the Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP), the Office of Mental Health (OMH), Community Behavioral Health (the nation's first municipality-owned managed behavioral health care organization), and Mental Retardation Services.

In 2004, an executive order was signed and the Office of Behavioral Health and Mental Retardation became the Department of Behavioral Health and Mental Retardation Services (DBH/MRS). A key principle guiding system change in Philadelphia has been that the organization leading systems transformation must begin the change process internally. That understanding was reflected in the following activities:

- Internal focus groups were conducted about how to more effectively promote recovery orientation within DBH/MRS and the system as a whole.
- Education and training about recovery was required for all DBH/MRS staff.
- Recovery representation within DBH/MRS was increased by hiring people in recovery as DBH/MRS staff and consultants and by recruiting recovery volunteers for DBH/MRS workgroups.
- Cross-unit collaboration via internal workgroups and ad hoc task forces was increased.
- Community representatives were included in internal committees and work groups (e.g., Fiscal, Monitoring, IT).
- Units across the organization were required to develop "unit recovery plans" to identify specific ways their work could be changed as a result of the system moving to a recovery orientation.
- Leadership training.

Within the newly integrated DBH/MRS, the Office of Addiction Services was created (December 2005) to serve as the Single County Drug and Alcohol Authority and to oversee activities related to the funding, coordination, and integration of prevention, screening/assessment, early intervention, primary treatment, and recovery support services. It was in this role that existing partnerships were evaluated and revived and new partnerships were forged.

Much of the early transformation process focused internally on DBH/MRS via increased recovery representation within the DBH/MRS staff, extensive training, and significant input from community constituents on how DBH/MRS polices and practices needed to be re-aligned with system transformation goals. As the transformation process proceeded, each division of DBH/MRS was asked to formulate the role of their unit in the systems transformation process and the activities within the unit that would support the goals and priorities within the transformation process. Each unit plan detailed the internal and external partnerships critical to the plan's success.

Create Partnership Planning and Advisement Structures

The behavioral health systems transformation process in Philadelphia required a fundamental reconstruction of all relationships within the service system. The structures created to effectuate this relationship reconstruction included (in the sequence in which they were created): 1) a Recovery Advisory Group (Fall 2005), 2) a Systems Transformation Steering Committee and four issue-specific workgroups (Faith-based/Grassroots Initiative Workgroup, Evidence-based Practice Workgroup, Trauma Workgroup, and Cultural Competence and Health Disparities Workgroup), four ad hoc groups to do systems-level planning related to authorization of care criteria, length of stay criteria, criminal justice/forensic services, and strategic planning. The work of these early

groups was then integrated into a newly created Office of Addiction Services Advisory Board in June 2007. The OAS Advisory Board quickly created a Subcommittee on Children and Adolescents. The partnership model that emerged through the work of these structures included six distinct goals.

The first goal was to enhance the partnership between addiction treatment service agencies and the individuals and families they serve. Mechanisms that helped facilitate this partnership included:

- Increasing recovery representation and client representation within addiction treatment agency decision making (e.g., encouraging development of consumer councils, alumni associations, recovery advisory boards, and recovery volunteer programs)
- New service planning frameworks (vision of a rapid transition from professional-directed treatment plans to client-directed recovery plans)
- Celebrating the role of recovering individuals and families via recovery celebration events, e.g., recovery conferences.

The second goal within the partnership model was to increase partnership activities between addiction treatment providers and between these providers and other community service institutions. Every effort was made to move what had been "backroom" meetings with individual providers to open forums that included all service providers and their representative groups. Joint proposals for multi-agency service projects were encouraged and efforts were made to weaken the competition between providers by celebrating the collective achievements of the provider network.

Goal three entailed strengthening the partnership between DBH/MRS, its contracted service providers, service consumers, and local communities of recovery. A key step in this process was the creation of the above-noted structures that allowed input into DBH/MRS policy-making. The work of these groups produced a series of documents (e.g., Blueprint for Systems Transformation, Office of Addiction Services Strategic Plan) that went through extensive stakeholder review and comment before being adopted. Other strategies to enhance the relationships between DBH/MRS and its closest stakeholders included:

- Involving other key organizations in the recovery transformation process, e.g., leaders from criminal justice, child welfare and family services, public health, and homelessness programs
- Visiting grassroots recovery support organizations and rotating meeting locations to increase contact between service organizations and within their natural environments
- Supporting development of the recovery community center as an effort to extend the existing treatment culture toward a broader community of recovery
- Utilizing community reinvestment dollars to fund recovery support services not reimbursable through traditional funding sources.

The relationship between DBH/MRS and its contracted service providers had evolved into an adversarial stance over a number of years. Including individuals and family members in recovery in all advisory groups, meetings, and conferences softened

that tension by reminding staff from both DBH/MRS and provider agencies that "This is not really about you." The whole system became much more client-focused through this inclusion and interaction.

As system administrators, we had to shift from a speaking position to a listening position, from a stance of direction to one of facilitation, and from a position of authority to one of true partnership and collaboration. As those relationships were forged one agency at a time, it was also necessary to create rituals that provided an opportunity to set aside "bad blood" that had developed in the past and negotiate new ground rules for proceeding forward. This was not an easy or quick process and entailed much testing and minor and major relapses on both sides. The following mutual understandings and commitments helped:

- We will occasionally regress to old patterns of thinking and acting, and we will continue to make mistakes.
- When wrong, we will promptly admit it, make direct amends, and recommit ourselves to the partnership and the new ground rules.
- We will periodically evaluate the partnership relationship to evaluate the extent to which we are achieving our aspirational values and take action to move us closer to those values.

Greater efforts were also made to conduct regular meetings with all program administrators to insure consistency of communication and their participation in the transformation process.

The fourth partnership goal called upon DBH/MRS to increase its direct contact with indigenous recovery support institutions. It was through this initiative that DBH/MRS began to explore how the resources of other community institutions, (e.g., recovery advocacy organizations, recovery community centers, the faith community, etc.) could be mobilized to help initiate and sustain long-term individual/family recovery. These involvements reminded us that recovery transcends what happens within the walls of a treatment center and helped us visualize a continuum of support that integrated both professionally-directed clinical services and non-clinical recovery support services for individuals and families.

Goal five involved more closely aligning DBH/MRS goals and activities with the broader community development goals and activities of the City of Philadelphia. The intent was to create a synergy of enhanced impact by aligning multiple efforts. Efforts were made to link our planning efforts to three concerns that were galvanizing the Philadelphia community: 1) homelessness, 2) violence, and 3) the service needs of children and adolescents.

The final partnership goal was to increase recovery community capital in Philadelphia by enhancing the relationship between DBH/MRS and state, regional, and national initiatives. Key activities here included:

- Co-hosting a SAMHSA/CSAT/ATTC/DBH/MRS conference on recovery-focused systems transformation
- Providing training and consultations to other states and cities wishing to emulate aspects of the Philadelphia systems transformation process

- Participating in national efforts congruent with local system transformation goals, e.g., using processes developed by the Network for the Improvement of Addiction Treatment to enhance client access to services, reduce client no-shows, increase admissions to treatment, and enhance treatment retention
- Volunteering Philadelphia as a "laboratory for recovery transformation" to facilitate statewide systems transformation efforts in collaboration with the following state organizations: 1) the Department of Public Welfare Office of Mental Health and Substance Abuse Services, 2) the Department of Health Bureau of Drug Abuse Programs and Division of Alcohol and Drug Program Licensure, and 3) the Governor's Office of Policy and Planning
- Working to align the state's "Recovering Pennsylvania" initiative and Philadelphia's recovery-focused systems transformation process, e.g., efforts to align policies to support behavioral health service integration via recovery-focused funding policies.

Create a Transformation Blueprint

The larger number of activities generated by systems transformation, and the system maintenance functions that must occur simultaneously, can threaten to derail the change process by creating overload and a sense of chaos. Avoiding or managing this potential requires creation of a system transformation blueprint that precisely details the desired and planned changes, when such changes are expected to occur, how such changes will occur, what groups and individuals are responsible for leading each change initiative, and the resources required to implement and maintain each area of change. Early system transformation priorities focused on seven key areas: 1) community inclusion/opportunity, 2) holistic care, 3) peer culture/peer support/peer leadership, 4) family inclusion and leadership, 5) partnership, 6) extended recovery support, and 7) quality of care. How these priorities were to be addressed were set forth in two documents: the recovery transformation blueprint (Fall 2006) and the Addiction Services Strategic Plan (Drafted in the fall 2006 and refined through extensive review and comment through 2007) (see http://www.phila.gov/dbhmrs/strategicplanning/spi_re_intro.html).

The development of a blueprint and strategic goals and objectives provided a means of focusing and integrating existing and new initiatives and provided a conceptual map that helped minimize discouragement about the sheer enormity of what was being attempted. There were numerous points in which energy of groups seemed to wane. Evaluating and recognizing progress being made on the blueprint and strategic plan helped re-energize people. Efforts were made to balance each meeting with a celebration of progress and work on next steps, keeping in mind that systems transformation is a long journey. To acknowledge this, one of the authors (Lamb) developed the ritual of opening or ending each meeting with the mantra, "The struggle continues—The victory is certain!"

Provide Tools and Contingencies to Support Partnership

Early responses to systems transformation within the recovery advocacy and treatment provider communities went from resistance to skepticism to commitment at a conceptual level, but fears continued about what this would all mean. Historically, the main DBH/MRS partnership was its relationship with its funded treatment agencies. There was some initial resistance from treatment agencies to DBH/MRS's expansion of its partnerships to include such groups as recovery advocacy and support organizations and faith organizations. Treatment providers feared a loss of status and a potential loss of the resources that would be diverted to support these other initiatives.

Those fears and pockets of continued resistance were addressed by: 1) developing consensus on precisely how service practices would change within a recovery-oriented system of care, 2) providing concrete tools to help implement those practices, 3) providing incentives (acknowledgment and funding enhancements) for recovery-focused practice alignment and innovation, and 4) providing technical assistance to organizations having difficulties with the shift in philosophy and practice. Key activities in these areas included:

- Conducting recovery storytelling training to enlarge the number and skills of local recovery advocates
- Involving key treatment providers in the Network for Improvement of Addiction Treatment (NIATx) to enhance local providers' access and engagement protocols
- Working with PRO-ACT to distinguish the roles of sponsor, recovery coach, and addiction counselor
- Working with PRO-ACT to develop ethical guidelines for the delivery of peer-based recovery support services
- Developing new treatment and recovery support approaches via piloting, evaluation, and encouragement for system-wide implementation, e.g., the structure and activities of the NET Consumer Council
- Providing financial incentives to enhance recovery support services within medication-assisted treatment

Highlight the Fruits of Recovery Partnership

Restructuring behavioral health care systems goals and relationships is rigorous and at times exhausting work. Celebrating the fruits of recovery partnership can help sustain investment in the transformation process. Everyone—from clients to local treatment administrators, from allied agencies to mayors and governors—needs to see and celebrate the fruits of systems transformation. Concrete manifestations of systems transformation in Philadelphia included the following:

- Involvement of national leaders on recovery and systems transformation to motivate and educate local system stakeholders
- Extensive training on trauma, wellness, and recovery and funding of new service initiatives for the integrated treatment of co-occurring disorders
- Recovery celebration events (e.g., marches, conferences) that created a way to honor the efforts of individuals and families in recovery and other individuals and organizations who are playing key roles in the system transformation process
- The opening of Philadelphia's first recovery community center, which served more than 2,300 individuals in its first seven months of operation

- Mini-grants to 65 organizations to enhance their organizational transformation efforts or to seed new recovery support services
- Creation of seven coalitions between community-based organizations and faith-based organizations with behavioral health treatment providers to address prevention and recovery support needs within key neighborhoods within the City of Philadelphia
- A 26-week Peer Leadership Academy through which more than 60 individuals and family members in recovery have been trained to assume leadership roles in Philadelphia's recovery-focused systems transformation process
- A Peer Specialist Initiative through which more than 140 individuals in recovery were trained and hired within the Philadelphia behavioral health care system.

The recovery celebration events in particular provided a vehicle for celebrating personal, organizational, and systems recovery. These events included conferences that brought together recovering people, addiction professionals, and allied service professionals for dialogue; conferences with more than 1,000 attendees that were organized, facilitated, delivered, and evaluated by people in recovery; and large public celebration events such as the 2008 Recovery Walk, which drew more than 4,500 individuals. A pivotal point in the history of systems transformation in Philadelphia occurred when Mayor Michael Nutter stepped to the podium at the March 28, 2008 Recovery Conference to address recovering individuals, family members, addictions professionals, and allied service professionals. When those 1,200 participants stood to see themselves and be acknowledged by local political leaders as "a community," it was a "coming of age" moment for the systems transformation movement in Philadelphia.

Build Institutional as Well as Personal Relationships

There is a tendency to grossly underestimate the time that will be required to transform a complex service system. This has important implications for partnership development within systems transformation. More specifically, key institutional partnerships cannot be based solely on the relationships involving a small number of key individuals. What we painfully learned in Philadelphia is that unexpected events such as job re-assignments and prolonged sick leaves can disrupt partnership development when such partnership efforts are based on a small number of key leaders. The lesson here is that partnerships between organizations must be built from the top down and across organizations so that these are institutional relationships rather than person-dependent relationships. Philadelphia, like most cities, also has a core of long-tenured behavioral health leaders who will retire in mass in the next decade. Any partnerships forged as part of the systems transformation process must be able to survive these coming leadership transitions.

Develop Ways to Measure Partnership

There are so many simultaneous initiatives occurring within a systems transformation process that it is difficult to see what progress, if any, is being made. Within each partnership structure, we found it helpful to evaluate how we would know if a particular

effort was successful. Here are two examples of how this was achieved. When the OAS Advisory Board was established in 2007, we conducted an exercise in which the founding members were asked to fill in the following sentence: *The OAS Advisory Board will be a success if a year from now* _____. Table 1 in the appendix lists the criteria that were generated and the Board's evaluation based on those criteria a year later. We found this process extremely helpful in evaluating the work of the advisory committee based on criteria generated by the committee members themselves.

Systems transformation involves significant shifts in policies and practices, and we found it important to help people personalize these needed shifts. One of the methods we used to do this was a series of Tools for Transformation documents. Each of these documents looked at a particular area of service practice, e.g., extended recovery support services, and provided separate checklists through which DBH/MRS staff, service providers, and individuals/families in recovery could evaluate themselves related to this area. All of these checklists evaluated the quality of partnership relationships and offered potential strategies for strengthening partnerships related to each area being evaluated.

We are currently developing Report Cards for both DBH/MRS funded organizations and the overall systems transformation effort. We are also currently defining the micro- and macro-level recovery benchmarks to measure systems transformation and refining data systems to assure that such benchmark data can be consistently collected and analyzed.

The Stages of Systems Recovery

Prochaska, DiClimente, and Norcross (1992) have outlined a model for understanding the stages of personal recovery. These stages also approximate the stages of recovery-focused systems transformation in Philadelphia as experienced by contracted treatment providers and DBH/MRS staff. Table 2 outlines such changes and the stage-dependent strategies used to move the transformation process forward.

Table 2: The Stages of Systems Transformation

Stage	Attitude toward Overall Systems Transformation	Attitude toward Partnership Development	Core Strategies
Pre-contemplation	Program Level: everything is fine; treatment works; we just need more money to do more of what we're currently doing; we are already recovery-oriented; no one will pay for this recovery stuff. Systems Level:	Isolation or limited contact between system stakeholders and between stakeholders and the larger community; tendency to view other stakeholders as "not getting it"; treatment programs and other community agencies	Listening exercises (focus groups with clients/families and providers); education and consciousness raising via charismatic leaders; solicitation of internal and environmental feedback;

	System design is fine; we just need to elevate quantity and quality of existing services by providers.	view each other as resource competitors.	promoting strategies of self-evaluation;
Contemplation	There are significant problems with the current design of addiction treatment but obstacles to addressing them are insurmountable; recovery-related practice changes considered periodically but lost amidst distractions; efforts lost in culture of low funding, low expectations but high demand for services.	Possible advantages of new partnerships enter organizational consciousness and are periodically discussed without follow through; professionals begin raising questions about ethics of self-disclosure and dual relationships.	Insight development; pro and con analysis of change or no change; use of critical incidents as opportunity for eliciting commitment to change; recovery-focused education and training conducted at conceptual and attitudinal level; insight-oriented interventions; promoting inter-organizational boundary transactions; expanding inclusiveness of who is brought to table; e.g., use of national and local recovery advocates to challenge status quo
Preparation	We have decided and are committed to making major changes in service philosophy and practices to increase long-term recovery outcomes; goals are set to begin this process within the coming year. Still	We have identified key internal and external partnerships that need to be strengthened. We are spending more time in self-evaluation and environmental scanning, but have	Self-assessment and planning tools developed for individuals and organizations; increased availability of training and technical assistance; mutual stakeholder support for

	more talk than action.	not moved from planning to implementation.	processing planning activities.
Action	We are making recovery-focused changes in service philosophy, policies, and practices. We are moving through superficial changes toward the achievement of substantial changes. Many change-related activities are continuing. The transition from old to new is variably experienced as overwhelming, chaotic, and exhilarating. We decide we cannot do this alone; request and mobilize help and ongoing support. Unit recovery plans developed within DBH/MRS to actualize each unit's role in transformation process.	Intra- and intersystem boundary transactions have increased dramatically; we are involved in multiple internal and external change initiatives; each program/unit contains early adopters and resisters; change process absorbs latent conflict between individuals, units, and organizations; resisters are progressively isolated.	Systems transformation defined in behavioral terms; contingency management—making system rewards contingent on pro-recovery policies and practices; increased availability of training and technical assistance; intersystem transfer of new recovery tools, e.g., mechanisms for recovery representation, recovery planning formats, recovery checkup protocol; focus on getting system aligned, coordinated, and integrated across local, state, and federal levels.
Maintenance	We have come a long way but still have to catch ourselves when we slide into old patterns of thinking and acting, particularly during periods of distress, e.g., funding crises.	Rituals of regular gathering defined with high level of participation, e.g., advisory council meetings, annual recovery conferences, recovery celebration events.	Procedures for fidelity monitoring and refinements in service philosophies, policies, and practices; continued freshening of celebration and recognition ceremonies; acknowledgment

			and visibility, e.g., use of internal leaders as consultants to other communities; pride in whole system as a community of recovery.

Like individuals in recovery, it is not unusual for systems to cycle through these stages multiple times before achieving a sustained and successful transformation process.

The stages involved in partnership development through the systems transformation process are illustrated in the history of the Advisory Board of the Office of Addiction Services. There have been three stages in Advisory Board composition: 1) a balance sought between OAS staff/consultants, providers, people in recovery, and representatives from other systems and city departments, 2) conscious inclusion of child and adolescent advocates, and 3) a move to increase recovery representation. The meeting format transitioned from information dissemination to board discussion and recommendations to OAS to an increased role in OAS decision-making. The planning and facilitation of Advisory Board meetings also went through distinct stages:

1. OAS staff established agenda and facilitated the Advisory Board meetings.
2. OAS staff established agenda and an OAS consultant facilitated the meetings.
3. Stakeholder (provider and recovery advocate) co-chairs established for the Advisory Board.
4. Co-chairs included in agenda setting for all meetings.
5. Co-chairs assumed responsibility for facilitating the meeting, with consultants available to facilitate particular agenda items

Two future steps are planned: 1) training OAS advisory member volunteers in meeting facilitation, and 2) co-chairs facilitating the meeting, with other members facilitating meeting agenda items. The working style of the board has also changed from one of all work being done during the board meeting to workgroups between meetings reporting out and facilitating discussion on key issues. All of these changes reflect concrete ways in which relationships based on power and authority are changing to relationships based on partnership.

“Deeper and Broader”

We are four years into the systems transformation process in Philadelphia and are again evaluating our progress to date. As we pull stakeholders together as part of this evaluation process, the theme of “deeper and broader” resounds in meeting after meeting.

The “deeper” reflects calls to move the change process and the existing partnership relationships from areas that generated rapid consensus to areas that touch on areas of greater threat to vested ideas and interests. “Deeper” also means that the vision and core values of the change process have been formulated and that it is now time to let that vision and those values permeate all system policies and practices. Moving from small changes to big changes builds momentum and hope for the overall transformation

process. It also reflects a larger recovery vision of outward healing from individuals, families, organizations, neighborhoods, and whole communities. In terms of partnership, "deeper" also implies that building partnership relationships is not a task with a defined beginning, middle, and end. These partnership relationships must be regularly fed and deepened or they will die from lack of attention.

The "wider" suggests that not all community stakeholders were equally engaged in the transformation process and that we need to reach out to those groups and bring them into the transformation process. Discussions to date in Philadelphia regularly note that we need to more clearly define and adapt the transformation process for such groups as child and adolescent service providers, medication-assisted treatment providers, and treatment providers closely linked to the criminal justice system—groups who have not always felt like they were full partners in the transformation process. Similarly, not all units within the Department of Behavioral Health and Mental Retardation Services were equally involved or supportive of the transformation process.

We anticipate that our intensified involvement with these external organizations and internal units will generate new lessons and further refine the transformation process. We suspect that transforming any large, complex behavioral health organization or system will need to unfold in layers and waves. With sustained effort, involvement can be achieved even from those inside and outside the lead agency who believed that recovery-focused systems transformation was a passing fad that they could wait out.

Summary

In 2005, the City of Philadelphia committed itself to creating a more recovery-oriented system of behavioral health care for its citizens. A central component of this transformation process was the reconstruction of relationships between the multiple stakeholders involved in the City's behavioral health care system. This paper describes the partnership model that has been so critical to the success of work to date toward this goal.

Essential steps in this process included:

- A sustained exercise in listening
- Conducting a self-inventory of the state of system relationships
- Developing the vision of a transformed system of care
- Generating consensus on the need to move toward a partnership-based versus power-based relational model
- Forging consensus on partnership values to which all parties would be accountable
- Beginning the transformation process internally to model commitment to new values
- Creating structures through which new partnerships could be initiated and sustained
- Developing a transformation blueprint/plan that defined goals, roles, and relationships
- Providing tools and contingencies (rewards) for movement toward partnership model

- Visibly celebrating the fruits of transformation and the new partnerships that were created through the transformation process
- Creating institutional partnerships that are not dependent on only a small number of key people
- Recognizing that partnership development will take sustained time and effort and will develop in stages across multiple stakeholder groups
- Measuring system relationships as part of the larger evaluation of system transformation efforts.

Transforming behavioral health care systems involves at its essence transforming the relationships within such systems. It is our hope that other communities can benefit from the Philadelphia experience of how we have attempted to manage the pitfalls and potentials through a sustained transformation process.

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Appendix

Table 1: Department of Behavioral & Mental Retardation Services, Office of Addiction Services Advisory Board, Benchmarks for Success

The members of the OAS Advisory Board identified benchmarks for success during their July 18, 2007 meeting. This worksheet was completed a year later to assess the Advisory Board's progress.

Please circle the status of the benchmark as:
A = Accomplished B = Making progress C = Improvement needed
D = Deteriorating E = N/A

A year from now, we would have been a successful Advisory Board if we…

1.	have identified a series of concrete, achievable priorities for system transformation and outlined the steps necessary to achieve them and measure their success.	A 3	B 4	C	D	E 1
2.	have developed, implemented, & communicated a strategic plan with a vision, goals, priorities, & strategies of implementation.	A 5	B 2	C	D	E 1
3.	have implemented at least 1-2 new initiatives, either a new program or strategies to enhance/modify existing programs.	A 5	B 2	C	D	E 1
4.	have a plan that is initiated and introduced at a conference for all stakeholders – conference will broadcast the vision and promote change actions by all stakeholders.	A 3	B	C 2	D	E 1
5.	have developed a plan that truly affords barrier-free access to recovery.	A	B 5	C 3	D	E
6.	have followed through with our discussions.	A 1	B 6	C	D	E
7.	are still meeting.	A 5	B 3	C	D	E
8.	have accomplished some of the tasks outlined today (July 18, 2007 orientation meeting), such as addressing issues of line staff by developing more training and reducing the paperwork.	A	B 5	C 3	D	E
9.	have learned from one another how to put people first and ourselves next.	A 3	B 6	C	D	E 1
10.	have an environment where people are receiving better	A	B	C	D	E

	services/treatment including compassion and understanding.	1	5	1		
11.	have an environment where people will have an opportunity to succeed in life.	A 1	B 5	C 1	D	E 1
12.	have put our plans into action.	A 1	B 6	C 1	D	E
13.	have stimulated the production of a working operational plan for OAS.	A 1	B 6	C 1	D	E
14.	have achieved our organizational goal.	A	B 8	C	D	E
15.	have people who have primarily been excluded from addiction services or have been underserved by the system have full and unfiltered access to a fuller continuum of services.	A 1	B 2	C 4	D	E 1
16.	there is evidence of greater collaboration among service systems in terms of actual utilization and service plan achievement.	A 1	B 4	C 1	D	E 1
17.	if 60% of the addiction services providers have adopted or been adopted by a church, mosque, synagogue, or community center that has opened its doors to the consumers.	A	B 2	C 4	D	E 1
18.	have seen more addicts get help and stay clean.	A	B 3	C 4	D	E 1
19.	Have allowed our group conscience to lead and guide us.	A 1	B 4	C 1	D	E 2
20.	have created a vision for a recovery-oriented service system.	A 5	B 3	C	D	E
21.	have a vision that is used to develop a plan to implement the vision (stages of change management).	A 2	B 4	C 1	D	E 1
22.	have a plan with clear bench marks to measure the achievement of each element of the plan.	A 1	B 5	C 2	D	E
23.	have families that are part of the team and allowed to take part in all areas of their child's treatment.	A	B 6	C 1	D	E
24.	have an increased climate of trust and partnership between CBH, providers, and the community.	A	B 5	C 2	D	E

25.	have good programs rewarded and programs that hurt people and refused to change (after much effort on DBH part) are de-funded.	A	B 2	C 6	D	E 1

OAS Advisory Board: Benchmark worksheet July 2007
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