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"The Struggle Continues, The Victory is Certain"
Transforming Addiction Treatment and Recovery Support in Philadelphia

An Interview with Roland Lamb
Office of Addiction Services,
Philadelphia Department of Behavioral Health
and Intellectual disAbility Services

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Introduction

For much of the past decade I have had the privilege of consulting on the recovery-focused transformation of the City of Philadelphia's behavioral healthcare system. That work has been one of the richest learning experiences of my professional career and the most personally rewarding due in great part to the opportunities to work with Dr. Arthur Evans, Jr. and Roland Lamb. After recently completing interviews with Dr. Evans, I enticed Roland to be interviewed about his perceptions of the systems transformation process. On my many visits to Philadelphia, I was continually in awe of the pace at which Roland operated and the breadth of knowledge and skill and personal passion he brought to this work. Please join me in this engaging conversation.

Personal/Professional Background

***Bill White*:** Roland, perhaps we can start this discussion by exploring how your background influenced your later work in Philadelphia. Service to others and to the community seems to be part of your DNA. Can you describe the roots of this commitment?

***Roland Lamb*:** I come from a long line of Baptist ministers (on both sides of my family) and from a family ethic of service. Commitment and dedication to service are not acts but a way of life and key to my salvation. No matter what I did, it was instilled in me that I had something better to

do, and my life was and is not complete if I am not doing it. I came to believe that my life was to be a ministry. My own experiences, struggles, and strengths are central to my constant awareness of my character, and my growth. And that struggle continues.

***Bill White*:** When and how did you enter work in the addictions field?

***Roland Lamb*:** My formal entrance into the addiction field began shortly after graduating from college in 1973. I began work at what was then St. Luke's Hospital Helen Goldman Clinic Methadone Maintenance program. After my second week on the job, I was stabbed in the neck by a program participant who took exception to my interceding in his beating of a female program participant. (From that experience, I learned that staff should always be there for each other and that programs should at least be safe.) I was hospitalized and, believe it or not, continued to explore addiction treatment as a career specialty. In addition to the methadone clinic, I began working on the weekends in what was then the Lower Kensington Environmental Center (LKEC) known as the Firehouse. It was part of a fledgling organization known as Northeast Treatment (NET), one of the early Therapeutic Communities in Philadelphia. A year later, I went to work for what was then Philadelphia Psychiatric Center (PPC) in their Multi-Agency Adolescent Poly-drug Program (MAAPP). I went into high schools to work with kids at risk and/or identified as having alcohol and other drug problems. I worked out of the Westminster Clinic—PPC's community-based Outpatient Drug Program—and later became a counselor in their outpatient adult program.

For me, this was the golden age of drug treatment. The Federal eight-year treatment grants were in effect, and I had a great deal of exposure to the growing science of addiction treatment. Led by Dr. Al Friedman, PPC D&A programs were cutting edge. I was exposed early on to family therapy and had the opportunity to attend the orientation at the newly established Family Institute. I had the opportunity to participate in the Child Guidance Program and was introduced to Jay Hailey, Duke Stanton, and Ivan Nagy. Most importantly, I was supervised by Dan Gottlieb, worked with a wonderful staff, and was mentored by Sam Sylvester from the University of PA.

When the 8-year grants expired, I collaborated with staff of three community-based clinics run by PPC to form Parkside Human Services—a minority-run organization. As Director of the methadone clinic, I had the opportunity to work with Thomas McLellan, George Woody, Dave Metzger, and Dave Zanis of the Treatment Research Center of the University of PA (this was before it became the Treatment Research Institute). I later worked with Paul Fudala on the Levo-Alphaacetlyemethadol Study in Philadelphia. I also collaborated with Dr. Altha Stewart on the National Basketball Association (NBA) Player's Aftercare Program. My professional development has also been greatly influenced by my associations with Reverend Henry Wells of One Day At A Time (ODATT), Dr. Benny Primm, Arthur C. Evans Jr., and my work with you over these past years.

***Bill White*:** I want to explore in some depth your work with the recovery-focused systems transformation process in Philadelphia, but could you first describe your work in Philadelphia before Dr. Arthur Evans, Jr. arrived in 2005?

***Roland Lamb*:** I have always been blessed to be around great visionaries who have been motivators and caretakers of my enthusiasm. In addition to the folks I have mentioned earlier, I had the opportunity to work with Estelle Richman, formerly Philadelphia's Health Commissioner, Director of Social Services, Managing Director, PA Secretary of Welfare, and currently the Chief Operating Officer for the U.S. Department of Housing and Urban Development. Estelle was the visionary behind the first municipality-run managed care organization, Community Behavioral Health (CBH). She invited me in 1996 to be involved with the early development of CBH

and the creation of the Office of Behavioral Health, which combined the County authorities of the Office of Mental Health and the then Coordinating Office of Drug and Alcohol Programs. Prior to Dr. Arthur Evans coming, we began the early work of integrating our behavioral health system. So, we had a number of different concepts, initiatives, and system changes that were all on the front burner when Estelle left Philadelphia to become the Secretary of Health for the State of PA. When Arthur arrived, we had had a system rich in resources and talent. Arthur brought a paradigm shift toward an integrated **recovery** model and a heightened passion in person-directed care. He also raised the stakes by challenging us to transform our system within this new recovery-focused vision.

Systems Transformation: Roots and Beginnings

***Bill White*:** Philadelphia had a long and distinguished history in addiction treatment before the systems transformation process began. How would you describe the state of treatment in Philadelphia before the transformation?

***Roland Lamb*:** Treatment rich. Philadelphia has a strong legacy of addiction treatment and recovery, including the legacy of the AA movement in Philadelphia starting in 1940, the Saul Clinic (the first—1945—clinic in Philadelphia strictly for the treatment of alcoholism), Philadelphia General Hospital's first methadone program, and programs like Philadelphia Psychiatric Center, Eagleville Hospital, Gaudenzia, Northeast Treatment, and North Central.

In the '80s, the crack epidemic in Philadelphia gave rise to the recovery house movement. People in early recovery banded together in support of each other's recovery in the very neighborhoods in which their addictions once flourished. Recovery houses began in abandoned homes, then in donated crack houses, and then in property seized from absentee landlords for back taxes. Since then, entrepreneurs have created new networks of recovery residences that became at first an alternative to a difficult to enter treatment system and later an adjunct to treatment providing pre- and post-treatment engagement. Also existing but very low key were some faith-based recovery ministries that worked in tandem with AA meetings in churches.

After the failure of the for-profit managed care of the public behavioral healthcare system and the closing of area State hospitals, the concept of an integrated managed care organization that would be run by the City was proposed that would manage in consort with the IDS, MH, and addiction authorities all of the behavioral health dollars from a single point of accountability.

At the same time, programs of diversion and early release from incarceration were putting more persons into treatment and the Forensic Intensive Recovery (FIR) had been created along with Treatment Court. So, by the time talk first began of systems transformation, Philadelphia had greatly expanded to over two thousand medically monitored non-hospital residential beds, 200 medically managed hospital beds, over 8,000 outpatient/intensive outpatient slots, 4,000 methadone maintenance slots and hundreds of recovery houses (some consistent with recovery, others less so).

***Bill White*:** Given the distinguished work that was already underway, the obvious question is, "Why was there a need to transform addiction treatment in the City of Philadelphia?"

***Roland Lamb*:** I'm thinking of the words of Maya Angelou: *"You did then what you knew how to do. When you knew better, you did better."* With all of our resources we found ourselves with a system that responded well to a crisis, able to deliver a diverse array of service episodes, graduate/complete folks from a treatment episode and send them home. But what we had become was provider-focused and constricted by diagnostic codes that led to deficit-based labeling of those seeking care. We had

become a system of acute care lacking an understanding of and support for long-term recovery. As a result, we found that despite the tremendous efforts of those in recovery and the providers serving them, there was far too much recycling through serial detoxification and readmission to brief residential and outpatient treatment that was disconnected from recovery maintenance supports in the community.

Most of all, we had become a system so preoccupied with deficits, we had difficulty seeing the value in those seeking and in care, those providing care, and even the care itself. We decried the inability of people to get into treatment, stay in treatment, and sustain recovery after treatment. We expected one program to treat the whole person and then release them into the community able to sustain recovery on their own. We were like a drawbridge built with the bridge up and no consistent access to the assets that existed on either side. The community was not closely connected to treatment programs, and treatment programs often lacked strong connections to recovery support resources in the community.

***Bill White*:** Could you elaborate on this drawbridge metaphor?

***Roland Lamb*:** With respect to those seeking recovery from addiction and the many challenges that come with it, we have done a great job addressing acute/crisis needs of those seeking care. We are managing care in our emergency rooms, crisis centers, and residential facilities. At our best within this model, we screen, assess, engage, retain, treat, and discharge/graduate, but we lack connection to the experience of living a life of recovery in the community and the struggles that come with such an effort. We lack the continuity of care that extends recovery initiation in the treatment setting to recovery maintenance in one's natural environment in the community.

We really are like a drawbridge built with the bridge up. For too long, we have existed with professional treatment estranged from the rich inventory of supports in the community. They have been divided by rivers of funding, diagnostic categories, regulations, and disagreements over particular treatment philosophies. What we are trying to do is bring the community into treatment and bring treatment into the community. To do that, we have had to lower the drawbridge and break down the isolation of these two worlds. One of the ways we have done this is to train and employ recovery specialists who have knowledge of both worlds and serve as a link between these worlds. By investing in the community and in coalitions between grassroots community organizations and treatment providers, we can bring added value to treatment to extend our presence into the community via recovery support services for those in care who need continued supports. Each mutually enhances the other.

Acute care, deficit-based systems contribute to recidivism, a narrow focus on crisis care, disconnected serial episodes of care, and the intergenerational transmission of addiction and related problems. We could have certainly been satisfied with that status quo, but we would not have been able to sustain it. The approach had to change, and the first people who asserted that were individuals and families in recovery.

***Bill White*:** When you look back today, what were the most important first steps in the systems transformation process in Philadelphia?

***Roland Lamb*:** The first step was to acknowledge that our most important resource was *people in recovery*. It was their message of the lived experience of long-term recovery that helped us move beyond just talking about addiction and addiction treatment. They were the ones who convinced us we needed to focus on more than just surviving addiction. We—the Department of Behavioral Health and Intellectual disAbility Services and our provider network—had to build credibility through relationships with those in recovery, their families, and indigenous recovery support organizations within the community.

We had to bring them into the process of defining what we meant by recovery, creating a vision of a recovery-transformed system, and including people at all levels of the discussion and decision-making. There is nothing like seeing people empowered in their recovery take ownership through this process, both for their own recoveries and for the larger systems of recovery support. To achieve this required several things. First, we had to bring together people in recovery from different cultures of recovery in ways that they could transcend the differences that had historically separated them. Second, we had to help everyone in the system—Medical Directors, CEOs, board members, support staff, clinicians, security guards, and each of our own DBH/IDS staff—redefine their roles within this recovery-transformed system. At every level of the system, we needed and began to find recovery champions.

***Bill White*:** What new structures had to be put in place to reflect that vision and those values?

***Roland Lamb*:** When organizations embark on the system transformation process, the first challenge is to establish trust—trust in what you say and that what you are doing is consistent with the vision and values that are being elevated. And you ask them to trust even when you don't yet have organizational and/or system fidelity across all functions. You can promote the values of person-led care, but you have to support that in your operational tactics, such as in what you fund and how you authorize care. So there has to be alignment, coordination, and ultimately integration of the transformation vision and values in everything you do. Not everyone in the transformation immediately gets it. You are going to have early adopters at one end of the stakeholder spectrum and those dependent on the security of the status quo at the other end and in between the majority moving in one direction or the other. It is this middle group that will be most influenced by the consistency of the message and the consistency of our behaviors while the transformation is underway. As some have said, *"behavior doesn't lie; people do."*.

You have to engage in creating a learning environment that at its core encourages the exploration of how concepts become strategy and how strategy becomes tactics, or as Arthur puts it: Concept, Practice, Context. Everyone and every group has to share in living the vision and reinforcing the values. That can only come with the creation of *high performing collaborations and partnerships*.

***Bill White*:** What obstacles stand in the way of such trust-grounded partnerships?

***Roland Lamb*:** One obstacle to transformation is what is perceived as an implied accusation that we have been doing something wrong. This is true whether you are the one seeking treatment and/or in recovery, the provider of care, or one of the various stakeholders involved in the provision of social services, regulating and/or paying for services. Potential defensiveness must be addressed by emphasizing system strengths and the development of new understandings and new technologies that allow us to elevate service practices and their outcomes. This is the foundation the mutual trust, respect, and safety that successful systems transformation requires. That means we have to provide permission to make mistakes and learn from them. If we need for those in recovery to feel its OK to come back even if they have used or made a mistake, don't we also want our providers to feel it's OK if they make a mistake implementing recovery-focused service practices? We are asking providers in the transformation to buy into person-directed care, adopt a holistic wellness approach, validate hope, guarantee choice, provide empowerment, support peer culture and support, encourage leadership, promote community integration, recognize spirituality, and wherever possible, facilitate family inclusion for those they serve. That's a lot for providers to take on.

***Bill White*:** To what extent must the "us versus them" mentality be changed through this process?

***Roland Lamb*:** The field is splintered by multiple divisions: drug-free versus medication-assisted treatments, recovery community versus treatment community, prevention vs. treatment, AA/NA vs. WFS and SOS, and on and on. Those we serve, their, families, and communities are not well-served by such divisions. As we looked at such splits, we began to talk about the fact that we as a community and system of care had been wounded and needed a process of recovery—a process that could restore faith in ourselves and each other and help us (in the words of Rabbi Twersky) recover our humanity. Starting to rise above the "us versus them" has been an important step in the transformation process in Philadelphia.

***Bill White*:** Could you give examples of how this trust philosophy was implemented at multiple levels?

***Roland Lamb*:** I have always been impressed by Arthur's use of the "Y*ou can do it; we can help"* slogan, primarily because it lays the foundation for a continuum of trust. This began for us by just listening as we created forums, workgroups, committees, task forces, and coalitions where people in recovery with lived experience, their families, and neighbors could be heard. We invited them to move beyond their experience of the problem to become part of the solution by helping us transform an entire system of care. We began this with a collaboration with Pennsylvania's Recovery Organization – Achieving Community Together (PRO-ACT) to develop Philadelphia's first Recovery Community Center. We took a road trip together to Connecticut to visit Phil Valentine and Connecticut's recovery centers. We came back and put together a visionary team of recovering persons and in a couple of months, got the recovery center up and running. This could not have happened without the kind of trust we are talking about.

We created working forums that included providers and when we found ourselves in conflict around philosophy, practice, and/or performance, we dialogued. We worked together to correct the problem. This is not to say we don't have problems anymore. On the contrary, in some ways, our problems are more intense because we are at a tipping point in our transformation. Early on, we in the Office of Addiction Services formed working groups to address inconsistencies in what we were saying about care in recovery and how we practiced authorizing and applying diagnostic and placement criteria and managed care. Our early working groups evolved into what is now the Office of Addiction Services Advisory Board that is made up of people in recovery, recovery advocates, a diverse mix of providers, Department staff, stakeholders from the community, academia, and the research community. The board, co-chaired by a provider and recovery advocate, has been an important forum for planning and project implementation.

The Office has been blessed to have the active participation of the Mayor's Drug and Alcohol Commission, which is made up of various community stakeholders and members of city departments. The Commission has for some 15 years sponsored with the Department of Behavioral Health and Intellectual disAbility Services the annual Making A Difference Dinner that has grown to over 400 and awarded and recognized contributors to recovery in Philadelphia from the community, programs, and institutions as well as such notables as Tom McLellan, Bill White, Judge Louis Prezenzia, and Lisa Mojer-Torres. But Bill, more than anything, we have taken every opportunity to celebrate recovery and those who have gone from surviving in their addiction to thriving in their recovery. At every venue, we seek to have people in recovery tell their stories.

We also have continued to improve medication-assisted treatment services within the transformation process. We convened the Methadone Maintenance Treatment providers workgroup (a collaboration with our providers both inpatient/residential and Outpatient, DBH/IDS staff, the State Licensing authority,

and the DEA). Under Arthur's leadership, we have included members of each program's consumer groups in our decision making process. With the guidance of this group, we have been able to expand the scope of services, reduce caseloads, increase co-occurring services via more available psychiatry time, and provide case management.

***Bill White*:** This partnership principle seems to be one of the most important within the Philadelphia systems transformation process.

***Roland Lamb*:** When one thinks of transforming an entire system, it is important to recognize the importance of all of the stakeholders in concept but more importantly in practice. This is why developing and nurturing high performing collaborations and partnerships is crucial as an organizing construct. *Person First* was an organizing principle even before we began the transformation. This was a term that first became a template for high performing collaborations and partnerships with the MH community. Often, the vision of Person-Directed Care is resisted the most by those in recovery we seek to empower as well as those who serve them who we expect to empower them. It certainly is challenging to those providers of formal treatment who hold to a strict medical model. So, it becomes essential to actively partner with both groups as we move the transformation process. Simultaneous to empowering people in recovery and their families and service providers, we needed to reach out to the larger community, including regulatory and political stakeholders, the faith and educational communities, the business community, and the whole spectrum of non-licensed community outreach/support programs.

***Bill White*:** What are some examples of how you did this?

***Roland Lamb*:** We supported partnerships between treatment providers and grassroots community organizations, funded community coalitions, provided grants to community- based programs for recovery-focused initiatives, partnered with recovery advocacy groups such as PRO-ACT, sponsored a number of faith-based recovery initiatives, provided recovery-focused educational forums that brought all these stakeholders together, supported major recovery celebration conferences and events and participated in numerous community health fairs and events. I think our most significant accomplishment has been our persistent inclusion of those in recovery, their families, providers of services, and community stakeholders in all aspects of the transformation process. This is evident in a number of initiatives that span the Mayor's Drug & Alcohol Commission, creation of the Office of Addiction Services Advisory Board, the Child and Family Task Force, the Asian Task Force, multiple homeless initiatives, and collaborations with Philadelphia's child welfare, criminal justice, and education systems.

***Bill White*:** What happens when these new fledgling partnerships begin to be strained or even break down?

***Roland Lamb*:** There are moments of inconsistency that can strain these new partnerships, and it is important to have partnerships that allow for conflict resolution that can reinforce the mutual commitment to the vision and values. For example, when we experienced a disconnect between our efforts to move to a recovery-oriented agenda of care and our continued authorizing of that care from an acute care deficit-based approach, we needed to engage both our internal partners (our staff) and our external partners (those in recovery and providers) in a dialogue about what recovery enhanced treatment looks and feels like. We all had/have to be willing to trust the other in ways that make everyone vulnerable and uneasy. Everyone has to trust that we can make mistakes, and we will all focus on correcting them without focusing on blaming each other or playing the gotcha game. So, when our system acted in ways that were inconsistent with the espoused

vision and values, we convened focus groups of the various stakeholders to address the challenges from every perspective. For several months, focus groups met and became work groups that drilled down on concerns, highlighted corrective strategies, and addressed the immediate crisis that had incurred. Because this process worked so well and we all felt we wanted a real-time way to walk through our system and resolve conflicts, those work groups are now the Office of Addiction Services Advisory Board.

The greatest challenge for us as a system is to trust one another and the process, which brings me to what I call the Caterpillar Chronicles: *Chameleons Change, Caterpillars Transform.* From the new life represented in the egg, to the growth of the caterpillar, to the transformation within the chrysalis, to the rebirth that is the butterfly, we appreciate little of the process if we don't understand the relationship each stage has to the next. System transformation requires that we appreciate each stage regardless how slow, painful, and unpredictable, trusting that the end product is the foundation for a community of recovery. That requires new models of collaboration.

***Bill White*:** How did you manage resistance to allocating a portion of DBH/IDS funds to community organizations that were not among traditional addiction treatment providers?

***Roland Lamb*:** Within the Department, there are different behavioral health, stakeholder, and work cultures that all see themselves and each other's roles very differently. We often lacked information about each other and were prone to maintain obsolete information that reinforced a death grip on our respective technologies, practices, and decision making. The goal with transformation was to get these respective cultures living together as citizens of one Recovery-Oriented System of Care community with changing roles and increased accountability for all. That required leadership within and across these organizational units.

Not satisfied with telling providers to change, we went out and brought in the Network for the Improvement of Addiction Treatment (NIATx) to help us align recovery principles with our own operational tactics. Again, this is Arthur at his visionary best, knowing about NIATx, having a relationship with them, and seeing the integral role they could play in the transformation process. By working with an initial 15 providers around the four simple goals of reducing no-shows, reducing waiting times, increasing access, and improving continuity of care, we began to see improvements in all of these areas. Now, we are working on NIATx Phase V to completely integrate NIATx throughout our entire system, including internal alignment within our own Department.

Empowering People at Multiple Levels

***Bill White*:** Dr. Evans and you were both very consistent in your portrayal of a new model of service relationship. How well did professionals in the system manage the transition from their past role as expert to this new service partnership?

***Roland Lamb*:** I think Arthur should get a lot of credit for how this message has been delivered. There is a risk in any major change effort that the focus becomes what's wrong with the system rather than the potential areas where the system can be improved. The Department could take the same deficit-based approach to providers that we have pointed out as a characteristic of the traditional acute care system. By supporting training and education around evidence-based practices across the network, we are continually reinforcing a new vision of system-wide relationships.

In our traditional systems of care, we seek to cure, rehabilitate, or rid people of their problems. We have seen this as a helping process. With systems transformation, we expect those seeking and in recovery to be served. Rachel Naomi Remen describes this distinction in her *In the Service of Life:*

Serving is different from helping. Helping is based on inequality; it is not a relationship between equals. When you help, you use your own strength to help those of lesser strength. If I'm attentive to what's going on inside of me when I'm helping, I find that I'm always helping someone who's not as strong as I am, who is needier than I am. People feel this inequality. When we help we may inadvertently take away from people more than we could ever give them; we may diminish their self-esteem, their sense of worth, integrity, and wholeness. When I help, I am very aware of my own strength. But we don't serve with our strength, we serve with our Selves. We draw from all of our experiences. Our limitations serve, our wounds serve, even our darkness can serve. The wholeness in us serves the wholeness in others and the wholeness in life. The wholeness in you is the same as the wholeness in me. Service is a relationship between equals.

For one who serves, the first thing one must do is listen, first for affect then for effect. In the relationship, there is an acknowledgment that despite one's addiction, there are untapped resources that can be mobilized to support successful recovery. From this relationship comes esteem for the person in recovery that promotes their recovery efforts and a new role for the traditional helper. So, both the person in recovery and those that serve them experience a transformation in thinking and a new style of relationship.

***Bill White*:** What kinds of actions on your part helped support that transition?

***Roland Lamb*:** Regardless of the initiative, policy, or practice, we tried through the Office of Addiction Services to align, coordinate, and integrate our major initiatives while modeling a new pattern of relationship. We have taken a leadership role in such things as:

- supporting recovery specialist roles throughout the system,
- transforming residential services for mothers with co-occurring disorders,
- advocating recovery-oriented methadone maintenance (ROMM) via the work that you and Lisa Mojer-Torres have done,
- supporting development of the Philadelphia Recovery Community Center,
- mapping recovery housing and related recovery support resources,
- pioneering projects for the homeless, including the Journey of Hope project,
- expanding recovery-focused D&A case management,
- creating the Office of Addiction Services Advisory Board (includes recovering persons in treatment),
- aligning our efforts with the Mayor's Drug and Alcohol Commission,
- introducing telephonic outreach to care management process, and
- soliciting outside resources through the Homeless Engagement Intensive Case Management (HEICM) SAMHSA/CSAT grant and Access To Recovery (ATR) SAMHSA/CSAT grant.

Throughout this process, we have provided training and technical assistance to providers and incentivized recovery-focused treatment enhancements.

We assertively seek out collaborations and partnerships both internally and externally consistent with the vision and values of the transformation. We continue to promote the involvement of recovering persons throughout our planning process. We are currently involved in the implementation of the recently published Practice Guidelines. We maintain many of the mechanisms that give those in recovery and treatment programs access to the Department and the decision making process. We have been a leader in

supporting the partnership with our regional recovery advocacy partner, Pennsylvania Recovery Organization Achieving Community Together (PROACT), we are also reinforcing our system vision and mission with our other community stakeholders/partners such as Community College, Temple University, University of Penn, One Day At A Time, New Pathways, and the Recovery Community Center. We have also continued to support Recovery Houses and Recovery Enhanced Treatment Services through the continuous reassessment of how we are using our resources. All of these are examples of new service partnerships.

In a recovery-oriented system of care, the terms treatment and therapeutic are expanded to include services that support long-term recovery. That means we now have to adjust how and what we fund. It's no longer satisfactory to just "graduate" from treatment. Treatment represents just one event within the larger and more enduring process of long-term recovery. Our service continuum must reflect that longer time perspective. Therefore, funding, regulations, policies, and procedures need to be re-thought.

Assertive Community Outreach and Recovery Celebration

***Bill White*:** One of your goals has been to build tentacles of support throughout the community that can reach people years before they would have traditionally entered addiction treatment. How is Philadelphia achieving that?

***Roland Lamb*:** We have funded non-licensed outreach and recovery supports. If people are seeking help for addiction-related problems at organizations that we have not historically funded, then that is where we need to be. Supporting these organizations is a way to bring added value to the gains made within our funded treatment system. Since the '80s, One Day At A Time has been a grassroots recovery activist organization of recovering persons committed to making a difference in a community beset by drugs and poverty. They were the driving force in establishing recovery houses in Philadelphia, and they have a history of reaching the homeless, those afflicted with HIV/AIDS, and those reentering the community from incarceration who are addicted. New Pathways, a program initially funded by SAMHSA/CSAT to provide outreach for those at risk for HIV/AIDS, since 1999 has been connecting and staying connected to those at risk for HIV/AIDS. For eight years, their Pathfinder group has stayed connected to chronically homeless men in shelters. The Philadelphia Recovery Community Center provides services for those seeking and in recovery. All of these programs provide supports regardless of whether or not you are in a treatment program. More importantly, they provide continuity of contact in a primary recovery support relationship through pre-treatment, in-treatment, and post-treatment recovery support services. We estimate that in 2010, the DBH/IDS may have spent $120 million on licensed addiction treatment for 25 – 30,000 persons. In that same year and for less than $3 million, we estimate those grassroots entities saw 65,000 persons.

***Bill White*:** What other projects reflect this philosophy of assertive community outreach?

***Roland Lamb*:** We are launching a faith-based recovery initiative to mobilize local faith communities to organize recovery ministries. Deputy Commissioner OmiSade Ali is developing a curriculum with Dr. Pat Scoles of Philadelphia Community College that will greatly aid this effort. Some of the other notable outreach efforts include the outreach teams of the NET Consumer Council, the New Pathways outreach teams, and the outreach that is linked to the Journey of Hope Project. Outreach activities are also a dimension of our recovery celebration activities. I cannot say enough how important our celebrating recovery has been. This has encompassed Recovery Month in September where we have the Recovery Walk (with more than 15,000 attending the 2011 march), Recovery Night at the Phillies,

the First Friday series at Community College where recovery stories are shared, the recovery murals project, which visually celebrates recovery through community art projects, the recovery leadership training programs for people in recovery, the activities at the Recovery Center, the annual Making a Difference Dinner, and our newest project—Recovery Idol, where we are showcasing the talents of those in recovery.

Leadership

***Bill White*:** As I have observed you these past years, I have seen two quite distinct forms of leadership—one directed at helping lead systems transformation in the community and the other directed at providing leadership within DBH. How would you contrast the demands of these two roles and your relative success in each?

***Roland Lamb*:** Both internally and externally, I have felt like a coach, mentor, student, instigator, educator, and public servant**.** There are basic ingredients that make up this transformation and that have guided my behavior. First are the Vision and Values we developed and committed ourselves to. I have had to ask myself many questions. Do I really believe that we can position ourselves to make the system better via transforming it to a recovery focus? Am I consistently strengths-based and person-directed in my orientation? Am I willing to be transformed as part of the transformation process? Do my relationships internally and externally exemplify the values inherent in recovery transformation? As a leader, am I:

- Carrying the transformation vision and values internally and externally?
- Celebrating the achievements of people in recovery and their families and professional allies?
- Encouraging an environment of organizational and personal learning?
- Assuring organizational agility?
- Focusing simultaneously on celebrating present accomplishments and eliciting a vision of next steps in quality improvement? .
- Managing for innovation through diversity?
- Managing via outcomes and available evidence?
- Closing disparities in access and quality of behavioral health?
- Communicating effectively—internally and externally?
- Regularly asking those in recovery, their families, providers, stakeholders, and staff what they think?
- Assuring that cultural competence is reflected in care and practice guidelines and in all aspects of care and support?

***Bill White*:** Is there a particular philosophy of leadership that has helped you withstand the intense demands that accompany systems transformation?

***Roland Lamb*:** My approach to leadership is based in a consciousness of service that is characterized by modeling, sharing, challenging, and inspiring. Transformation is something that I am doing and as such, I need to be constantly assessing my behavior. Despite the title, I am not an owner but a caretaker. I am continually assessing how we do what we do better and challenging staff, those in recovery, providers, and those in the community to answer that question. As a champion of our transformation, I also seek to inspire others to take the risk of moving forward with the transformation process.

***Bill White*:** Real systems transformation threatens a lot of institutional interests and is inevitably a highly political process. How can leaders protect themselves and the momentum of systems transformation through this process?

***Roland Lamb*:** I think you do this by embracing the transformation while understanding at any moment what and who you can trust. Can you make the case that you are doing more than just changing a process or technology? Accept that you

cannot do it alone nor do you need to be able to sense that at the highest levels what you are doing is supported. Influence and infect everyone about the transformation. In a transforming system, you cannot protect yourself waiting to be clear about your role, or someone telling you exactly what you will be doing; you must have an internalized sense of the vision and values of the transformation.

***Bill White*:** Are there any final word you wish to share with our readers?

Roland Lamb: I would like to acknowledge that any success I have had is due to what I have learned from people in recovery and those on the frontlines of recovery support. They are my ultimate teachers and my heroes.

***Bill White*:** Roland, thank you for your willingness to discuss your life's work, your sustained friendship, and thank you also for all you have done and continue to do for people in recovery.

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