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The Recovery-focused Transformation of Addiction Treatment: An Interview with Terence McSherry

William L. White

Introduction

Much has been written about the recovery-focused transformation of Philadelphia's behavioral health care system, and visitors continue to flow into Philadelphia to study this process and its outcomes. In February 2012, I had the opportunity to interview Terence McSherry, CEO of Northeast Treatment Centers (NET), who has been deeply involved in transforming his own organization as well as contributing to the larger transformation process underway in the City of Philadelphia. I have visited NET on numerous occasions and written about some of its groundbreaking applications of recovery management principles. I consider NET one of the more innovative addiction treatment programs in the country and Terence McSherry one of our most creative and competent addiction treatment administrators. Please join us in this engaging conversation.

Professional and Organizational Overview

Bill White: Could you describe your professional background before coming to Northeast Treatment Centers?

Terence McSherry: After completing a Masters' Degree in Public Administration, I worked in various planning and operations roles with the City of Philadelphia Department of Public Health. During that time, I went back to school and got an additional Masters' in Public Health with an emphasis on Community Health Administration. Since that time, I have always worked in the direct service field in administrative, management, or planning positions. I came to Northeast Treatment Centers in 1980 as part of a total reorganization of the existing agency.

Bill White: Could you provide an overview of the scope of NET's service activities?

Terence McSherry: NET is a comprehensive service organization with 3 major areas of emphasis: child welfare-related services, mental health services, and addiction treatment services. About 40% of our service activity is in the delivery of child welfare and child dependency services. We operate several residential programs for dependent and delinquent boys and girls. We operate a very large children's mental health treatment program whose services are delivered in the home and in the schools here in Philadelphia. We operate a series of alternative programs for in-home services for delinquent youth in Philadelphia, and we operate several children's programs in the state of Delaware, including residential and partial hospitalization programs. We also operate a medically monitored detox program in Delaware—one of the few in the country that has operated for more than 25 years with 2,500 admissions a year for sub-acute detoxification.

The other programs we provide here in Philadelphia include a medium term (4-5 months) residential program and an extensive menu of intensive outpatient and outpatient programs. We provide both traditional drug free addiction treatment, and we operate a fairly large methadone medication-assisted treatment program in Philadelphia as well.

Bill White: Could you give our readers a sense of the size of NET's service operations?

Terence McSherry: We have over 450 staff employed, our annual budget is approximately $40 million, and we serve more than 5,000 individuals and families each year.

Systems Transformation in Philadelphia

Bill White: What were your initial reactions upon hearing Dr. Arthur Evans articulate a vision about recovery-focused systems transformation in Philadelphia?

Terence McSherry: My initial reaction was, "Well, it's about time somebody representing mental health leadership began talking about recovery." Recovery was the language we used in the addiction treatment system, but this had not yet taken hold among mental health service providers. Now that language and recovery concepts pervade everything we're doing in Philadelphia, but many organizations are still figuring out in depth what this new recovery orientation means in terms of service philosophies and practices. This has been an exciting and rewarding process for those of us involved in it.

Bill White: Was there an early point that you recall fully committing NET to this process and deciding that NET could serve as a model of recovery-focused systems transformation?

Terence McSherry: I first recall lots of discussion with peers and colleagues in other parts of the service delivery system here in Philadelphia about the tension between what we were trying to move toward and our encounter with long-standing rules, regulations, and restrictions that made moving forward very difficult. We made progress on the terminology and the concepts faster than we did on service practices and service policies. Those were the early growing pains of systems transformation here.

But I recall recognizing what an opportunity this was for us, particularly when we started to talk about the role of peers and what we could do, not just provide acute treatment but also support long-term recovery. Suddenly, we were no longer just talking about episodes of care or intake and assessment in the way we had for years. We began talking about the long-term commitments of a system to a population whose recovery involved more than just the traditional service providers. And we have had to think about recovery supports beyond traditional treatment services. Part of this was a return to what we had lost. When we started these discussions, I can recall having had peers at NET 10 years earlier, but we lost funding for them over time. This new, or renewed, recovery orientation helped us bring those back.

I remember a conversation I had with Arthur Evans very early on. (He's very approachable.) When he said he wanted to integrate peers throughout the system, I remember saying to him, "I'll have peer specialists before you do," and I did. Early on, we kind of had to boot-strap it: find our very best graduates and bring them along and gradually build a core of peer specialists and get them trained where we could. Today, there are a lot more resources to support the recruitment and training of recovery support specialists.

Bill White: Terence, could you describe some of the changes in the culture of NET and how NET service practices have changed through this transformation process?

Terence McSherry: It's now so embedded that it's hard to remember what it was like before. We began to understand that the role of the provider was not to cure or just provide a series of interventions. It was instead to support each person we served so he/she could find and pursue his/her own pathway of long-term recovery. That task belongs to those we serve; our role is to define how we can help provide tools and encouragement to make that journey easier. That assistance includes creating venues in which people seeking recovery can share their respective

experiences and support each other. Rather than commit ourselves to only be available when people are in the greatest pain, we are committing ourselves to be co-travelers through the whole process. We had to change both how we saw those we served and how we saw our own roles.

Bill White: How did NET staff and clients first react to this changing definition of their roles and the service relationship?

Terence McSherry: It varied. I have to say that we have been blessed with some really terrific leaders at the clinical level who have embraced the concepts very early on, embraced it because it makes sense. Embraced it because it gives a philosophical framework that's consistent with their experience of what's the best way to bring the person in recovery from a passive recipient of a set of procedures to owning and directing his/her own recovery process. Through that process, we had to redefine our role as one of helping them reach their aspirations for the future. That led us to look for opportunities for greater patient self-governance, which admittedly we approached very gingerly. But as time went on and people started to take more responsibility among themselves in a variety of ways, the process took on a life of its own. A critical step was when we encouraged development of a consumer council in which each program group would meet together and take up various self-governance issues. They would then go to the clinical staff and administration and say, "Look, this is how we think that this program could do a better job for us."

Consumer Council and Peer Specialists

Bill White: I've been very impressed with the Consumer Council members during my visits to NET. What impact has the Council exerted on NET?

Terence McSherry: Interestingly, and not necessarily predictable ahead of time, they have become a central force in our own transformation process. We always have representation of the current people in service, and they are very insightful. They know what they need. They know what works for them and what it takes for them to be comfortable within the service process. They have helped us reshape a lot of the logistics of service to be much more consumer friendly and helped us shape a warmer, more recovery-focused atmosphere. Joe Schultz and John Carrol, our clinical leaders, have been a leading force in welcoming the Consumer Council into this highly participatory process.

Bill White: Could you describe the number of peers that you've added as part of the service network of NET and how these roles were funded?

Terence McSherry: We presently have approximately 20 people who work as peer specialists at NET. A number of them have been in that role since this program was founded 4 or 5 years ago. They do all kinds of things, including staff and supervise the two recovery support centers that we operate. They are the primary initial point of contact for people who are newly being inducted into programs. They do that because they speak the language. They can tell people what to expect. They can reduce the anxiety that people have coming into a treatment program, and they also can make it clear that playing the usual games in treatment is not part of the culture here and will be quickly recognized.

Our peers are now the glue that keeps it all working around here. They really let us know how things are going and how things need to be changed over time. And it shows through the number of people who continue in care and after completing their service time here, keep coming back to the recovery centers for their own support and to support others. It's really quite astounding. Recovery has to do with the time in the trenches. This is a very, very good way to do it.

The peer specialists are funded as part of the treatment program that we offer. The treatment program is paid for on a fee-for-service basis, and we have been able to pay for peers out of the increased income related to higher retention rates. We have found peer services to be very cost-effective. We've dramatically reduced the number of people coming in and dropping out after a week or two. That really costs a lot of money, time, and frustration for everyone involved. When you cut that down, you have a more efficient program, and everybody's better off.

Systems Relationships

Bill White: From a provider perspective, how has the relationship between the Department of Behavioral Health and Intellectual disAbility Services (DBH) and treatment providers changed through the transformation process?

Terence McSherry: There has been a marked shift in recent years from a prescriptive "go by the rules, we know more than you do" stance to a much more collaborative "tell us what is working and how we can be of help" and more of a "you might try this or that" approach. At present, there is less a feeling of being policed and a much greater degree of partnership and collaboration. There is less a sense that DBH is looking to find fault and a much greater sense that they are

seeking opportunities to help. That does come with an expectation that you will improve the quality of what you are doing.

Bill White: You've served in a leadership position within the Advisory Council at DBH's Office of Addiction Services. What do you think are the most important accomplishments of the Advisory Council?

Terence McSherry: I think a number of things. First, the group that's assembled is very clear that they're an advisory group and not a decision-making group, and that frees us to offer a wide range of recommendations related to the transformation process. Second, the composition of that council is unique in that it has representatives from many different sectors of the community, including people in recovery. That has brought many fresh perspectives to DBH and the Office of Addiction Services. People in recovery on the Council are very active in trying to make sure that the voices of recovery are heard on key issues. And this is not always a unified voice. People bring their own individual perspectives and their own present or past treatment experiences, and that has greatly enriched the work of the Council. It has brought perspectives rarely heard by governmental decision-makers. I have seen a number of areas where a proposed regulation or policy was changed based on feedback provided by the Advisory Council.

Medication-assisted Treatment

Bill White: How has the system transformation process influenced medication-assisted treatment at NET?

Terence McSherry: The medication-assisted treatment at NET is delivered in an entirely recovery-oriented fashion. For the past 6 or 7 years, that treatment has been delivered in a way that's consistent with all the other recovery-focused activities that I've described. We have an analog of the consumer council, and there is strong peer leadership within that program, including a patient advocacy newsletter. We help print the newsletter but everything else is managed by the people in recovery we serve.

Bill White: What have you done to encourage the development of these assertive and articulate advocates that are emerging within NET?

Terence McSherry: It's mainly, Bill, that we haven't done anything to discourage them. We believe in what they're doing. We believe that some of those we serve will be called to this advocacy work and that it can be an important part of their

recovery. We encourage them to do it. We make small resources available to them by way of computers, and we'll print things for them, but we don't in any way control or interfere with it. I have to admit there's a certain amount of trepidation sometimes with that position, but we are committed to it.

Bill White: Could you describe some of the obstacles that you've experienced as you've tried to expand or relocate medication-assisted treatment programs at NET?

Terence McSherry: The depth of opposition to siting of needed behavioral services in general and medication-assisted therapy in particular has really been astounding to me. I have had the experience of attempting to site programs in at least 5 different locations throughout the City of Philadelphia, mainly in the lower northeast and the northeast section of Philadelphia. Every single time, we have encountered opposition so intense that we have had to withdraw our plans in spite of all the work we had done to try to reduce such resistance.

The degree of ignorance and animosity displayed in these situations was astounding to me, as was the absolute unwillingness to listen to experts within the treatment field who were not associated with NET. What was particularly disheartening was the degree to which people used the language of recovery in opposition to this approach to treatment. I have had a very difficult time dealing with this.

Bill White: What are your thoughts about what we as a field need to do to address that intensity of social stigma?

Terence McSherry: Continuing education obviously is important, particularly challenges to prevailing myths about methadone treatment and wider dissemination of the addiction brain disease science. We also have to get some champions who are willing to take this on. We need advocates of medication-assisted treatment to do what recovering alcoholics did when they stood publicly to champion the need for alcoholism treatment. Medication-assisted treatment is a large subsection of our field, but we have not yet had the public education and advocacy on this as we have other areas of the field. We need strong advocates to challenge these prevailing public attitudes. And we may also need legal action in this area.

Next Steps at NET

Bill White: What do you envision as the next steps in NET's continued transformation?

Terence McSherry: For us, it's applying a lot of the same principles in a wider and wider fashion and trying to learn as we go along. We started this transformation process in our drug-free outpatient programs, extended it to our intensive outpatient programs and our medication-assisted programs. We are now applying these principles to our children's programs.

We're not just talking about applying this recovery orientation to addiction anymore. We're talking about other behavioral issues as well, and we are talking about resiliency. In particular, we are extending our peer support services to older youth and also foster parents. We still feel like we are in the early stages of the reaching the full implications of these concepts.

Lessons Learned

Bill White: People from around the world are coming into Philadelphia and visiting NET to study this transformation process. What has this transformation process meant for the City of Philadelphia?

Terence McSherry: I think the number of people coming from other places to see how it's being done here is a good indication that something very important is unfolding here in Philadelphia. When people come to NET, we immediately send them to talk to the peer specialists and the Consumer Council. They do all our work for us because they're perfect examples of what this process is all about. People come away shaking their heads saying, "Wow, I didn't even know that could be!" And we're doing it here every day.

Take our local Recovery Month walk as an example. It's grown from less than 500 people with a couple of signs to more than 15,000 people in last year's march to Independence Hall. Such numbers would have been unthinkable 10 years ago. Systems transformation has made a huge cultural difference, certainly among those in recovery and those charged with providing addiction treatment and behavioral health services. It has profoundly changed how we think, how we provide services, and how we relate to those we serve. It will never be possible for somebody now working in Philadelphia to go to another state or another country in the world and not be influenced by what has unfolded here.

Bill White: What has been the most enjoyable part of this process for you personally?

Terence McSherry: My background is public health, and that provides a wider perspective on what has happened here in Philadelphia. I'm not a clinician, so my perspective is not based on seeing changes person by person, but I cannot escape

the effects I see in the lives of individuals who have come to us in such horrible condition who are now in long-term recovery, some serving as peer specialists or on our Consumer Council, and who have become success stories within our city. Witnessing that is a spectacular experience.

We can't get away from the fact that we need resources and dollars to organize needed help, but the key is still people, and we have found a way to mobilize people in recovery that is helping us stretch our limited resources to reach ever-greater numbers of people and to change our organizational culture. And we believe our organizational culture can change the community culture. That's what we are really trying to do. There has to be a long-term commitment. There are things of great value that treatment programs were driven away from in the '70s and '80s that are now coming back stronger than ever.

Bill White: Terence, let me ask you one final question. What kind of guidance would you suggest for CEOs around the country or world who are considering leading such a transformation process within their own organizations?

Terence McSherry: You have to talk to the persons you're trying to help. You have to listen. And that's not that easy. It's filled with assumptions on both sides of a table or whatever might be where you're meeting. You need to kind of work through all those. You need to find a couple of key people on your staff or bring them in from outside. You need to get concepts across that find language that fits with where you want to go. And then be persistent in applying that language across the board and basically lead by example and lead by inducement rather than by being patient. Be confident that your eventual outcome, whether you see it or not, will be much better for your effort.

Bill White: Thank you for this interview and for all you and your staff do.

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