The Philadelphia Alliance
Behavioral Health Domain
Strategic Considerations for Addiction Services in Philadelphia
[First Position Statement re Draft Plan for DBH Addiction Services]

We support the DBH Addiction Services' (AS) initiative to transform Philadelphia's services and supports for people with substance use and addictions to the recovery management approach recommended in the AS Addiction Treatment Strategic Plan. *(Ref. A Model to Transcend the Limitations of Addiction Treatment, White, Boyle, Loveland, p. 9 AS Strategic Plan)*

We support the premises identified by White et al for creating a recovery management service approach *(White, William, Recovery Management: What if We really Believed That Addiction Was a Chronic Disorder?, GLATTC Bulletin, pp.1-2):*

"Alcohol and other drug problems present in transient and chronic forms. The evidence is overwhelming that the course of severe substance use disorders and their successful resolution (addiction, treatment and recovery careers) can span years, if not decades. Severe and persistent AOD problems have been depicted as chronic and progressive for more than 200 years, but their historical treatment more closely resembles interventions for acute health conditions. Acute models of treatment (i.e. those based on single, self-contained episodes) are not the best frameworks for treating severe and persistent AOD problems. Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months, and years following treatment."

We support the critical assumptions identified by William White

"A single brief episode of treatment rarely has sufficient effect for those with the most severe substance use disorders…to sustain recovery following the intervention. Multiple episodes of treatment, if they are integrated within a recovery management plan, can constitute incremental steps in the developmental process of recovery. Treatment episodes over time may generate cumulative effects. Particular combinations and sequences of professional treatment interventions and peer-based recovery support services may generate synergistic effects (dramatically elevated long-term recovery outcomes)." (*White, Recovery Management:…, p 3*):

We support the recovery management approach's wrapping of traditional interventions within a more sustained continuum of:

- "pre-recovery support services to enhance recovery readiness
- in-treatment recovery support services to enhance the strength and stability of recovery initiation, and
- post-treatment recovery support services to enhance the durability and quality of recovery maintenance." (*White, Recovery Management:…, p. 3*)

We support the principles that distinguish recovery management from less seamless, comprehensive and integrated approaches. The principles and values include:

- "emphasis on resilience and recovery processes (as opposed to pathology and disease processes)
- recognition of multiple long-term pathways and styles of recovery
- empowerment of individuals and families in recovery to direct their own healing
- development of highly individualized and culturally nuanced services
- heightened collaboration with diverse communities of recovery, and
- commitment to best practices as identified in scientific literature and through the collective experience of people in recovery." (*White, Recovery Management:…, pp. 3-5*)

PRINCIPLES to Promote Transformation:

In the context of the above referenced premises, assumptions, continuum of sustained supports, and principles, and the Addiction Services commitment to creating a seamless, integrated recovery management approach, members of The Philadelphia Alliance are committed to working with AS to build the essential elements of a system of recovery management. Additional guiding principles and recommendations for AS's consideration are presented below:

1. An integrated approach is absolutely critical. We want to create seamless, integrated approaches to Recovery Management – with support from people in recovery.

2. We totally agree about the need for long-term case management and supports.
   a. Ongoing connections with clients should be retained – for the benefit of continuity.
   b. We see ongoing supports as essential to integration and continuity of care; and we recommend that case management become a component of AS's contracted, recovery management approaches.
   c. Treatment providers have already established a sense of trust and safety with the clients they serve. For many clients, residential or outpatient treatment providers may be the first safe and supportive settings that they have known and the ones that they can form the strongest relationships with.

3. We recommend the inclusion of people in recovery as part of the planning and thinking process. (Perhaps an Advisory Council could be created that would work with the Strategic Planning workgroup.)

4. Transformation should be well-planned, which will require time and a deliberate pace.

5. Therapeutic Dose. Planning must promote awareness and adherence to the principle that any treatment requires the proper level and duration treatment to be effective.

6. Recognition that relapse is part of the recovery process. Learning is cumulative. Individuals who need treatment should be viewed in terms of their "treatment career" and not just episodically. The illness should be treated like diabetes, rather than the flu.

   a. Treatment works, including residential treatment. Literature and studies have consistently demonstrated the need for multiple treatment episodes to treat the chronic illness of addiction.
   b. There is a recognition that relapse occurs, often in relation to an absence of supports.

7. Suggest that we collectively brainstorm about "What does the client need"? Think about the structure from that perspective. Think in terms of what does a person with a particular condition need at a particular time. Consider the whole person.

8. The transformation goals (stated in Strategic Planning Workgroup) should be discussed in depth in the workgroups and then identified distinctly in the Draft Plan in their modified form.

9. The service system should be based on a consistent method for assessment and placement. The PCPC is the state-mandated instrument. Interpretation and objectified criteria must be consistent.

10. Consider proactively the need to implement specialized treatment options for populations with special needs, such as women, women and children, adolescents, and others.

<u>Reaction, Concerns, and Recommendations regarding the DRAFT PLAN</u>:

1. We want to work with you, (DBH), as an active partner in designing what the system should look like and planning for transformation of the system.

2. The Goals stated in the first meeting of the AS Strategic Planning Workgroup (12/15/06) are used here to organize our commentary about the Draft Plan. We believe the list of transformation goals should be examined and perhaps be made longer and broader, to include things such as workforce development issues, criminal justice issues, and establishing natural networks of people in recovery. Here are our comments regarding the stated goals.

3. Reaction & Recommendations re Transformation Goals, (as stated in Strategic Planning group).

   a. ***Refocusing of recovery from substance abuse/addiction to community-based programs instead of inpatient/residential treatment facilities.***
      - We totally agree that there needs to be a continuum of services, filling current gaps.
      - Don't undervalue the place and importance of residential treatment. As currently utilized, there need to be more supports and better integration.
        - We can do better with the existing services, while we are developing new services and structures.
      - Continuity of care should be operationalized with more real live connections between levels of care.
      - One idea for how to operationalize recovery "on the street" is mobile resource teams that could provide varying degrees of support and service, according to a person's needs at a point in time. We urge consideration of this type of treatment-when-needed program. (i.e. models similar to ACT teams or the SAFE model.)
      - We agree with the idea of community-based services; we are largely community-based services.
      - As written, the above goal statement appears to be critical of inpatient/residential treatment, an appearance that we believe is not intended. We suggest a language change to something like: … "A refocusing on the development of recovery management approaches with a more comprehensive, seamless, community-based emphasis that would facilitate reduced dependence on intensive acute care services."

   b. ***Implementing a strategy to develop In-Plan D&A case management.***
      - We absolutely support this goal!
      - We believe this should be a provider-based service.

   c. ***Reconfiguring inpatient/residential rehabilitation into phases of care with different expectations and rates of reimbursement.***
      - We totally agree there needs to be a continuum of services, filling current gaps.
      - Critical are appropriate step-downs and step-ups, as well as vital supports for individuals' transitions, including long-term case management.
      - To support a more fluid approach to treatment, we need to work together to develop a behavioral health system that is more responsive to clients needing to re-enter treatment at various points in their treatment career.
      - Objectified criteria is part of a consistent method for assessment and placement.
        - Is CBH/DBH using the PCPC for placement decisions, or other criteria, or a variation of the legislatively mandated PCPC?
      - Flexibility is also critical in effectively utilizing an array of services.
      - Rates of reimbursement always need to be sufficient to support the desired service.

d. ***Evolving a system of halfway houses and recovery supported living sites directly aligned with treatment facilities.***
    - This sounds like part of the goal above (in c.). We support such a goal, given appropriate standards and resources being in place.

e. ***Align, coordinate and integrate a clearly articulated clinical content and expectations of the outpatient levels of care.***
    - If by "outpatient levels of care" you mean everything other than residential, we support this goal. As the plan states, a new spectrum of supports and services is needed.
    - We also support longer terms of outpatient and structured day supports, such as D/A partial hospitalization programs to be added to patient care options.

4. Why are the statements about reduction of residential beds so firmly concluded?
    a. Is there a perception that residential is not working.
    b. Is DBH saying there is not the need for the number and type of beds that exist? Are fewer people meeting the criteria for residential services?
    c. Is it that DBH needs the money to do other things, and that is where they see the resource? Is this asset reallocation? The reasons for the conclusion are not stated.
    d. In terms of outcomes, research has shown the importance of Lengths of Stay (LOS). This is directly related to the concept of "therapeutic dose".
    e. Residential services have an appropriate place in the continuum; and it works if well-integrated with appropriate step-downs and the clients stay long enough.
    f. A key element of community-based programs is the availability of decent housing. Of course other variables, such as family and income are also critical.

5. The efficient and effective functioning of Addiction Services is diminished by the disarray in criminal justice;
    a. We recognize that FIR is aimed at a specific population, but the operational principles should be used throughout the criminal justice system.
    b. **The Dept should create and fill a position of Coordinator for Criminal Justice Programs –** to address barriers and increase efficiency and coordination of referrals.

6. There are a number of broad statements in the Draft Plan regarding residential assets and liabilities that need to be examined more closely. For example, "contrived models of cookie cutter treatment", and other negative, judgmental statements. Perhaps these statements were in reference to the state of the art in general, and not specifically in Philadelphia

7. There needs to be accountability built into other system structures, (in addition to provider services), to optimize long-term recovery. For example, there should be more stringent standards for recovery houses.
    a. DBH could incentivize collaboration with good recovery houses. Relationships could be facilitated and linkage improved.
    b. Providers could provide long term case management and coordinate housing and other supports that an individual needs – better than any other component of the service delivery system.

8. The Community Center idea needs more thought and development.
    a. The desire has been stated to create new services and structures with the existing providers; and the Draft Plan emphasizes the principle of integration; and yet some of the statements in the plan seem to place the treatment provider on the sidelines. The system needs to be integrated; and the providers should be the integrating principal, pulling the other parts of the system together for the person they are serving.

   b. We support the plan to improve system integration and to move toward a seamless service capability, creating and incorporating collaborative partnerships and access to natural supports, self-help and advocacy groups.

9. The information presented at the first meeting of the Strategic Planning workgroup was helpful in informing the group about an overview of the service system. We think it would be useful to have even more information depicting an outline of the system. For example, what are the dollars associated with each level of care? That would be good information to have, as we look at the entire system for system planning - from a systems overview perspective.

10. We would like to have more discussion about the background information and premises for the conclusions in the Draft Plan in terms of research or consumer experience.

11. We would like to see an attitude and a course pursued similar to the Recovery activities for people with mental illness, as part of the OMHSAS Transformation. People who suffer from substance abuse/addiction should also have hope, resilience, and live meaningful and productive lives as much as possible, just like people with mental illness.