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Citation: White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, 8(5), 34-38.
Posted at **www.williamwhitepapers.com**

A Recovery Revolution in Philadelphia

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The City of Philadelphia has a long and distinguished role in the history of addiction treatment and recovery in America. One of the city's most famous and beloved sons, Dr. Benjamin Rush (1746-1813), was the first to articulate a disease concept of chronic drunkenness and call for the creation of special institutions for the care of the inebriate. Philadelphia's Franklin Reformatory Home for Inebriates (founded 1872) was among the most prominent of early inebriate homes and asylums. When a lay alcoholism therapy movement rose in the early twentieth century, Philadelphia was again distinguished by the collaboration of lay alcoholism therapist Francis Chambers and noted psychiatrist Dr. Edward Strecker at the Institute of the Pennsylvania Hospital. Chambers' acceptance as an interdisciplinary team member in one of the nation's most prominent psychiatric hospitals stands as an important milestone in the professionalization of addiction counseling (White, 1998).

In the mid-1940s, Philadelphia physicians A. Wiese Hammer, C. Dudley Saul, William Turnbull, and John Stauffer worked with a local committee of Alcoholics Anonymous to establish an alcoholism unit at Philadelphia General Hospital. Such units were pre-dated by decades and set the stage for the later rise of modern hospital-based addiction treatment. In 1968, Gaudenzia House joined the ranks of the America's earliest therapeutic communities, and in that same year, Eagleville Hospital and Rehabilitation Center became one of the first modern centers to fully integrate the treatment of alcoholism and drug addiction within the same facility.

As a national addiction treatment infrastructure emerged, Philadelphia continued to be a center of intervention through the family-centered work of Drs. Alfred Friedman, Jack Friedman, Duke Stanton, and Ivan Nagy at the Philadelphia Psychiatric Center (now the Belmont Center) and the Philadelphia Child Guidance Center, and Dr. George Woody's work on the treatment of opiate dependence on behalf of the Philadelphia Veterans Administration. Philadelphia also garnered national recognition for its vibrant recovery home movement (led by the Rev. Henry Wells and One Day at a Time) and its addiction-related research activities (e.g., the work of such individuals as Drs. Charles O'Brien, Tom McLellan, and James McKay).

Today, Philadelphia is poised to exert an even greater influence on the future of addiction treatment. This article describes the behavioral health system transformation process that is underway in Philadelphia and discusses how the innovations in Philadelphia will affect addiction counselors across the country.

The Context for Change

Several national trends form a backdrop to the dramatic changes that are unfolding within the City of Philadelphia's behavioral health care system. The first and most important of these trends is the explosive growth in addiction recovery mutual aid structures (support groups, clubhouses, recovery support centers, recovery homes, recovery schools, recovery job co-ops) and the rise and maturation of vibrant grassroots recovery advocacy movements in both the mental health and addiction arenas. These movements are calling upon traditional mental health and addiction treatment agencies to transform themselves into "recovery-oriented systems of care" and to use recovery as a conceptual bridge to improve services for persons with co-occurring disorders (White, 2005; White & Davidson, 2006). These movements have exerted a profound influence on national behavioral health policy, as reflected in the recommendations of the President's New Freedom Commission Report *Achieving the Promise* (2003), SAMHSA's *Transforming Mental Health Care in America* (2005), and the National Institute of Medicine's *Improving the Quality of Health Care for Mental and Substance-use Conditions* (2006). New pilot initiatives at the Federal level (CSAT's Recovery Community Support Program and Access To Recovery) and state-level system transformation efforts (such as the work of the Connecticut Department of Mental Health and Addiction Services) reflect this trend to integrate behavioral health services within a recovery-oriented system of care. In the addictions field, system transformation efforts are also being fueled by research-based calls to shift addiction treatment from a model of acute biopsychosocial stabilization to a model of sustained recovery management (McLellan, Lewis, O'Brien, & Kleber, 2000; White, Boyle, & Loveland, 2002).

In addition to these broader influences, three local milestones set the stage for dramatic changes in Philadelphia's behavioral healthcare system. The closing of the Philadelphia State Hospital in 1990 marked the final philosophical shift from an institutional to a community-based service model. The 1997 creation of Community Behavioral Health (CBH), a private non-profit managed behavioral health care organization, gave the City of Philadelphia direct control over the majority of the funds it expends for behavioral health care services. The final stage-setting event was the creation of the Department of Behavioral Health and Mental Retardation Services (DBH/MRS) in 2004 and the recruitment of Dr. Arthur Evans to lead the behavioral healthcare systems innovations at DBH/MRS. The creation of DBH/MRS, which provided an opportunity to weave CBH, the Office of Mental Health, and the Coordinating Office for Drug and Alcohol Abuse Programs into an integrated behavioral health care system, marked a critical milestone in Philadelphia's system transformation process.

Other influences that made Philadelphia an ideal laboratory for such sweeping innovation were the political commitment of Mayor John F. Street to reform behavioral health services, a strong addiction recovery advocacy organization, an established network of more than 85 addiction treatment providers, growing interest in alcohol and other drug problems among the local faith community, nationally recognized addiction research capabilities (e.g., the Treatment Research Institute), and the Pennsylvania Department of Public Welfare Office of Mental Health and Substance Abuse Services' parallel interest in behavioral health system transformation under the leadership of Estelle Richman.

The Revolution Defined

Transforming behavioral health care systems involves revolutionary changes in four areas: core values and concepts, constituency relationships, service practices, and funding and regulatory policies. Here is how changes in these areas unfolded and continue to unfold in the City of Philadelphia.

Core Values: Behavioral health system transformation in Philadelphia started by involving everyone in the process—particularly recovering people and their families. A lot of time was spent asking questions and listening to people's ideas about how the existing behavioral healthcare system could be changed to better meet their needs. What emerged after months of such discussions was a clear vision: create an integrated behavioral health care system for the citizens of Philadelphia that promotes long-term recovery, resiliency, self-determination, and a meaningful life in the community. A Recovery Advisory Committee clarified that vision by developing a consensus definition of recovery and by defining nine core recovery values. The nine core values were hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach. Seen as a whole, these values shifted the focus of attention from the interventions of professional experts to the experience and needs of recovering individuals and families. The recovery definition and recovery core values were then used to guide the system transformation process in both mental health and addiction service settings.

Relationship Reconstruction: If there is a single word that describes the changing pattern of relationships within the system transformation process in Philadelphia, that word is *partnership*. Relationships between service practitioners and service consumers and between DBH/MRS and its local service providers are moving from authority-based relationships to relationships based on mutual respect and collaboration. Recovery representation is being promoted at all levels of system decision making. The focus on recovery has also resulted in an emphasis on the value of peer-based recovery support services. Considerable efforts are being invested to expand the availability, quality, and sustainability of recovery support services and to expand the settings in which such services are available. New relationships, such as the linkage between treatment agencies, the faith community, and other indigenous institutions, are also a visible part of the system transformation process. DBH/MRS has assertively involved recovering people and their families at every stage of the systems transformation process in order to affirm that recovery is a living reality in the City of Philadelphia.

Changes in Service Practices: Long-tenured addiction counselors have witnessed the rise and fall of many faddish ideas, many of which generated little if any sustained changes in clinical practices. Asking "How will this new recovery orientation change what we do with clients?" is a reasonable response in light of such history. Based on the system transformation process to date in Philadelphia, here are 10 ways clinical practices are likely to change in similar system transformation efforts across the country.

1. Engagement: Greater focus on early identification via outreach and community education; emphasis on removing personal and environmental obstacles to recovery; shift in responsibility for motivation to change from the client to service provider; loosening of admission criteria; renewed focus on the quality of the service RELATIONSHIP.

2. Assessment: Greater use of global and strength-based assessment instruments and interview protocol; shift from assessment as an intake activity to assessment as a continuing activity focused on the developmental stages of recovery.

3. Retention: Increased focus on service retention and decreasing premature service disengagement; use of outreach workers, recovery coaches, and advocates to reduce rates of client

disengagement and administrative discharge.

4. Role of Client: Shift toward philosophy of choice rather than prescription of pathways and styles of recovery; greater client authority and decision-making within the service relationship; emphasis on empowering clients to self-manage their own recoveries.

5. Service Relationship: Service relationships are less hierarchical with counselor serving more as ongoing recovery consultant than professional expert; more a stance of "How can I help you?" than "This is what you must do."

6. Clinical Care: Greater accountability for delivery of services that are evidence-based, gender-sensitive, culturally competent, and trauma informed; greater integration of professional counseling and peer-based recovery support services; considerable emphasis on understanding and modifying each client's recovery environment; use of formal recovery circles (recovery support network development).

7. *Service Dose/Duration*: Dose and duration of total services will increase while number and duration of acute care episodes will decline; emphasis shifts from crisis stabilization to ongoing recovery coaching; great value placed in continuity of contact in a primary recovery support relationship over time.

8. Service Delivery Sites: Emphasis on transfer of learning from institutional to natural environments; greater emphasis on home-based and neighborhood-based service delivery; greater use of community organization skills to build or help revitalize indigenous recovery supports where they are absent or weak.

9. Post-treatment Checkups and Support: Emphasis on recovery resource development (e.g., supporting alumni groups and expansion/diversification of local recovery support groups); assertive linkage to communities of recovery; face-to-face, telephone-based, or Internet-based post-treatment monitoring and support; stage-appropriate recovery education; and, when needed, early re-intervention.

10. Attitude toward Re-admission: Returning clients are welcomed (not shamed); emphasis on transmitting principles and strategies of chronic disease management; focus on enhancement of recovery maintenance skills rather than recycling through standard programs focused on recovery initiation; emphasis on enhancing peer-based recovery supports and minimizing need for high-intensity professional services.

Changes in Funding and Regulatory Policies: The conceptual, relationship, and practice changes described above cannot be effectively implemented and sustained without substantial accompanying changes in funding and regulatory policies. In Philadelphia, DBH/MRS is working with its multiple constituencies to plan and implement such changes. To date, the focus has been on providing regulatory relief (reducing duplicative and excessive regulatory requirements), generating more recovery-focused regulatory standards, shifting the focus of program monitoring from one of policing to one of consultation and support, generating new RFPs for recovery-focused service initiatives, and exploring models for long-term funding of recovery support services. The DBH/MRS has invited the State Department of Public Welfare to join it in using the City of Philadelphia as a laboratory for recovery-focused regulatory and policy reform.

The Revolution Spreads

Philadelphia is not alone in pursuing this recovery revolution, but DBH/MRS is among the vanguard of those behavioral health systems seeking to radically transform their systems of care as a whole. There are several indications that such transformation may be the wave of the future. First, there is a growing body of research documenting the limitation of acute care models of addiction treatment (see White, Boyle, & Loveland, 2002) and

affirming the potential role of assertive and sustained approaches to continuing care (Godley, Godley, Dennis, Funk, & Passetti, 2002; Dennis, Scott, & Funk, 2003). In tandem with these findings, major funding organizations are exploring the potential of peer-based recovery support services as an adjunct or alternative to traditional treatment services in an effort to improve long-term recovery outcomes (see http://rcsp.samhsa.gov/). As federal and state agency leaders seek ways to implement recovery-focused policy recommendations, their eyes will be drawn to states like Connecticut and to urban behavioral health care systems such as the Philadelphia Department of Behavioral Health who are paving the way for such innovation.

Getting Prepared

And what will all this mean for the addiction counselor? I would offer the following prescriptions for addiction counselors whose communities will be embracing similar behavioral health system transformation efforts.

- Find ways to learn about, and, if you are so inclined, to participate in the new recovery advocacy movement (see www.facesandvoicesofrecovery.org for key papers on this movement and a national directory of recovery advocacy groups).
- Become a student of recovery: study the growing body of recovery-focused research reports on the varieties of recovery experience and the effects of professional- and peer-based support on long-term recovery processes and outcomes.
- Embrace local system transformation efforts by volunteering to serve on advisory groups, task forces, and training committees.
- Provide leadership in advocating recovery-focused changes in service practices within your own service site.
- Seek out opportunities to explore how traditional ethical standards governing addiction counseling (based on ethical standards governing brief psychotherapy) will need to become more nuanced and, in some cases, significantly altered within models of sustained recovery support.

A revolution in behavioral health care is unfolding in the City of Philadelphia. If that revolution has not already reached your community and your organization, it is likely to do so in the very near future. As addiction counselors, we need to prepare ourselves and contribute our core values, knowledge, and skills to such system transformation efforts. What is at stake here is the future of addiction treatment and recovery in America.

Resource Note: Readers wishing to know more about recovery-focused system transformation are encouraged to read two recently released papers:

Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change. (2007). Philadelphia: Department of Behavioral Health and Mental Retardation Services.

An Integrated Model of Recovery-Oriented Behavioral Health Care. (2007). Philadelphia: Department of Behavioral Health and Mental Retardation Services.

Additional information on behavioral health system transformation in Philadelphia is available online at:

http://www.phila.gov/dbhmrs/initiatives/INT_index.html.

An interview with Dr. Arthur Evans about the Philadelphia systems transformation process is posted at: www.williamwhitepapers.com

Acknowledgement: I wish to thank Dr. Arthur C. Evans, Dr. Ijeoma B. Achara-

Abrahams and Roland Lamb of the Philadelphia Department of Behavioral Health and Mental Retardation Services for their helpful comments on an early draft of this article.

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