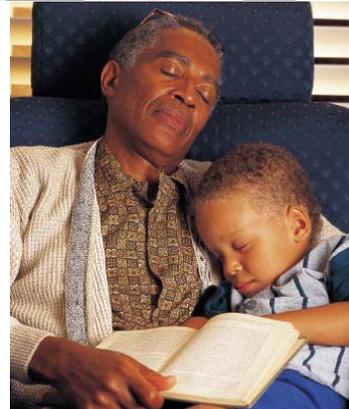


# Recovery - Focused Transformation of Philadelphia's Behavioral Health System

## A Declaration of Principles and a Blueprint for Change



# **Recovery-Focused Transformation of Behavioral Health Services in Philadelphia: A Declaration of Principles and a Blueprint for Change**

Department of Behavioral Health and Mental Retardation Services

## **The History of Systems Transformation in Philadelphia**

Philadelphia has a long history of leading innovative change efforts that focus on re-integrating people with behavioral health concerns into the community. The transformation process in Philadelphia essentially started with the closing of the Philadelphia State Hospital. The impetus for this closing came from people within the Philadelphia behavioral health community who had a vision of a life in the community for people who previously would have been institutionalized for life. Out of this closure came Community Treatment Teams which provided services to people where they lived in the community and the Consumer Satisfaction Team which sought input from the people receiving services about the quality and effectiveness of those services.

Philadelphia's innovative and visionary leadership continued with the development of Community Behavioral Health (CBH) in 1997. This managed behavioral health care company brought the formerly separate funding streams for mental health and substance abuse treatment together under one plan and set the stage for the integration of all behavioral health services in Philadelphia. These initiatives and the ideology associated with them laid a strong foundation for the development of a service system that was responsive to and driven by the needs of the people being served. Since that time, the behavioral health system in Philadelphia has continued to progress and advance the goal of community integration.

## **The Need for Continued Transformation**

In recent years, other behavioral health systems around the country have begun to adapt their policies, services and structures to become increasingly recovery-oriented and directed. Much of this restructuring was prompted by the work of The New Freedom Commission on Mental Health. This commission, created in April of 2002, was charged with examining the problems and gaps in behavioral health service delivery systems around the country. Additionally, they were asked to develop a set of concrete recommendations that could be immediately implemented by Federal, State, and Local governments along with health care providers (The President's New Freedom Commission on Mental Health: Executive Summary).

The Commission concluded that behavioral health systems around the country are not oriented to the single most important goal for people receiving services: the goal of recovery and a life in the community for everyone. In its vision statement, the commission articulated the following:

*We envision a future when everyone with a mental illness will recover, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning and participating fully in the community. (The President’s New Freedom Commission on Mental Health, 2003)*

The findings of The Commission, and the vision that they subsequently articulated were not surprising for many people receiving behavioral health services. Over the past two decades the nation’s consumer survivor movement has grown and vehemently advocated for changes in the nature of service delivery. Members of consumer survivor advocacy groups have argued that:

*Traditional mental health programs orient to lifetime dependency. They rely on diagnosis, force, medications, and maintenance. They do not focus on initiative and strength. Traditional mental health programs integratesystems by segregating consumers into those systems. Innovative consumer/survivor programs orient to human capacity and possibility. They focus on person, character, choice, interaction, and action. Innovative consumer/survivor programs integrate systems by integrating consumers into their families and into the larger community. (Center for Mental Health Services National Advisory Council, Subcommittee on Consumer Survivor Issues).*

While this transition was occurring in mental health, a new recovery advocacy movement was simultaneously unfolding within the addictions field. This movement is also being championed by people in recovery and supported by many advocates, providers and scholars, who call for sweeping changes in developing and delivering services.

At its core, this movement represents a shift away from a crisis-oriented, professionally-focused and professionally-directed model of care to a model that is directed by the person in recovery and views the recovery process as a lifetime journey. In this way of viewing treatment, people receive services that support them in selecting and managing their own long-term pathways and styles of recovery. (Details of the recovery movements and their significance for both addiction and mental health services nationally and in Philadelphia are offered in the Institute of Medicine’s recently-released *Improving the Quality of Health Care for Mental Health and Substance-use Conditions* and in the document entitled “A Conceptual Framework for Recovery in Philadelphia: History, Opportunities and Implications for Practice released as a companion to this blueprint).

The confluence of the Freedom Commission and the Institute of Medicine’s findings, the growing vibrancy of consumer advocacy groups, and the influence of research in both mental health and addictions fields has stirred a new level of energy, commitment, and focus on transforming behavioral health service systems across the nation.

As a result of its long history of creativity and innovation, and the foundation that was previously built, Philadelphia is again poised to lead the nation into a new frontier of behavioral health care. While many services systems focus on examining recovery in

either their addictions or mental health system of care, the Department of Behavioral Health and Mental Retardation Services (DBH/MRS) is taking a holistic approach that places recovery as a conceptual bridge for increased integration of mental health and addiction services. DBH/MRS is also unique in its degree of control over what are typically fragmented funding streams and associated policies.

For these reasons and many others, “we” as a collective group of stakeholders in this venture, are in an enviable position nationally to model behavioral health recovery practices and to boldly fund services based upon need rather than arbitrary payment practices. We are also fortunate to be working on this transformation effort in a state where there is a stated commitment in the recently released *Call to Change* to work at transforming all service systems within the state to recovery-oriented services. We can plan knowing that our work is in keeping with the direction courageously laid out by the Office of Mental Health and Substance Abuse Services (OMHSAS).

While we have unique assets because of our history of innovation and unified funding streams, like all behavioral health systems, we function in a challenging time in history. Since the inception of HealthChoices, the system has benefited from being able to expand and develop new services through the use of reinvestment dollars. This supply of funding is shrinking and will continue to shrink in the coming years. We are in a time of uncertainty as both federal and state governments are under pressure to continue to reduce funding for Medical Assistance (MA) services.

As a city, Philadelphia is experiencing major challenges that may require re-direction of funding toward the issues of violence prevention, homelessness, prison overcrowding and school climate issues. There is an increase in the number of uninsured people in the city, who need behavioral health services but who have no obvious mechanism for those services to be reimbursed. Finally, there exists the strong possibility that resources allocated to community-based programs will be reduced because of funding constraints and donor fatigue.

It is important to acknowledge these challenges as they have the potential to affect all that we are doing and dream of doing. At the same time, the directions proposed in this blueprint offer enough flexibility and creativity to respond to both the threats and opportunities. A Recovery-oriented system of care is even more critical in the face of these funding constraints and social challenges. It can, for example, better equip the people it serves to face challenges by connecting them with both formal and informal supports and services. Such a system works hand in hand with the natural community to expand support from one’s family of birth and/or choice to friends, faith-based groups, community organizations, local business and industry and educational institutions. We can and will align our attitudes, practices, policies, and fiscal decisions to ensure that all children, adults and families receiving behavioral health services in Philadelphia have access to the treatments and supports needed to live a meaningful life of recovery in the community.

Currently no blueprint exists to guide behavioral health systems through the complex process of transformational change. It is consequently essential that we initiate and sustain a collaborative planning process that will allow opportunities for a refinement in our mission and strategies as we proceed. This document will serve as a conceptual framework for future planning and as our initial implementation guide.

Like recovery itself, this will not be a linear process. As the process unfolds, our vision will become more focused and our strategies will become more refined as we evaluate their effectiveness. The vision and action steps articulated here simply represent a starting point. This document

- Describes the framework that will guide the planning process;
- Presents the vision, mission, and core values/principles that will drive the transformation process;
- Identifies those changes in DBH/MRS management practices and the design and delivery of local behavioral health services that are anticipated within the transformation process;
- Outlines the phases, goals and timelines within each phase of the transformation process;
- Provides an overview of the system priorities over the course of the next 24 months and begins to explore implications of these priorities for DBH/MRS, providers and people in recovery and their families;
- Describes how the systems transformation process will be evaluated, and
- Calls on all individuals and institutions concerned with the quality of behavioral health care in Philadelphia to actively participate in systems transformation.

This document is not intended to capture all of the detail associated with our transformation process. Instead, our goal is to articulate the process and concepts on which future actions will be built. We will be consistently providing additional resources that support the attainment of our goals. One of the hallmarks of the transformation that DBH/MRS is undertaking is the development of authentic partnerships with people in recovery and the provider community. The nature of these partnerships is such that the details around implementation and detailed timelines can only be determined in conversation with all parties. This document is intended to serve as an impetus for that dialogue.

Transformation is a continuous process of innovation and learning. It is differentiated from a traditional change process by the fact that the endpoint is constantly evolving. In a traditional change process, we start at point A and anticipate ending at point B. In transformation however, we hold a clear vision of the end point in our sight, but the steps to achieving that end point in large part have to be determined in motion. Consequently, sometimes we will hit the mark straight on, and on other occasions we will have to modify our approach based on lessons learned from one another.

In this way the process that the system is undertaking is not unlike that undertaken by each person in recovery. It is an individual process with the goal of recovery and one which takes advantages of opportunities along the way, learns from mistakes, and is continually moving forward.

To be successful, we must build a learning community based on trust, respect and an understanding that the goal of recovery is not just important for people with mental health and/or substance abuse challenges and their families. Rather, the hope and realization of recovery touches every individual, family, and organization in our community. This document is intended to serve as a guide for that dialogue. We invite you to join us in pursuing this vision of a transformed system of behavioral health care in Philadelphia.

The Executive Management Team  
The Department of Behavioral Health and Mental Retardation Services

The Philadelphia Recovery Advisory Committee

## **I. The Transformation Planning Process**

It has been critical that the systems transformation planning process be directed by and responsive to the needs of various stakeholders in the system. To that end, the Recovery Asset Baseline Assessment was initiated as a strengths-based approach to change. This

initiative utilized focus groups and surveys to increase understanding of diverse stakeholder perspectives of the current strengths and opportunities in the service system. The overarching goal was to identify the collective strengths in the system so that they may be built upon as the system transformation values and principles are advanced.

As such, 30 focus groups were conducted with people in recovery, family members of people in recovery, advocates, and providers of care (including front line staff, managers, and executive staff). Additionally, approximately 3,000 surveys utilizing the Recovery Self Assessment were also completed by individuals from these stakeholder groups. The findings from this initiative are detailed in the report entitled “Recovery Asset Baseline Assessment,” which is released as a companion piece to this document. Additional copies can be obtained through the Department of Behavioral Health and Mental Retardation Services. These findings have and will continue to help shape system transformation priorities.

The transformation planning and implementation process is being guided by senior DBH/MRS staff in collaboration with several stakeholder groups. One of these groups, The Recovery Advisory Group (RAC), comprised of a broad range of stakeholders (see membership list attached), is playing a significant role in leading us through transformation by articulating the values and principles that will inform our collective planning. Additionally, several additional workgroups and taskforces will help to shape our vision for the future.

In June 2006, senior leaders of DBH/MRS met to formally review system transformation accomplishments, to date, to identify obstacles to system transformation goals and to formulate an overall agenda for future system transformation efforts. DBH/MRS leaders will continue discussions with multiple constituent groups to refine the vision and implementation steps that will help us achieve a truly recovery-oriented system of care for the City of Philadelphia. In addition these leaders are actively involved in discussions with OMHSAS and other state leaders to identify and work at minimizing regulatory barriers to our transformation goals.

With regard to managing the process, it is anticipated that due to the complexity of this transformation, a wide variety of activities and initiatives will be required to both initiate and sustain change over time. All of the activities however, are a part of an overall change strategy which has three components: 1) Aligning Our Concepts, 2) Aligning Our Practices and 3) Aligning Our Context. These three components together create an interconnected feedback system. While we may put more energy into one strategy at a given point in time, they will continually impact and inform each other.

#### **Aligning Concepts:**

One component of our change strategy, Aligning Concepts, is targeted at promoting conceptual and philosophical clarity regarding our collective vision of transformation. This component attempts to define the core values and ideas upon which a recovery-oriented system of behavioral health care will be built.

### **Aligning Practices:**

Another component, Aligning Practices, is designed to operationalize the concept of recovery and some of the accompanying values and principles. The question we will attempt to answer as we strive to align our practices is: “What does a recovery- oriented system of care look like and how will it differ from traditional systems of care?” The activities that will take place as we seek to align practices will all be geared to translating the theoretical concepts into concrete practices at various levels and in diverse parts of the system. Practice changes will need to be made within DBH/MRS as well as within provider agencies.

### **Aligning Context:**

A third component of our change strategy, Aligning Context, will consist of activities which are designed to sustain the transformation over time. We recognize that while practice changes are a necessary part of the transformation process, these changes cannot be implemented in a vacuum. To be sustained over time, they must be simultaneously accompanied by contextual changes that will facilitate their long-term success. Many of these changes in context will include policy and fiscal changes, increased political advocacy, activities that increase community support for people in recovery, as well as efforts that enhance recovery capital within the communities in which people live.

These three change strategies are cyclical. The extent to which we are able to obtain conceptual clarity, determines our ability to successfully operationalize our transformation values. The manner in which recovery oriented practices are operationalized and implemented has further implications for the types of regulatory relief and community support that will be necessary to sustain lasting change. Our ability to achieve those regulatory changes has immediate impact on the kinds of services and supports we can develop.

As such, none of the three elements of our change strategy will occur in isolation. They are intricately connected to each other and are continuously influencing each other. At various phases in our change process, one component may play a more central role than the others. These are discussed in greater detail later in this document when we review the phases of our system transformation. For now, we will review each of the three components of our change strategy and the types of activities associated with them.

## **II. Activities Associated with Each Change Strategy**

**Strategy - Aligning Concepts (Toward Conceptual Clarity):** What ideas and values should drive the system change process?

Over the past 18 months DBH/MRS has undertaken multiple processes and action steps to develop a foundation of conceptual clarity. These action steps are detailed below:

**ACTION** —————> Establishing a Vision and Mission

The transformation to a recovery-oriented system rests on a common vision, mission, recovery definition, in addition to core recovery values and principles. It is also based on an understanding of the anticipated changes that will need to be implemented internally within DBH/MRS and within local behavioral health service organizations funded by DBH/MRS. The process of establishing conceptual clarity began with the generation of a vision and mission statement for the behavioral health system in Philadelphia.

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

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

## **ACTION ———▶ Developing a Philadelphia Recovery Definition:**

Since June of 2005 the Recovery Advisory Committee (RAC) has helped to set the direction for Philadelphia's transformation efforts. The RAC is composed of people in recovery (both from SMI and substance use disorders), family members, providers, advocates, and DBH/MRS staff. This group was charged with developing the recovery definition for the DBH/MRS. The RAC carefully considered Pennsylvania's recently released *Call to Change* as it met to formulate a recovery vision for the city of Philadelphia. The Philadelphia definition of recovery is in keeping with the direction OHMSAS has laid out in this important document.

### **Recovery Definition**

*Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in ones community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.*

## **ACTION —→ Developing Recovery Values and Guiding Principles:**

The RAC has also identified the following **Values and Guiding Principles** for the systems transformation effort:

**Hope** People can and do recover. Change is always possible, and the extent of change is often beyond what we can imagine. Hope is nurtured by seeing and hearing others living meaningful lives in recovery and giving back to their families and communities.

**Choice** Each person's opinions, wants, needs and individual recovery pathways are respected and elevated above all other considerations. Services are individualized and built around the person rather than fitting the person to a "program." All parties in the system recognize that there are many pathways and styles of recovery and that people have a right to choose their own path.

**Self-direction/empowerment** People in recovery lead their personal path of recovery. They do this by exercising independence and choice. The individual identifies personal life goals and in collaboration with others, directs his or her recovery by designing a unique path towards those goals. People have the opportunity to choose from a range of options and to participate in all decisions that affect their lives.

**Peer culture/Peer support/Leadership** There is recognition of the power of peer support within communities of recovery as reflected in: 1) hiring persons in recovery as Certified Peer Specialists and other positions; 2) assuring representation of people in recovery at all levels of the system; 3) developing respectful collaborative and referral relationships between treatment institutions and the service structures of local recovery mutual aid societies and assertively linking people to peer-based recovery support services (e.g. mutual self help groups, informal peer support etc.); 4) acknowledging the role that experiential learning within a community of recovery can play in initiating and sustaining a recovery process; and 5) developing opportunities for people in recovery to have active leadership roles at all levels of the system.

**Partnership** Relationships of all parties within the behavioral health care system are based on mutual respect; service designs shift from an expert model to a partnership/consultation model where everyone's perspective, experience and expertise is welcomed and considered. The power of relationships as the context for healing and growth is acknowledged and respected.

**Community inclusion/opportunities** The focus is on nesting recovery in the person's natural environment, integrating the individuals/families in recovery into

the larger life of the community, tapping the support and hospitality of the larger community, developing recovery community resources; and encouraging service contributions from and to the larger community. Connection to community is viewed as integral to long-term recovery.

***Spirituality*** A personal relationship *with a* “God of one’s own choosing” is seen as a potentially valuable resource for recovery support and is respected as a chosen component of an individual’s recovery support system. This relationship can be sustained either independently or within a structured religious belief system. There is respect for explicitly religious, spiritual and secular pathways of recovery.

***Family inclusion and leadership*** Family members are *actively* engaged and involved at all levels of the service process. Families are seen as an integral part of policy development, planning, service delivery and service evaluation. It is recognized that families come in many varieties. Both families of birth and families of choice are respected and valued. Assessment and service processes are family-focused. Services are integrated where multiple family members are involved in care across programs and agencies.

***Holistic and wellness approach*** Services are designed to enhance the development of the whole person; care transcends a narrow focus on symptom reduction and promotes wellness as a key component of all treatment and support services. Services are strengths-based, culturally competent and trauma-informed.

The recovery definition and guiding principles are consistent with the values that were expressed by stakeholders, who participated in the Recovery Asset Baseline Assessment process. These values and guiding principles will form the bedrock of all planning, development and outcome measures in the system.

**ACTION ———> Additional Action Steps Taken to Enhance Conceptual Clarity**

A critical step in the process of coming to conceptual clarity is developing a shared vision, body of knowledge and understanding of critical concepts. To that end DBH/MRS has engaged in providing many educational opportunities over the past twelve months to enhance conceptual clarity about the mission, core values and the planned system transformation. These include

- Hosting numerous all stakeholder community meetings in the Spring of 2005,
- Sponsoring several conferences (Day System Transformation Conference, Blue Ribbon Commission for Children’s Behavioral Health, Faith Based Conference, and the Addictions System Transformation Conference) with local and national presenters. These took place in the spring of 2006 and were designed to further delineate the implications for practicing from a recovery-oriented perspective for various components of our system.

- Designing and delivering the Recovery Foundations Training Series, a two day training offered twice a month since January 2006. Each training consists of a diverse group of stakeholders in an effort to model the open learning community that is desired in the system. The trainings are designed to provide participants with a general understanding of the recovery orientation and begin to orient them to some of the concrete implications for practice.
- Hosting the First Friday Series, a colloquium series of primarily local presenters from across the system that was initiated in February 2006. The series is intended to further ground stakeholders in some of the system transformation concepts by highlighting some of the strengths in our system relative to recovery-oriented practice. The presenters include providers, people in recovery, family members of people in recovery and DBH/MRS staff. It is an informal event also designed to support the development of a learning community where information and experience is exchanged in an open dialogue.
- Distributing several Requests For Information (RFI) documents to ensure that stakeholders throughout the system have a shared vision for change (e.g. Day Services RFI and Prevention RFI). This was a deliberate strategy to implement the value of partnership in practice, and to tap into the knowledge of all stakeholders in the system when developing transformed services and supports.
- Developing and distributing the Recovery White Paper, which is partially based on the work of the Recovery Advisory Committee, and this document, and the soon to be released addictions services strategic plan.

## **Strategy - Aligning Practice: How Will System Transformation Affect Practices in Provider Organizations and DBH/MRS?**

### **Practice Alignment and DBH/MRS: Transformation and Systems Management**

The systems transformation that is underway will require significant changes in the operation of DBH/MRS. In a transformed system it is critical that DBH/MRS model the values and priorities that have been identified. To that end, DBH/MRS is re-assessing all internal operations with the goal of aligning all areas of internal functioning toward a greater recovery orientation, greater collaboration internally, a stronger emphasis on a partnership relationship with providers and the goal of reducing burdensome and duplicative processes for providers. The integration of CBH and Behavioral Health Special Initiatives (BHSI) will be completed.

Further steps will be taken to move from the current reality of similar functions operating in separate parts of DBH/MRS to an integration of key functional arms including but not limited to Clinical Services, Provider Management, Research and Evaluation, and Information Services. In addition DBH/MRS will continue to work at developing strong working partnerships with sister social service departments within the city of Philadelphia.

During the next 18 months major expansion is not expected. Instead the focus will be on reconfiguring existing services to advance the system transformation goals, improving the management of current resources and enhancing the DBH/MRS service system through targeted development based on identified need.

Reconfiguration efforts will include the MH Day Program Transformation, reconfiguration of the substance abuse service system, converting congregate Community Rehabilitation Residences (CRR) into Supported Living models. As the transformation proceeds other RFI/RFP's will be developed in order to transform current levels of care.

In an era of system transformation and fiscal constraints, making sure that all services are directed toward supporting recovery is a key goal of the planning process. This will entail evaluating and modifying detox, residential rehabilitation services, psychiatric inpatient services, extended acute services, school based behavioral health services (SBBH) and behavioral health rehabilitation services (BHRS) in ways that insure they support the goals of the system transformation

The process of developing an internal infrastructure to use data to build a more efficient continuous service system has begun. This process will continue and expand with the goal to improve continuity of care, identify clear gaps in services and to fill these gaps in a planful way that promotes a more seamless and recovery-focused system. Some of this development may lead to new services, much of it will lead to the reconfiguration and re-alignment of existing services. New services will be added when there is clear documentation of substantive unmet need.

Aligning practices at the systems level will take several years to actualize. What we offer here is our current thinking of the areas that will need to be restructured to support systems transformation. Over time, other areas in need of restructuring will likely emerge. This needed evolution will advance the movement toward one integrated system, promote efficiency, support clarity of roles, and insure that we are capable of supporting providers as they make practice changes.

**ACTION → Practice Alignment within DBH/MRS**

**Initial Practice Alignment within DBH/MRS**

**Philosophical Reorientation** DBH/MRS will bring unit philosophies, policies and procedures into congruence with the emerging recovery philosophy.

**Systems Relationships** DBH/MRS will develop recovery-focused partnerships with provider organizations; expand the network of collaboration to strengthen relationships among DBH/MRS; local treatment providers and local recovery advocacy/support organizations; and use “recovery” as a conceptual bridge for increased integration of behavioral health services (bridging the historical separation between the mental health and addictions treatment fields).

**Needs and Resource Identification** DBH/MRS will focus its data collection and analysis activities on: 1) identifying geographical areas and populations in greatest need of services, 2) mapping existing treatment and recovery support assets, 3) identifying service priorities based on the analysis of gaps between service needs and resource availability, and 4) document recovery rates, pathways, styles and stages across multiple demographic and clinical populations.

**Policy Development** DBH/MRS will develop a process that assures broad constituency participation (including people in recovery and their family members) in DBH/MRS policies and enhances the overall involvement of individuals/families at policymaking making and policyadvisement roles in local service programs. The Department will begin a rigorous process of aligning policies to support recovery- oriented practices.

**Service Planning** DBH/MRS will take a collaborative approach to service planning. Additionally, it will develop and communicate periodic plans that summarize the progress of behavioral health systems transformation and that outline forthcoming priorities and goals.

**Service Funding** DBH/MRS will 1) provide financial incentives, using performance based contracting strategies to support providers in moving toward a recovery-focused service orientation, 2) provide financial disincentives and eventual de-funding of organizations failing to embrace recovery orientation, evidence-based practices and cultural competency, 3) pilot financing models for post-treatment monitoring and long-term support, 4) advocate for needed funding reform with the State, and 5) modify our funding policies and procedures to align funding with our System Transformation Vision .

**Service Monitoring** To align our monitoring activities with our system transformation efforts, the DBH/MRS will 1) streamline and integrate the compliance monitoring processes, 2) develop recovery-oriented benchmarks that shift the monitoring focus from service procedures to outcomes for people in recovery; 3) provide training, technical assistance and individualized consultation to assist programs in developing more recovery-oriented practices; 4) develop a partnership model between DBH/MRS and service providers (versus a regulatory enforcement model), e.g., co-development of annual plans for recovery

orientation enhancements, 5) connect training, technical assistance and consultation services to the monitoring process. These activities will be piloted with programs funded through re-investment dollars before being expanded to the rest of the system.

**Research and Evaluation** DBH/MRS will 1) develop measurable systems indicators that will provide benchmarks of the degree to which transformation activities are producing recovery-oriented changes in process measures (e.g., earlier engagement, reductions in administrative discharges, measures for each of the priority areas outline below) and outcome measures (e.g., prevalence of those in long-term recovery), 2) evaluate effects of policy decisions and service interventions on the prevalence of addiction and addiction recovery, 3) mobilize local research resources to conduct recovery-oriented evaluations and comparative research, 4) utilize internal and external expertise to evaluate practices that hold promise in producing long-term recovery outcomes, and 5) provide technical assistance to local service programs to help them to enhance their self-evaluation capabilities.

### **Practice Alignment at the Provider Level**

While DBH/MRS is aligning internal practices and processes with our collective vision of systems transformation, providers of behavioral healthcare will also be asked to simultaneously reshape service practices to be consistent with a recovery orientation. As systems around the country grapple with concrete ways to provide more recovery-oriented practices, providers often are left on their own to figure out how to adjust current practices to be consistent with the goal of recovery and community integration. This inevitably leads to frustration and impedes progress.

Thus over the next two to three years, DBH/MRS will be offering targeted training and technical assistance (TA) to support providers in implementing the practice changes that are needed. The content and process for this training will be identified through a workgroup that is currently forming and will include representatives of all stakeholder groups. TA will accompany new reinvestment programs and will be selectively targeted for other projects closely related to system transformation initiatives.

Aligning practices with a recovery orientation will be a complex process that is impacted by policy and fiscal constraints. Nevertheless, we are confident that by working on the system level and the provider level goals simultaneously, and in a collaborative fashion, we will be able to achieve significant progress.

Some of the areas that will be the focus of practice changes will emerge as we go through the transformation process and as people in recovery increasingly voice their opinions about service delivery. Other areas however, have already been identified nationally as

requiring changes. The national perspective is also consistent with the perspectives that local stakeholders offered through the focus groups conducted as a part of the Recovery Asset Baseline Assessment.

Later in this document we will identify our collective next steps and the priorities that we are focusing on in the short term. The areas identified immediately below however, represent our collective long-term vision of some of the changes that will need to occur in order to transform our service system. Our long-term vision for practice alignment at the provider level includes

**ACTION STEPS** —————> **Practice Alignment at the Provider Level**

**Long-Term Vision for Practice Alignment at the Provider Level**

**Service Engagement** Expand outreach services to reach individuals, families, communities at earlier stages of problem development.

**Service Access** Continue the rapid level of service access that has long characterized some components of the Philadelphia behavioral health service system (e.g. substance abuse treatment services) and increase the ability to access services in other areas (e.g. psychiatric access, housing with community supports).

**Recovering Person's Role** Emphasize the rights of people in recovery to participate in and direct service decisions, plan for services, and to move toward self-management of their own recovery journeys in collaboration with the people who serve them.

**Service Relationship** Shift the primary service relationship from an expert/patient model to a partnership/consultant model.

**Assessment** Move toward assessment procedures that are holistic, and strengths-based (rather than pathology-based) and continual (rather than an intake activity).

**Clinical Care** Move to clinical care services that are recovery-focused, evidence-based, developmentally appropriate, gender-sensitive, culturally competent and trauma informed. These services recognize that excellent clinical care is critical but is only one aspect of service needed among others in a recovery-oriented system.

**Service Retention** Enhance service retention rates (reducing rates of service consumer disengagement (NOTE: I struck this since many will not be in recovery yet) and rates of administrative discharge) by increasing the quality of clinical services and enhancing in-treatment recovery support services.

**Locus of Service Delivery** Increase the delivery of community integrated, neighborhood- and home-based services and expand recovery support services in high-need areas. This enhances normalization, the effectiveness of skill teaching and skill retention, and decreases stigma.

**Peer-based Recovery Support Services** Dramatically expand the availability of non-clinical, peer-based recovery support services and integrate professional and peer-based services.

**Dose/Duration of Services** Provide doses of services across levels of care that are associated with positive recovery outcomes. The intent is that intensity of services will naturally decrease over time as recovery stability and quality increases, but that recovery checkups when needed, early re-intervention, will continue for a considerable period of time. The system will develop innovative means for this connection (e.g., assertive phone follow up). Our vision is continuity of contact in a primary recovery support relationship over time.

**Post-treatment Checkups and Support:** Shift the focus of service interventions from acute stabilization to sustained recovery management via post-treatment recovery check-ups. Support the use of Peer Specialists for post-treatment follow up, stage appropriate recovery education, assertive links to recovery communities and, when needed, early re-intervention. Shift from passive aftercare to assertive approaches to continuing care.

**Relationship to Community** Greater collaboration with indigenous recovery support organizations (e.g., faith community); more assertive linkages of clients to local communities of recovery; greater role in recovery education/celebration in larger community and greater role in recovery advocacy (e.g., issue of stigma and discrimination).

## **Strategy-Aligning the Context: Activities to Sustain the Transformation Over Time**

To sustain the elements of our transformed system, significant efforts will need to be targeted at the community and broader systems in which Philadelphia's behavioral health system is embedded. People recover and sustain their recovery in their communities rather than in our treatment facilities. Thus just as DBH/MRS will be working internally and with providers to transform service delivery, the Department will also be working with the broader community to ensure that the people served have opportunities to maximize their potential in the community.

### **ACTION STEPS → Activities Geared at Sustaining the Transformation**

The changes that we will work toward to ensure the sustainability of our transformation include

- Increased community awareness and understanding of behavioral health illnesses;
- Decreased stigma regarding behavioral health issues;
- Increased local political support and understanding of the possibility of recovery and a meaningful life in the community for everyone. Developing a collaborative relationship with political leaders that engage their long term support with system transformation priorities;
- Stronger ties between the formal treatment system and informal community based supports;
- Stronger connection between the physical health provider community and the behavioral health provider community. Increase understanding of the behavioral health recovery potential and support needed for people with medical needs from the physical health care providers.

In addition to increasing community awareness, support, and opportunities, another critical element of aligning the context to sustain change will be identifying and addressing any regulatory barriers to the development of recovery- oriented care. The executive leadership of DBH/MRS recognizes that expectations for practice changes must be accompanied by regulatory relief in key areas. We have power to change many elements of our current practice, but in other areas we need the state to help address barriers to change. Our high level vision for the contextual changes needed to sustain this transformation will require stronger partnerships with federal and state officials aimed at:

- Providing regulatory relief via standards consolidation and integrated systems of program monitoring
- Breaking down existing funding silos that contribute to a fragmented, categorically segregated service system.
- Forging innovative financing models that can serve as the foundation for sustained behavioral health recovery support services.
- Creating data collection systems that will allow measuring system performance via key recovery benchmarks, (e.g., service access, service dose, recovery community links and recovery prevalence rates..).

### III. PHASES, GOALS AND TIMELINES FOR TRANSFORMATION

#### Phases of Philadelphia’s Behavioral Health System Transformation Initiative

The three components of the systems transformation planning process (aligning concepts, aligning practice, and aligning context) are being simultaneously implemented in what is envisioned as a four-phase process. This process is detailed in Table One below. Upon reviewing the table, it will be evident that we are now completing many of the components of Phase One of the Process. Phase One has centered primarily on developing Conceptual Alignment.

We are currently transitioning into Phase Two of our systems transformation process during which the greatest focus will be Practice and Contextual Alignment. As previously stated, however, our three change strategies (Conceptual Alignment, Practice Alignment, and Contextual Alignment) will not proceed in a linear fashion. We will continue to focus on increasing conceptual alignment.

In Phase Two of the process , our efforts to promote Conceptual Alignment will focus more on our ability to clearly operationalize recovery oriented principles into concrete practices, whereas in the first phase of our transformation processes, Conceptual Alignment was primarily oriented around achieving consensus on our collective values, guiding principles, and overall future direction.

The remainder of this document will detail the transformation plan specifically focusing on Phases Two and Three, promoting Practice and Contextual Alignment over the course of the next four years.

**Table One: Phases, Goals and Timelines of Philadelphia’s Behavioral Health System Transformation Process**

PHASE	GOALS	TIMEFRAME
ONE	<ul style="list-style-type: none"> <li>• Generate consensus on the desired future direction of behavioral health services in the city.</li> <li>• Develop initial conceptual clarity about the purpose of the transformation and critical guiding principles.</li> <li>• Bring multiple constituencies together to create conceptual clarity and begin the process of partnering for change.</li> <li>• Identify assets and opportunities in the system relative to a recovery orientation.</li> </ul>	January 2005– September 2006

PHASE	GOALS	TIMEFRAME
<b>TWO</b>	<ul style="list-style-type: none"> <li>• Develop and implement initial practice alignment priorities at the provider level.</li> <li>• Reorient internal DBH/MRS practices, procedures, and policies to be consistent with practice alignment priorities.</li> <li>• Identify areas in need of regulatory relief and begin to advocate for change.</li> <li>• Increase system leadership and direction from people in recovery and their families</li> <li>• Begin to gain community support for behavioral health transformation.</li> </ul>	September 2006 – June 2008
<b>THREE</b>	<ul style="list-style-type: none"> <li>• Evaluate and refine the initial system transformation activities that deserve priority based on priority areas.</li> <li>• Enhance practice alignment at the individual provider and systems level based on lessons learned.</li> <li>• Develop Models of Recovery Oriented Practices in the provider community which are infused with additional resources.</li> <li>• Expand priorities for practice alignment.</li> <li>• Obtain broader community support.</li> <li>• Increase advocacy at state and federal levels based on successes within the system and identified barriers to change.</li> <li>• Establish a culture of consumer direction and leadership throughout the System.</li> </ul>	July 2008–June 2010
<b>FOUR</b>	<ul style="list-style-type: none"> <li>• Utilize the feedback cycle to continue enhancing the system.</li> </ul>	July 2010 – June 2012

#### **IV. What to Expect in the Next Phase of Our Transformation Process**

##### **Phase Two**

**Timeframe:** September 2006 to June 2008

**Primary Focus:** Practice and Contextual Alignment

There are many directions that that we could pursue in order to promote practice alignment in Phase Two of our transformation process. DBH/MRS decided to identify initial priorities for practice alignment based on 1) the stakeholder feedback provided in the Recovery Asset Baseline Assessment; 2) the work of the Recovery Advisory Committee; and 3) feedback from the executive and senior management staff of DBH/MRS. As such, these priorities are thought to reflect the general consensus of numerous stakeholders in the system.

### **The Seven Priorities for Phase Two Are:**

- **COMMUNITY INCLUSION/OPPORTUNITY**
- **HOLISTIC CARE**
- **PEER CULTURE/PEER SUPPORT/LEADERSHIP**
- **FAMILY INCLUSION AND LEADERSHIP**
- **PARTNERSHIP**
- **EXTENDED RECOVERY SUPPORT**
- **QUALITY OF CARE**

The first five priorities are described earlier in this document. Extended Recovery Support refers to a way of looking at recovery as an ongoing journey that in many cases starts before someone ever accesses the service system and continues beyond the point of “stabilization” and is characterized by ups and downs, by greater and lesser needs for support.

We are asking the entire system to conceptualize the service delivery system in a way that includes this knowledge about recovery through

- Increased Access
  - Aggressive outreach and engagement;
  - Geo Mapping Matching behavioral health problem indicator with recovery resource and prevalence data by census track to identify areas of needed service infusion;
- Increased Retention
  - Transition from professionally directed Treatment Plans (aimed at acute biopsychosocial stabilization and recovery initiation) to Recovery Plans (aimed at sustained recovery maintenance);
  - Holistic, strength-based and continuing assessments;
- Increased Post-treatment Supports
  - Provider agencies have formal relationships with community organizations;
  - People in recovery are linked with natural supports;

- Formal post-treatment monitoring, support and, when needed, early re-intervention.

With regard to our final priority “Quality of Care,” the position of DBH/MRS is that a recovery-oriented system relies on excellence in clinical care/treatment. To support an individual’s recovery, the care delivered needs to be the best possible intervention, geared to the right stage in the recovery journey with careful attention to the person’s culture in the broadest sense of the word.

During the course of our transformation we will focus on different aspects of quality of care at different points in time. Some of these include using evidence- based practices, increasing the availability of trauma-informed services, addressing health disparities by enhancing cultural competence throughout the system and by developing specific programs for cultural groups (e.g. GLBT, Spanish speaking, hearing impaired, the Asian community, in addition to other cultural groups). We recognize that we cannot address all of these at once but will work continuously toward these ends.

These priorities represent seven specific areas of focus for the entire system during the next two years. They necessitate that during the next 24 months all of our systems activities be oriented to supporting them. Therefore, training and technical assistance will focus on these priorities, which will dictate how outcome measures are developed and policy and fiscal decisions are made.

Similarly, areas in need of immediate regulatory relief will be identified based on the extent to which they impede our collective ability to advance these priorities. All RFP’s will ask for an emphasis on them in any new service development Also processes and procedures at DBH/MRS will be restructured to support more effectively the integration of these priorities into our system of care.

## **V. The Implications of Our Seven Priorities For DBH/MRS, Providers and People in Recovery and their Families**

**ACTION STEPS** —————> **See Table Two For Strategies to Advance Our Priorities**

Table Two details some of the specific strategies that DBH/MRS, providers and people in recovery can utilize to advance our priority areas over the course of the next 24 months. This is not a comprehensive list, as detailing all of the potential strategies for change would make this document too prescriptive. Instead, we intend to lead this transformation in a recovery-oriented manner through partnership.

The examples in Table Two are provided to concretize the type of action steps that we envision will be critical to moving forward with specific priorities. We will provide opportunities and encourage open and ongoing dialogue about strategies to collectively advance these priorities, and obstacles that impede our progress.

## **VI. An Example of How Different Service System Enhancements Will be Utilized to Advance Our Priorities**

In addition to the seven priorities outlined above, during Phase Two we will also be focusing attention to a few service enhancements that are currently needed within our system. The areas of service enhancement that will be the focus of Phase Two include:

- Day Treatment Services
- Residential Services

These areas represent cross cutting initiatives that will be utilized to advance all of the priorities. Several examples could be provided here, but we will present the current Day Services Transformation Initiative here as a groundbreaking initiative that can form a “case study” for our understanding of how many of our service system enhancements will move forward.

### **The Day Services Transformation as a Template for Advancing our Priorities**

Consistent with the State’s blueprint for change, DBH/MRS has made a commitment to transform the existing partial hospitalization programs into recovery- oriented, community- integrated services that promote peer culture over the next 24-48 months. Both the process and the content of this transformation have been designed to be recovery oriented and reflect the three components of our transformation strategy (aligning concepts, practices and context).

**The Process:** Recognizing the impact a transformation of this magnitude will have on the system as a whole, DBH/MRS has engaged the provider community in the decision making process each step of the way, The Recovery Advisory Committee did much of the initial vision work (developing conceptual clarity). The provider community has helped develop the process through multiple meetings. An RFI (Request For Information) was sent to all the provider agencies that currently have partial programs in order to elicit from them their vision, their concerns and their description of the obstacles to this transformation effort. The feedback provided through the RFI is the basis for our ongoing conversation with the state. The decision to use this process was a deliberate one based on the system transformation values and priorities of partnership and the required design of these transformed services includes all the system priorities.

Recognizing that this effort will only succeed if contextual alignment occurs, DBH/MRS has engaged OHMSAS in a commitment to partner with us in this implementation. In conversation with them we are attempting to address the regulatory, funding,

documentation and licensing barriers identified by the previous conversations. They will be involved with us in planning each step of the way in order to achieve the results in which both parties are interested. In response to the RFI, additional training and consultation activities are planned to prepare the provider community for the process of responding to the RFPs due in the summer of 2006.

**The Content:** The proposed transformed services will address the five priority areas in the following way:

- **Community Integration:** While site- based services will still exist, the priority will be the development of services that support a life in the community. Funding for mobile services is being sought, agencies will be asked to develop partnerships in their local community to support the movement of people into the community, and services will be seen as a support to life in the community, not the person's life focus.
- **Holistic Care:** Providers are being asked to support persons in developing a life plan/recovery management plan based on the totality of who they are and what their hopes/dreams and goals for their life are rather than focusing primarily on symptom stabilization.
- **Peer culture/peer support/consumer leadership:** Providers will be asked to develop programs that support mutual self help both within the program and within the naturally occurring community. They will be required to include peer specialist services within their staffing patterns and to add people in recovery to their boards and include them in planning for this new service.
- **Family Inclusion/Leadership:** In response to requests by family members throughout the system these programs will participate in ACTIVE engagement of family members. Opportunities for family education and support will be part of the service design, family- friendly consent forms will be used whenever possible, and when desired by the person in recovery, family members will be included as active members of the team. Organizations will be expected to include family members (as defined by those being served) in their planning groups.
- **Partnership:** Recognizing that an undertaking of this magnitude will require full participation of all participants, partnership is required. Some evidences of this are the full participation of consultants in recovery in planning for and developing these services, full participation of the provider community in providing input and identifying barriers, regular meetings with OMHSAS to develop the mechanisms to make this transformation successful. At the provider level individuals in recovery and their family members in many cases have been involved in formulating the RFI responses and will be involved in formulating the RFP responses.

DBH will be providing technical assistance and consultation to the awardees during the implementation of these programs to assist the providers with the transformation process.

All training and TA activities will focus on supporting the implementation of our stated priorities, along with any other support that is needed to enhance the effectiveness of the programs.

## **VII. Looking Ahead: Phase Three**

**Primary Focus:** Practice Alignment and Context Alignment

Timeframe: July 2008 to June 2010

Planning for the continued transformation of our system is a dynamic rather than a static process. Therefore, it would be unrealistic to fully identify all of the strategies and approaches to be implemented in two years.. Much of what we learn in Phase Two will inform our thinking in and approaches to Phase Three.

Additionally, we intend to continue approaching our planning in a recovery- oriented way by establishing priorities and strategies based on the feedback of diverse stakeholders in the system. We anticipate that we will need to do another round of the Recovery Asset Baseline Assessment to see where our system is as we approach the end of Phase II and begin to plan for Phase III.

What we detail here is our current thinking about anticipated priorities for Phase Three of this transformation process. In addition to continuing our focus on the previous priority areas, in Phase Three we anticipate that our focus will expand to include the following areas:

### **Anticipated Priorities during Phase Three**

1. Locus of services more embedded in the community
2. Increased focus on quality of care
  - Evidence- Based Practices
  - Trauma -Informed Practices
  - Increasing cultural competence among all providers and decreasing health disparities.
3. Increased advocacy regarding regulatory relief using data that demonstrates the effectiveness of recovery oriented approaches implemented in Phase Two
4. Dissemination of findings from outcome studies in Phase Two and further alterations in practice patterns to reflect lessons learned.

## **VIII. Evaluating the Transformation Process**

The systems transformation led by DBH/MRS will be evaluated in two primary ways. First, periodic focus groups with key DBH/MRS staff, recovery advocacy representatives, service consumers, direct service personnel, program managers and administrators and representatives of key community organizations and allied fields will be conducted to evaluate progress on Systems Transformation Plan and its implementation.

Second, a formal review of systems benchmark data will be undertaken to measure the degree to which changes in the service system are affecting recovery-related benchmarks and long-term recovery outcomes. With improved data collection and analysis capabilities, it is hoped that a summary of the benchmark and outcomes data can be presented on an annual basis as a report card to the community of our progress toward achieving key recovery indicators.

During Phase Two, one aspect of the DBH internal re-alignment will include the identification of recovery measures and development of consistency of measures across the system. Evaluation will be done in terms of individual recovery progress, provider services in relation to providing recovery-oriented support and system-wide movement toward recovery-oriented support. The selection of these tools for measurement is currently underway as is the formation of an outcomes workgroup that will work at standardization of these tools across programs and across the system.

## **IX. How You Can be Involved in the Transformation Process**

Creating a more recovery-oriented system of behavioral health care in Philadelphia will require the commitment and talents of many people. If you would like to be a part of this movement, we invite your participation through such activities as the following:

- Participation in recovery-focused training
- Offering your ideas and feedback through participating in community forums hosted by DBH/MRS
- Acquainting yourself with the classic papers on recovery advocacy and key recovery-related research and research-to-practice articles.
- Volunteering to participate in the DBH/MRS focus groups and work groups that will guide the systems transformation process.
- Finding opportunities to listen to the stories of people in recovery and learn from them what helps and what hurts if you are a person who works in or provides services in the system.

We welcome your feedback regarding this transformation plan. If you have any suggestions, comments or concerns, please address them to Ijeoma Achara-Abrahams, PsyD at [ijeoma.achara-abrahams@phila.gov](mailto:ijeoma.achara-abrahams@phila.gov) or to Mike Covone at [Michael.Covone@phila.gov](mailto:Michael.Covone@phila.gov).

The City of Philadelphia has been on the cutting edge of behavioral health care for more than two centuries. The transformation we are currently undergoing builds on the strengths in our system and continues that tradition of leadership into the future. We invite you to join us to shape the future not only for people in recovery, but ultimately for all of us.

**Table Two: Phase Two Practice Alignment Priorities  
July 2006 to June 2008**

Priority Area	DBH/MRS Activities to Advance the Priority (examples)	Provider Activities to Advance the Priority (examples)	Consumer and Family Activities to Advance the Priority (examples)
<p><b>Community Inclusion/ Opportunities</b></p>	<p><b>Strategies</b></p> <p>Negotiating with state and federal funding agencies to re-align funding priorities to support community-based services and supports.</p> <p>Prioritizing community integration strategies in all new program proposals.</p> <p>Creating a Community Integration task force to identify and develop resources to support providers in increasing their knowledge and practice in this area.</p> <p>Developing and distributing resources on strategies for promoting community integration.</p> <p>Developing formalized partnerships with systems and organizations outside of behavioral health</p> <p><b>Initiatives</b></p> <ul style="list-style-type: none"> <li>• Faith Based Initiative</li> <li>• Coalitions of Care</li> </ul>	<p><b>Potential Strategies</b></p> <p>Developing expertise about formal and informal local community resources.</p> <p>Developing formal links between treatment institutions and natural support structures in the community.</p> <p>Supporting community connections through bridging activities (going w/ people and leading them into the community until they are comfortable).</p> <p>Volunteering to be a support person to someone who is checking out a community resource that you might also be interested in. Learn together.</p> <p>Utilizing people in recovery to develop and support community integration activities</p> <p>Increasing community organization activities aimed at the cultivation of non-clinical recovery support services outside the treatment agency.</p>	<p><b>Potential Strategies</b></p> <p>Beginning to dream. Identifying things that you would like to be a part of in the community.</p> <p>Sharing resources you know with each other and with your service providers.</p> <p>Identifying obstacles to community participation and sharing those with service providers, the Consumer Satisfaction Team and DBH/MRS at community forums.</p> <p>Participating in anti-stigma campaigns.</p>

Priority Area	DBH/MRS Activities to Advance the Priority (examples)	Provider Activities to Advance the Priority (examples)	Consumer and Family Activities to Advance the Priority (examples)
<p><b>Holistic Care</b></p>	<p>Working with state and local partners to develop more strength-based criteria for medical necessity, shifting to more recovery-focused regulations and development of person centered, strength- oriented assessment and documentation tools.</p> <p>Soliciting wellness approaches and strength -based approaches in all new program proposals.</p> <p>Developing standards and providing training related to cultural competence and strategies for reducing health disparities.</p> <p>Continuing collaborative efforts between CBH and physical HMO's toward the goal of decreasing the fragmentation of care.</p> <p>Developing models for integration of behavioral health care and primary medical care.</p> <p><b>Initiatives:</b>            -Cultural Competence/Health Disparities workgroup            -Trauma workgroup            -Faith Based Initiative</p>	<p>Developing a cultural competence team within agencies to address issues of competence and health disparities.</p> <p>Advocating and developing <u>recovery support programs</u> for specific cultural groups in the local community.</p> <p>Developing assessment processes that are ongoing and holistic (focused on the whole person, not just their behavioral health challenge and/or symptoms) and using &amp; refining global assessment; instruments (e.g., ASI, GAIN).</p> <p>Exploring the role of spirituality or religion in a person's life and connecting them with relevant resources or integrating it into the treatment approach.</p> <p>Exploring the individual's life goals and building the recovery process around the attainment of life goals rather than symptom reduction.</p> <p>Developing partnerships with other community organizations that can assist with addressing the needs of the whole person.</p>	<p>Participating in educational experiences to increase ability to advocate for self and others in both physical and behavioral health system.</p> <p>Sharing your stories to assist in development of change strategies.</p> <p>Volunteering to participate in activities designed to educate the community about the reality of recovery and diverse pathways of recovery.</p> <p>Advocating development of recovery-focused activities by community institutions, e.g., schools, churches, community centers.</p>

Priority Area	DBH/MRS Activities to Advance the Priority (examples)	Provider Activities to Advance the Priority (examples)	Consumer and Family Activities to Advance the Priority (examples)
<p><b>Peer Culture/Peer Support/Leadership</b></p> <ul style="list-style-type: none"> <li>• Leadership development</li> <li>• Peer specialist role</li> <li>• Recovery support programs in educational institutions</li> <li>• Employment of recovering people at all levels of the behavioral health system</li> <li>• Recovery-conducive employment resources</li> </ul>	<p>Hiring recovering persons within DBH/MRS as staff and as consultants for policy and program development.</p> <p>Developing a recovery leadership institute in partnership with advocacy organizations.</p> <p>Further development of peer specialist role, e.g., resources for role definition, orientation and training protocol, ethical guidelines for service delivery.</p> <p>Developing a peer culture workgroup to establish principles, practices, training strategies to promote further development of local communities of recovery.</p> <p>Promoting peer-based sober housing and employment models via funding resources, regulations promoting safety and quality and linkage of local efforts to national resources, e.g. Oxford Houses.</p> <p>Promoting use of recovery peers in non-traditional settings, e.g., community outreach organizations.</p>	<p>Hiring of people in recovery at all levels of the organization.</p> <p>Including people in recovery as representatives on all boards/policy-making bodies.</p> <p>Recognizing the contribution of peers, developing and celebrating mechanisms for peer leadership, peer support internally and learn about external mutual self-help groups.</p> <p>Training staff on varieties of recovery experience and diversity of recovery mutual aid structures.</p> <p>Including an evaluation of knowledge of national/local communities of recovery in the evaluation of all service personnel.</p> <p>Encouraging the development of diverse recovery support structures, e.g., starter packets for new groups, staff consultation and support.</p>	<p>Sharing community based mutual self-help resources with providers.</p> <p>Assisting peers in accessing recovery mutual aid resources.</p> <p>Developing oneself as a peer leader via training and mentor relationships.</p> <p>Serving as a member and volunteer of a local recovery advocacy and support organization (e.g., PRO-ACT MHASP).</p> <p>Seeking opportunities to serve in leadership roles throughout the behavioral health system</p>

<b>Priority Area</b>	<b>DBH/MRS Activities to Advance the Priority (examples)</b>	<b>Provider Activities to Advance the Priority (examples)</b>	<b>Consumer and Family Activities to Advance the Priority (examples)</b>
<b>Partnership</b>	<p>Collaborating with providers in the development of new programs, training, and policy decisions.</p> <p>Using collaboration and open communication as the guiding principle of all evaluation activities.</p> <p>Using the Recovery Advisory Committee in policy development for all aspects of the behavioral health care system.</p> <p>Increasing collaboration efforts with PRO-ACT and MHA.</p> <p>Developing incentives for providers to increase the extent to which they partner with people in recovery and the families of people in recovery.</p> <p>Increasing the number and type of opportunities that all stakeholders have to come together and plan for the future direction of the system e.g. community forums etc.</p>	<p>Including all stakeholders in meetings that involve planning for individual people in recovery. The contributions of all should be valued and respected.</p> <p>Conducting regular meetings between lead agency staff and representatives of local mutual aid service structures, (e.g., H&amp;I committees, recovery ministries) to build relationships and ease movement of people into these systems.</p> <p>Facilitating presentations to people at agencies from community groups and from agencies to community to groups.</p> <p>Conducting focus groups to obtain feedback from all stakeholders who receive or provide services at an agency and increase collaborative planning.</p> <p>Developing all recovery plans in collaboration and partnership with people in recovery</p> <p>Exploring ways to empower frontline staff</p>	<p>Participating in committees and boards.</p> <p>Advocating for other people in recovery and family members who may need support in speaking for themselves, to support the development of working partnerships.</p>

<b>Priority Area</b>	<b>DBH/MRS Activities to Advance the Priority (examples)</b>	<b>Provider Activities to Advance the Priority (examples)</b>	<b>Consumer and Family Activities to Advance the Priority (examples)</b>
<p><b>Recovery Support Planning and Implementation</b></p> <p><b>-Access</b> <b>-Retention</b> <b>-Post Treatment Supports</b></p>	<p>Disseminating information and sponsoring training events on peer-based recovery support services.</p> <p>Funding and evaluating innovative approaches to the delivery of peer-based recovery support services.</p> <p>Developing model protocol for the hiring, orientation, training and supervision of peer-based recovery support services.</p>	<p>Providing assertive pre-treatment engagement services for individuals on waiting lists to begin treatment.</p> <p>Analyzing factors related to unsuccessful completion of treatment and subject these factors to QI processes.</p> <p>Developing formal post-treatment monitoring processes for all admitted clients that follow graduates for a period of time to offer support and increase their success at full inclusion in the community.</p> <p>Developing recovery volunteer programs.</p> <p>Developing or enriching alumni associations.</p>	<p>Volunteering to lead and participate in treatment alumni associations.</p>

<b>Priority Area</b>	<b>DBH/MRS Activities to Advance the Priority (examples)</b>	<b>Provider Activities to Advance the Priority (examples)</b>	<b>Consumer and Family Activities to Advance the Priority (examples)</b>
<p><b>Quality of Care Initiatives</b>  <b>-Health Disparities</b>  <b>-EBP</b></p>	<p>Developing CQI mechanisms through data collection/analysis as well as recovering person/provider feedback that track individual recovery measures and program performance along various demographic and clinical variables.</p> <p>Conducting cultural competence assessment of the organization and develop a cultural competence plan for the department and the system.</p>	<p>Expanding access to primary health care via assertive linkage between treatment and primary care physicians or pilots that integrate primary health care within addiction treatment and continuing care.</p> <p>Getting involved in local and state advocacy efforts to maintain and increase funding for services.</p> <p>Conducting cultural competence assessments of your agency and develop cultural competence plans.</p>	<p>Participating in surveys or questionnaires geared at assessing the quality of the services people are receiving.</p> <p>Participating in CST interview to discuss the quality of services they are receiving when solicited.</p> <p>Giving feedback to the system when there are deficits in the quality of care being received by people as part of the complaint and grievance procedures.</p> <p>Becoming involved in political action to increase funding, eliminate disparities.</p> <p>Providing recommendations to your providers and DBH/MRS regarding what works and what helps.</p>

<b>Priority Area</b>	<b>DBH/MRS Activities to Advance the Priority (examples)</b>	<b>Provider Activities to Advance the Priority (examples)</b>	<b>Consumer and Family Activities to Advance the Priority (examples)</b>
<p><b>Family Inclusion and Leadership</b></p>	<p>Soliciting the guidance and expertise of the family members of persons in recovery to assist with planning activities and day to day operations of the system</p> <p>Developing standards to ensure that family members always have the opportunity to participate in the treatment of their loved one (if it is their choice)</p> <p>Ensuring that family members are a part of all system transformation committees.</p> <p>Developing opportunities for families and people in recovery to tell the system how they would like to be included rather than making assumptions about the type of involvement they would like to have.</p> <p>Hiring a cadre of family members to serve as advisors to the system.</p> <p>Developing formalized opportunities/funding for family members of people in recovery to support other family members.</p>	<p>Providing opportunities for family members of people receiving services to participate on board and have other leadership roles in the organization.</p> <p>Obtaining family guidance and feedback both before new services are developed and during the implementation of new and existing services through focus groups and surveys.</p> <p>Providing opportunities for people receiving services to have their families included in the process to the extent that they would prefer.</p> <p>Exploring the desire to rebuild connections with family members in situations where relationships have been severed and making this a priority in the treatment process if desired by the person receiving services.</p> <p>Considering hiring family members of people in recovery for various positions within the agency.</p> <p>Developing family support groups.</p>	<p>Seeking opportunities to serve on boards and in other leadership positions in provider organizations and the system in general.</p> <p>Participating in community forums, focus groups, surveys etc to share your expertise and perspective regarding what the strengths and challenges in the system are.</p> <p>Requesting, leading and/or participating in family support groups if desired.</p> <p>Participating in training programs such as “train the trainer” opportunities in order to position yourself to serve as a resource to the system.</p> <p>Continuing to advocate for the desired services for your loved ones and become connected with formal advocacy organizations to obtain support and increase the visibility of your message.</p>