The Evolution of Philadelphia’s Behavioral Health Response

This paper is the third in a series on system and community responses to trauma, published by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). The paper was written by Pamela Woll, MA, CADP, based on interviews with key players in the Philadelphia Trauma Transformation: DBHIDS Commissioner Arthur C. Evans, Jr., PhD, OmiSade Ali, MA, CADC, CCS, Ava Ashley, MA, JD, Steven Berkowitz, MD, Sandra Bloom, MD, Judith Cohen, MD, Edna Foa, PhD, Matthew Hurford, MD, Kamilah Jackson, MD, MPH, Antonio Valdés, MBA, Kalma Kartell White, MEd, CPRP and Arturo Zinny, LPC, MA. (More information about these sources is listed on the page 6.) The first paper in the series is entitled “Safety, Strength, Resilience and Recovery: Trauma-informed Systems and Communities”; and the second is “Seeding a System’s Response to Trauma: Philadelphia’s Integrated Network of Trauma-informed and Trauma-focused Behavioral Health Care.” These papers are meant to inspire change agents in other systems and communities to meet the challenge of trauma, carrying with them the hope gained and lessons learned in Philadelphia.

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has a long history of re-making itself to meet shifting realities and new insights about what is working and what is not. That history has given a place of national prominence to the city’s Recovery- and Resilience-oriented Systems of Care (ROSC) Transformation, begun in 2006. Now the Department is in the fifth year of a multifaceted Trauma Transformation effort. Beginning with behavioral health practitioners and reaching out to old and new partners within the city and its systems of care, the Department is combining evidence-based practices and innovative approaches, to raise the level of resilience and heal the effects of trauma in the City of Brotherly Love.

Philadelphia is a diverse city with a strong spirit, whose financial challenges have been putting its resilience to the test. With half of Philadelphia’s households living on less than $35,000 a year, unemployment rates topping 20 percent in many low-income neighborhoods and three of every ten residents living below the poverty line, many Philadelphians are weathering the kind of chronic toxic stress that can take its toll on body, mind and spirit. Resilience—the ability to “bounce back” and keep going under adversity—can be hard to hold onto when resources are running low.

Of the ten largest cities in the U.S., Philadelphia has the highest homicide rate. Trauma is very much in evidence there. Last year Medicaid paid for treatment of 5,100 residents with trauma-related diagnoses, and the Department of Human Services (DHS, the city’s child welfare agency) served 71,000 children and youth. Of the 3,700 children and adolescents served at the city’s Crisis Response Center each year, staff estimate that at least 75% have undergone trauma, a natural response to experiences that overwhelm the body’s and the mind’s capacity to cope. Adaptive though that response may be at the time, its effects sometimes leave people more vulnerable to acute or chronic physical, psychological, developmental, educational, occupational, economic, medical, behavioral, social, spiritual, cultural or legal challenges.

Steps Toward Transformation

Focusing first on the needs of women affected by poverty and abuse, change agents in Philadelphia began raising awareness of these issues in training sessions throughout the city in the late 1990s. When DBHIDS began its formal transformation to a recovery and resilience framework in 2005, the agency made an explicit connection between trauma and behavioral health challenges, and deepened its conviction that any success in promoting recovery and resilience would have to address this pivotal issue.
With one of the principal architects of Connecticut’s Recovery-oriented Systems of Care (ROSC) movement (Arthur C. Evans, PhD) now serving as DBHIDS Commissioner, Philadelphia began its ROSC transformation process in 2006. “Trauma-informed Approaches” was one of the ten core values that stakeholders articulated in that process, calling on Philadelphians to address the effects of trauma in the design of service systems, delivery of services, helping relationships, assessment and delivery of clinical and support services.4

In 2006 the Mayor’s Blue Ribbon Commission on Children’s Behavioral Health was convened, tasked with answering the question, “If we did not have the systems that we have now, what would we build to promote social and emotional wellness in Philadelphia’s children?” The comprehensive set of recommendations published in the Commission’s report clearly reflected an understanding of, and a determination to address, the kinds of challenges that trauma can bring to children and families.

Also in 2006, DBHIDS stepped up its direct efforts on trauma. Staff in the Child and Adolescent Services unit began a number of programs that addressed the problem in earnest, and DBHIDS created its Trauma Unit, which would become the Trauma Transformation Unit in 2008. They gathered people in the community who were working on these issues and began to plan a comprehensive response. Transformation of the behavioral health response to trauma started with a recognition that trauma is important, widespread and often unaddressed in our service systems. The early goals of this process were to:

• Raise awareness and understanding of trauma in behavioral health settings
• Ensure that behavioral health providers meet at least a minimum level of trauma competence, including the ability to identify post-trauma effects and connect people with trauma-focused services
• Ensure that effective trauma-focused treatment is available to a variety of populations

In 2010, DBHIDS began to plan a process that would seed the city’s behavioral health system with evidence-supported trauma-informed care (approaches designed to make a variety of situations and services safe for people with trauma histories) and evidence-based trauma-focused treatment (practices designed to heal the effects of trauma). The Department recruited four of the country’s leading experts in the field: Steven Berkowitz, MD, developer of Child and Family Traumatic Stress Intervention; Judith Cohen, MD, developer of Trauma-Focused Cognitive-Behavioral Therapy; Edna Foa, PhD, developer of Prolonged Exposure Therapy; and Sandra Bloom, MD, co-developer of The Sanctuary Model of trauma-informed care.

They envisioned an integrated network of trauma-informed behavioral healthcare organizations, each with expertise in evidence-based trauma-focused treatment for children, adolescents and/or adults. Portals to this network would include improved awareness and identification of challenges within the community; screening programs in a variety of community settings; and, for children/youth and their families, trauma-focused intervention in community settings. After three years’ worth of expert training, technical assistance, supervision and practice, key staff in 21 treatment agencies have been prepared to provide trauma-focused treatment (with six more in the current cohort), five people are providing intervention to children/youth and all participating agencies have been trained in The Sanctuary Model. (See the paper, “Seeding a System’s Response to Trauma: Philadelphia’s Integrated Network of Trauma-informed and Trauma-focused Behavioral Health Care.”)

Transformation of the Vision

As Philadelphia’s behavioral health response to trauma has evolved, its vision has expanded to include a stronger focus on safe, resilient, trauma-informed communities that are home to integrated, trauma-informed systems of safety and care. Behavioral health has a high stake in—and a great deal of responsibility for:
• Learning from the experience of its many partner systems—medicine, child welfare, criminal justice, education, public safety and the rest—and helping them hone their understanding of and response to trauma
• Helping communities, not only weather the effects of trauma, but also become safe and resilient places where trauma is less likely to take hold

This public health model looks beyond treatment to a variety of approaches toward public education, community resilience, safety, prevention, vigilance, effective intervention and integrated healthcare. This type of approach may well be able to reduce human suffering and conserve limited resources, so it is gaining momentum on a national level. As Philadelphia faces the future, the Department’s strategic focus is on the concrete manifestations of this vision: what a trauma-informed community will look like, existing models that might inform this process and trauma-informed policies that might make it a reality.

Another important part of this vision is the integration of the DBHIDS trauma transformation with the ROSC transformation that is, in reality, its natural companion. Trauma-informed care is one of the ten core values that underlie the ROSC movement, and recovery support is an essential element of any effective response to trauma, but even those points fail to capture the scope and depth of the connection between these two models:
• Trauma may well be the strongest driving force behind the vulnerability, instability and complexity of need that make recovery-oriented systems of care so essential.
• With its emphasis on strength-based, peer-driven, person-first (culturally competent), empowering and collaborative services and support—and its grounding in a multi-system approach—the ROSC model is an excellent vessel for both trauma-informed care and trauma-focused services.
• The two approaches are complementary. While ROSC has a strong focus on concrete activities, trauma-informed care provides deeper information on the way those activities are performed and the human beings who provide and receive services. Trauma-informed approaches are also designed to protect recovery.

The Art of Transformation

Although DBHIDS and its partners are not even halfway on their journey from the original to the expanded vision, observation and experience in this process—and in the more seasoned ROSC transformation—have yielded a number of insights and lessons learned. These lessons make up the rest of this paper, to help partners in this or any other transformation process find a more direct path toward their goals and their purpose.

Just as there is no reliable cause-and-effect formula for predicting the course of change in a human life, there is no simple formula for plotting out a transformation process in an organization, a system or a community. In large-scale change efforts, these systems are very much like individuals in search of healing. It is helpful to:
• Start with conceptual clarity before moving into action: It will save time and aggravation.
• Assess needs and readiness at the beginning, to avoid misdirection of time, energy and resources.
• Set clear standards for participation in new programs and initiatives.
• Decide what success will look like. Build outcome evaluation measures at the start, and use them to guide training and implementation.

From small human changes to large system-transformation processes, the best leadership tool may be a basic understanding of human nature, the difficulty with which we change and our need for respect and patience.

“Perseverance is required to bring about a change in anything. Knowing that people are going to make mistakes, we have to set up systems that will allow us to learn from our mistakes—and give us leeway to do that. It takes a lot of patience.”

—Sandra Bloom, MD
• Asked to embrace a different approach toward their work, many people will instinctively defend the status quo, as if changing would be an admission that their former work was inadequate.

• People may also fear change because they fear making mistakes and losing face. Change leaders need to create processes that will allow people to live through and learn from their mistakes.

• Leaders also need to understand that adopting a new way means the loss of the old way, give people room to grieve and respect the courage it takes to embrace the new.

Another common response to any new approach—especially in an under-resourced world where people are already overwhelmed—is to see it as yet another “flavor of the month,” another layer of responsibility and demand. In the case of transformation toward trauma-focused services and trauma-informed organizations, systems and communities, the truth is far more reassuring:

• Although evidence-based trauma-focused services do add some heavy tools to the clinician’s belt, they are often more precise and effective tools, well worth carrying.

• Trauma-informed care (TIC) is not an additional set of duties, but a new way of understanding the same challenges clinicians have been facing—and a more effective way of meeting the same responsibilities.

• By creating a safer atmosphere, TIC can increase stability, promote engagement, prevent crises, strengthen recovery and make the clinician’s job easier and more pleasant.

• As mentioned earlier, trauma-informed care is a natural fit with the recovery- and resilience-oriented system of care (ROSC) model that many behavioral healthcare systems have begun to embrace.

• Trauma-informed systems and communities are critical to the success of any public health approach or integrated system of healthcare. Toxic stress and trauma may be the most common factors raising vulnerability to a host of acute and chronic illnesses.5

New practices can be expensive, and sustainability is often a challenge. Beyond the early costs of training and implementation lie the need for expanded supervision, ongoing input from the experts and new ways of measuring and evaluating fidelity and outcomes. If there is too much financial resistance, it may be time to dig into the data on all the challenges that often follow trauma. The costs of effective trauma-informed approaches and trauma-focused services pale in comparison with the many costs of unaddressed trauma.

The Art of Relationship

Relationship—human connection—is often the most essential factor in building resilience, the strongest protection against trauma and the most powerful force in healing its effects. Relationship may also be the most pivotal factor in the success of any transformation or change process. To promote commitment and timely dissemination of information within the system, change leaders must form strong relationships, not just with leadership, but with front-line stakeholders as well. People at all levels are essential to this process.

Some of the most daunting challenges are the most concrete, including the difficulty of maintaining contact with a truly representative body of stakeholders, fitting multidisciplinary meetings into multiple schedules and addressing the transportation issues that often complicate an inclusive face-to-face approach. It is difficult—but important—to use technology to support relationship, rather than replace it. Web-based meetings and training can solve some logistical challenges, but when partner organizations lack the technology to join in, it can work against inclusiveness, and sometimes relationship building requires more tangible forms of connection.

Cross-system collaboration is essential. Behavioral health settings are not the natural habitat of many community members. Most people are more likely to turn first to other formal and informal sources of support:

• Primary care is one of the most important partners in collaboration. Many people consult their primary care physicians for behavioral health conditions long before they consider seeking behavioral health care.

• Faith and spiritual communities, including indigenous healers, are equally important in these efforts. Although some cultures consider trauma and behavioral health conditions “taboo” subjects, many who have reached across the cultural divide have found that these topics are acceptable if they learn how other cultures think of, talk about and experience these conditions. It can be a matter of respectful translation.

“People who get into leadership positions have to know when to lead and when to bite their tongues.”

—Sandra Bloom, MD
• In an inventory of community partners, it is important never to forget the many people offering peer support. Given the powerful effects of peer support on resilience, healing and long-term recovery—and the wealth of wisdom that can follow lived experience—these may be the most important partners of all.

Some behavioral health providers in Philadelphia have embedded community connection in their mission and vision and have lived that connection through their services and collaborative efforts. Their partners include faith communities, housing support, recovery groups, civic organizations, parenting education and training programs and many other community resources. Collaboration with these partners—and with the many other formal and informal sources of support in the community—can extend the movement’s reach, deepen the change agents’ understanding and strengthen the bonds between service systems and the larger community.

### Carrying the Message

Community awareness of trauma—particularly child trauma—is beginning to reach critical mass, but there is still much work ahead. In some communities people are still stigmatized for having been through experiences that can lead to trauma, and those who develop post-trauma effects may still be considered weak or “defective.” Whatever else the message carries, it is essential that it not stigmatize or stereotype people, and not sensationalize or “pathologize” their experiences or conditions.

Tools such as Mental Health First Aid (MHFA) can be helpful. This program trains community members and public safety personnel (e.g., police, fire) to identify, understand and respond to signs of behavioral health conditions and crises. MHFA provides separate training programs for general community members (preparing adults to help other adults), public safety staff and adults who work with youth. Philadelphia is one of the first major metropolitan areas to implement MHFA on a large scale.

Change agents can also use crises as opportunities for stakeholder education, fertile ground for sowing program information. For example, a high-profile incident in the community might be an appropriate subject for a community forum or a careful, respectful, and de-stigmatizing op-ed piece.

Public education efforts go hand-in-hand with education of the media—print media, social media, television and radio, including college and university outlets. Effective media outreach can reduce sensationalistic coverage of crises and promote community resilience and readiness, awareness of the signs and symptoms of trauma, enrollment in services, interest and involvement in the initiative and understanding and de-stigmatization of post-trauma effects. Resources from the Dart Center for Journalism and Trauma at Columbia University (http://www.journalism.columbia.edu/page/215-dart-center/) can support media education efforts.

In plans for community education, it is important not to forget people who are receiving services, and those who are considering making the courageous decision to seek help. People need to know what to expect when they seek services, their rights, their options and how to make the most of their time in treatment. Since the experience of trauma often revolves around shock and helplessness, it stands to reason that structure, consistency and knowing what to expect in treatment might be very empowering.

And finally, as important as it is to raise awareness of trauma and its effects, it is even more important to raise awareness of community resilience, to inspire hope and to catalyze those caring relationships that keep people strong and willing to seek help when help is needed. This is a message that everyone needs to hear, and change agents might need to hear it most often. Swimming upstream can be difficult. Having convictions that are just a little ahead of their time can leave change leaders feeling isolated, wondering if they might just be wrong. But stepping into that room, dialing in to that call, hearing the voices of others who see the same future—this is the reward. This is the fuel that keeps transformation going.

In Philadelphia, and in a growing number of communities large and small, change agents are finding one another. They are not giving up. They are re-inventing themselves, their systems and their communities to meet the future, and to leave it a little better than they find it.

“No matter where people show up in the community, somebody’s been exposed to enough of an understanding of trauma to know what to do and how to connect them to the resources they need. That is our vision, as a city and as a system.

—Arthur C. Evans, Jr., PhD
Acknowledgments

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References


3 Ibid.