The Impact Of Opiate Use on Philadelphia’s Chronically Homeless

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Philadelphia

- The US Census Bureau estimates that the City's population was 1,560,297 in 2014,
  - approximately 22% younger than 18 years old
  - 12.4% 65 years and older.
  - Over half of Philadelphia's population is women (52.7%).
  - 44.2% of the population is African American,
  - 45.5% are White,
  - 6.9% are Asian, and
  - 3.3% are other races. Among these, 13.3% are of Hispanic origin.

National Drug Early Warning System (NDEWS), Philadelphia Sentinel Community Site Drug Use Patterns and Trends, 2015, Suet Lim, Ph.D.

Table 1: Demographic and Socio-Economic Characteristics
Philadelphia County, Pennsylvania
2009-2013 ACS Five-Year Estimates

	Estimate	Margin of Error
Total Population (#)	**1,536,704**	**
Age (%)		
18 years and over	77.6%	**
21 years and over	72.1%	+/-0.1
65 years and over	12.2%	**
Median Age	33.6	
Race (%)		
White, Not Hisp.	36.6%	+/-0.1
Black/African American, Not Hisp.	42.0%	+/-0.1
Hispanic/Latino	12.7%	
American Indian/Alaska Native	<1%	+/-0.1
Asian	6.5%	+/-0.1
Native Hawaiian/Pacific Islander	0.0%	+/-0.1
Some Other Race	<1%	+/-0.1
Two or More Races	1.8%	+/-0.1
Sex (%)		
Male	47.2%	+/-0.1
Female	52.8%	+/-0.1
Educational Attainment (*Among Population Aged 25+ Years*) (%)		
High School Graduate or Higher	81.2%	+/-0.3
Bachelor's Degree or Higher	23.9%	+/-0.3
Unemployment (*Among Civilian Labor Force Pop Aged 16+ Years*) (%)		
Percent Unemployed	8.9%	+/- 0.2
Income		
Median Household Income (in 2013 inflation-adjusted dollars)	$37,192	+/- $424
Poverty (%)		
People Whose Income in Past Year is Below Poverty Level	26.5%	+/-0.5

NOTES:
Margin of Error: can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value.
**The estimate is controlled; a statistical test for sampling variability is not appropriate.

SOURCES: Adapted by the NDEWS Coordinating Center from data provided by the U.S. Census Bureau, 2009-2013 5-Year American Community Survey (ACS).

Philadelphia

- Among major cities in the United States, Philadelphia's poverty rate of 26.3% in 2013 is among the highest in the nation.
- According to the Philadelphia Inquirer (9/25/15) Philadelphia is the poorest big city in America and has the highest rate of deep poverty (people with incomes below half of the poverty line) of any of the nation's 10 most populous cities.
- There are approximately 60,000 children in the city who live in deep poverty.
  - The percent of children living in poverty in Philadelphia rose every year from 2006 and 2011 to 40%, compared to a national rate of 21%.
- The average number of Philadelphians who were enrolled in Medicaid is over 450,000, which is almost one-third of the city's population.
- At the same time, more than 75% of Philadelphia's population under the age of 18 is enrolled in Medicaid, which is an extraordinarily high percentage.
- In addition, 21% of Philadelphians speak a language other than English at home.

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Street Homeless In Philadelphia

Significance

(as of 8/20/2015)

- It is estimated that the chronically homeless make up approx. 30% of the population of the Philadelphia Prison System.
- Trends:

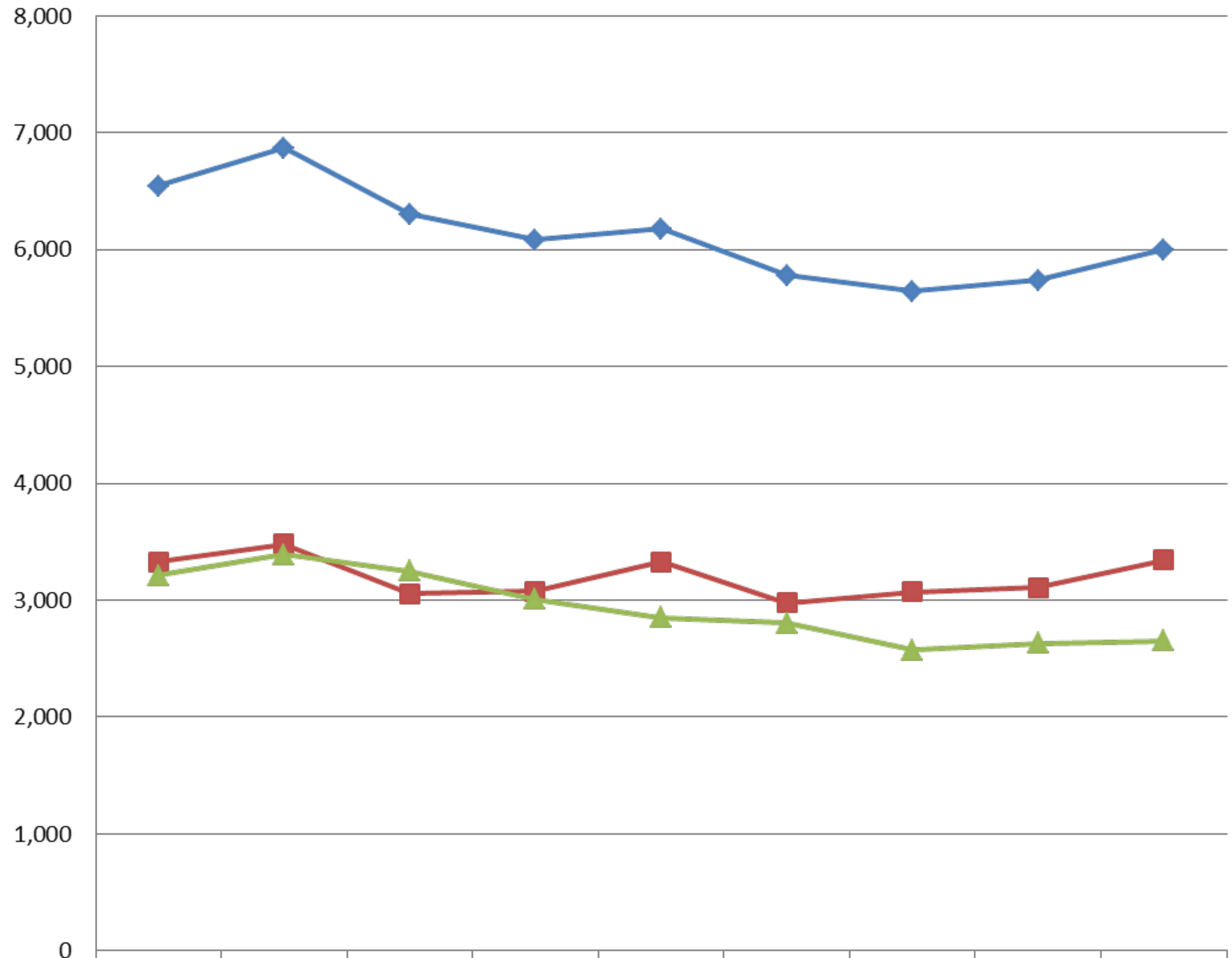
Philadelphia CoC

Homeless Point-in-Time (PIT)* Counts 2010 - 2015

* HUD defines the PIT count as "count of sheltered and unsheltered homeless persons carried out on one night in the last 10 calendar days of January or at such other time as required by HUD" (24 CFR 578.3).

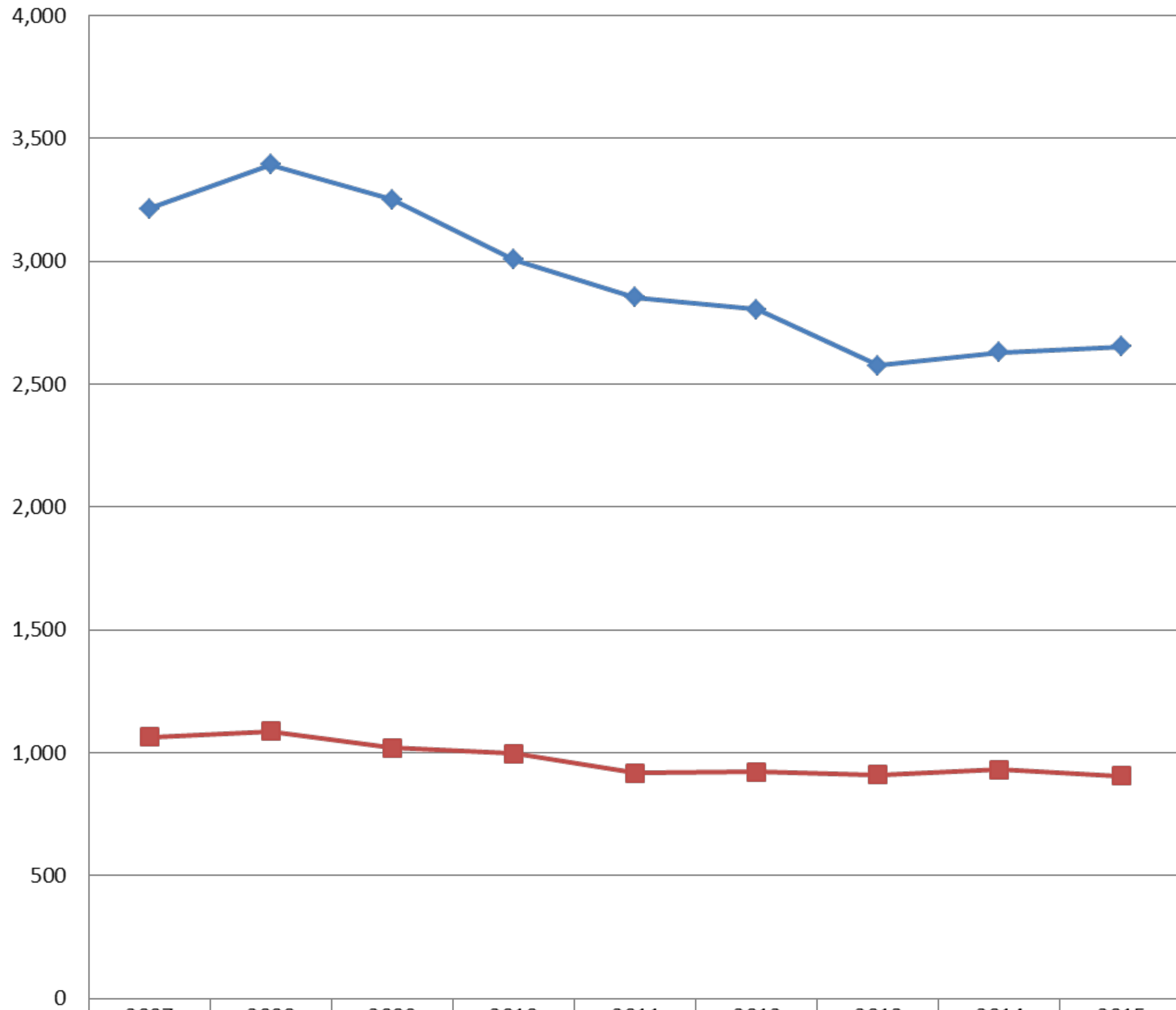
Chronically Homeless (Sheltered + Unsheltered)	**2015**	**2014**	**2013**	**2012**	**2011**	**2010**
Single Individuals	**739**	**612**	**597**	**590**	**649**	**580**
Persons in Families	**90**	**90**	**36**	**57**	**86**	**N/A**

Philadelphia Point-in-Time Homeless Count: 2007-2015
Individuals and Families



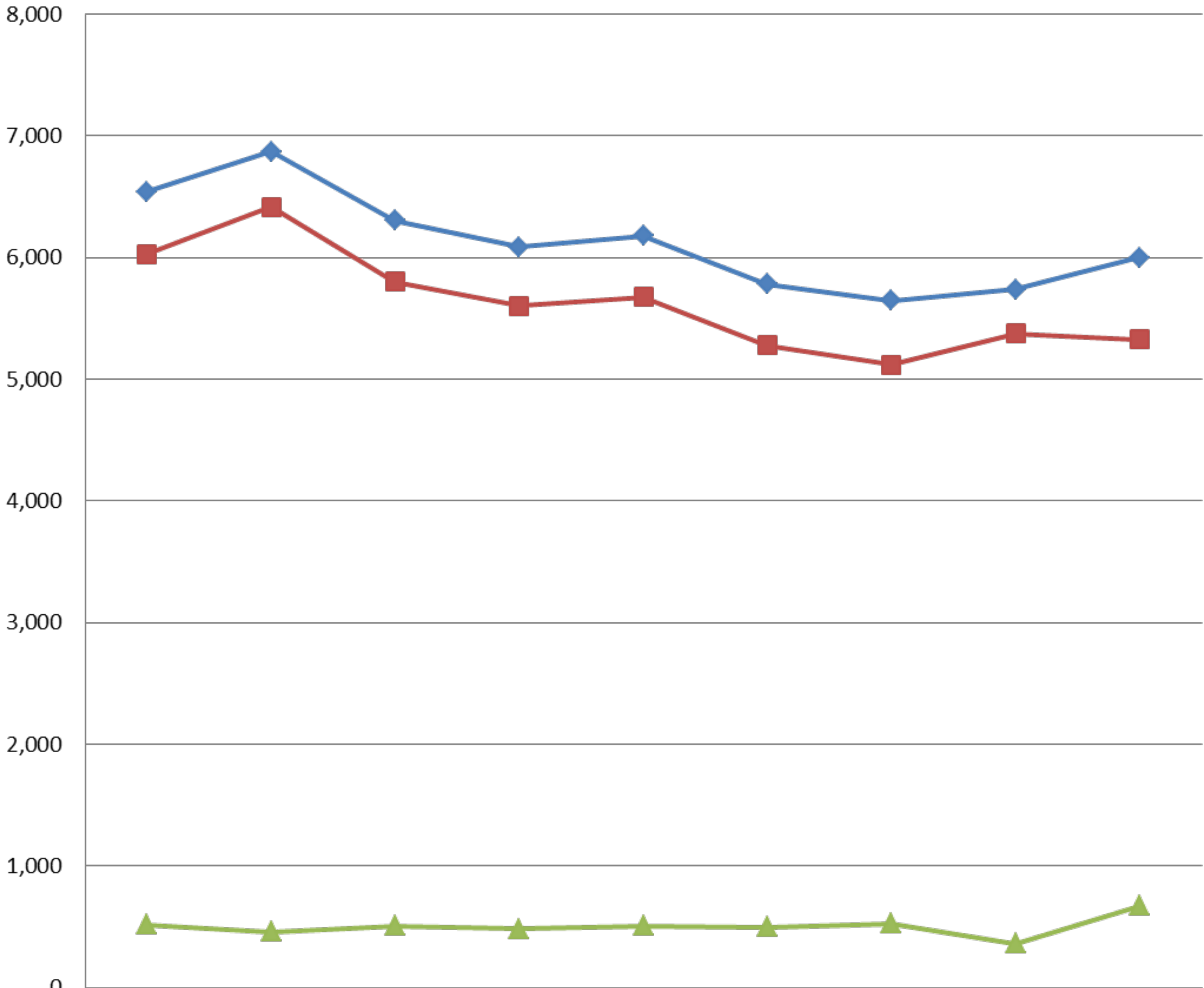
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total # of persons experiencing homelessness	6,543	6,871	6,304	6,084	6,180	5,780	5,645	5,738	5,998
# of Persons experiencing homelessness as individuals	3,329	3,479	3,054	3,077	3,328	2,976	3,070	3,109	3,346
# of Persons experiencing homelessness in families	3,214	3,392	3,250	3,007	2,852	2,804	2,575	2,629	2,652

Philadelphia Point-in-Time Homeless Count: 2007-2015
Families



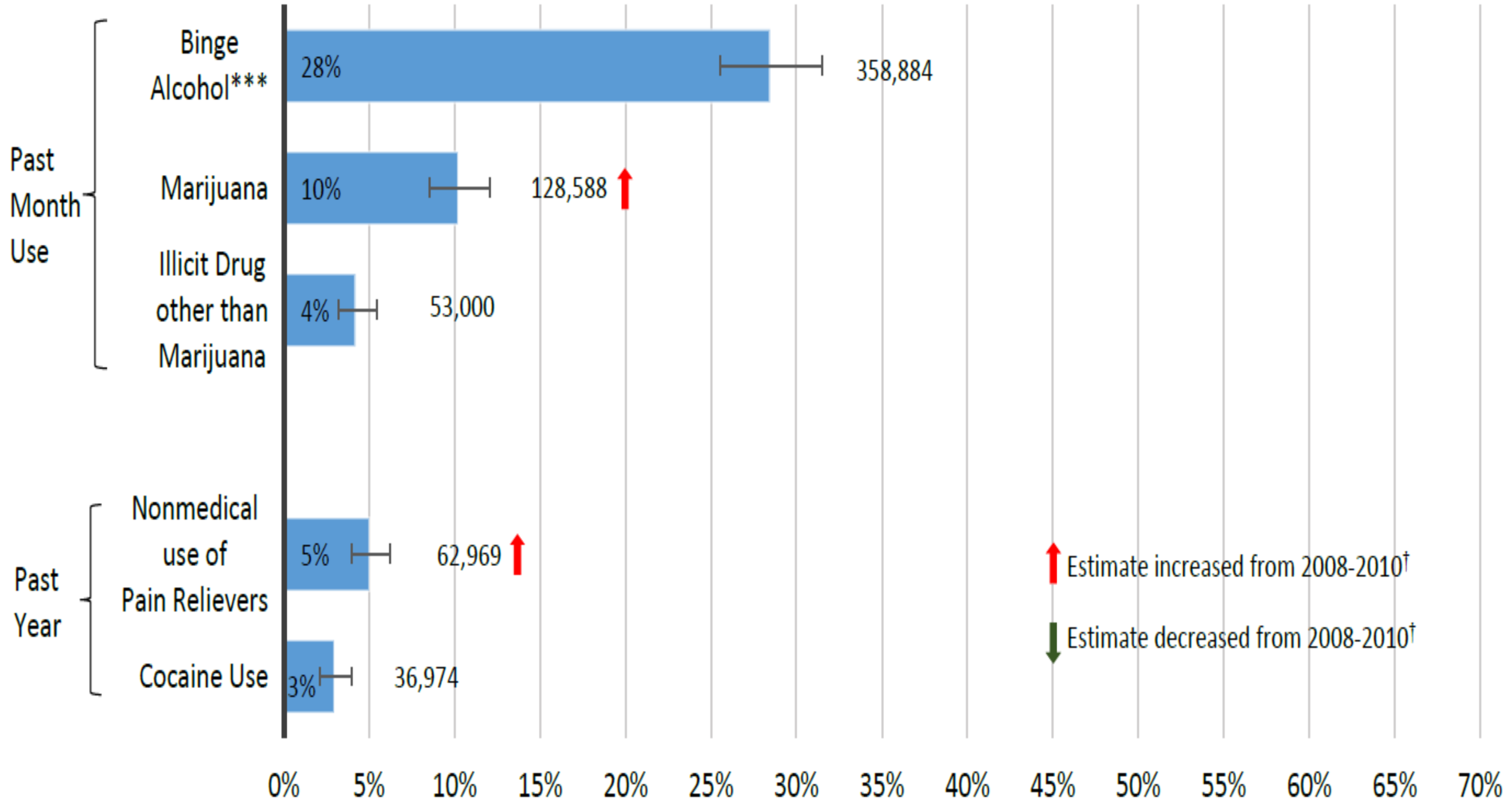
	2007	2008	2009	2010	2011	2012	2013	2014	2015
# of Persons experiencing homelessness in families	3,214	3,392	3,250	3,007	2,852	2,804	2,575	2,629	2,652
# of Family HOUSEHOLDS experiencing homelessness	1,063	1,087	1,020	996	918	923	911	932	906

Philadelphia Point-in-Time Homeless Count: 2007-2015
Sheltered and Unsheltered



	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total # of persons experiencing homelessness	6,543	6,871	6,304	6,084	6,180	5,780	5,645	5,738	5,998
Sheltered persons	6,026	6,414	5,798	5,603	5,674	5,280	5,119	5,377	5,328
Unsheltered persons	517	457	506	481	506	500	526	361	670

*National Survey on Drug Use and Health (NSDUH): Survey of U.S. Population**

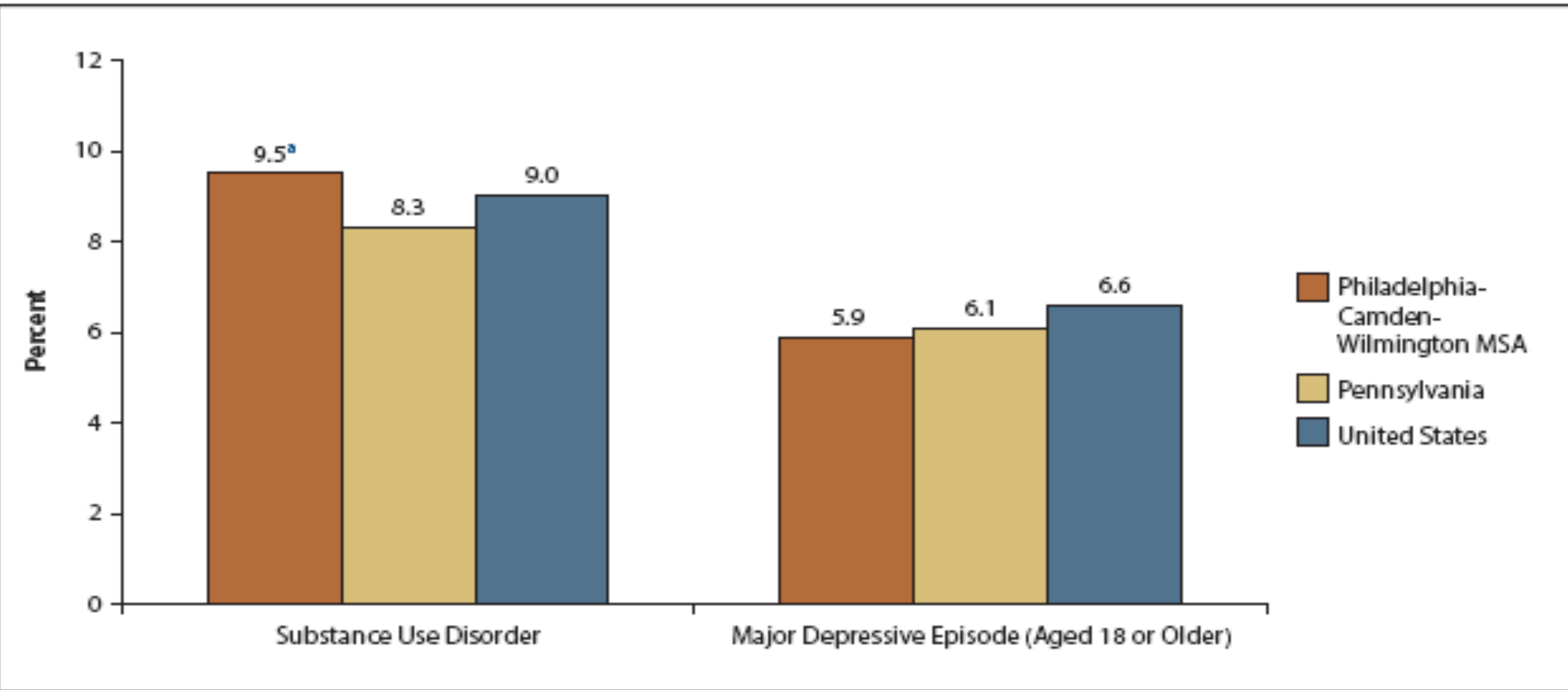


*U.S. Population: U.S. civilian non-institutionalized population. ^Philadelphia Region: NSDUH Substate Region 36 which comprises Philadelphia County.**Estimated Number: Calculated by multiplying the prevalence rate and the population estimate of persons 12+ years (1,261,900) from Table C1 of the NSDUH Report. ***Binge Alcohol: Defined as drinking five or more drinks on the same occasion. †Statistically significant change: $p<0.05$.

Source: Adapted by the NDEWS Coordinating Center from data provided by SAMHSA, NSDUH. Annual averages based on 2010, 2011, and 2012 NSDUHs.

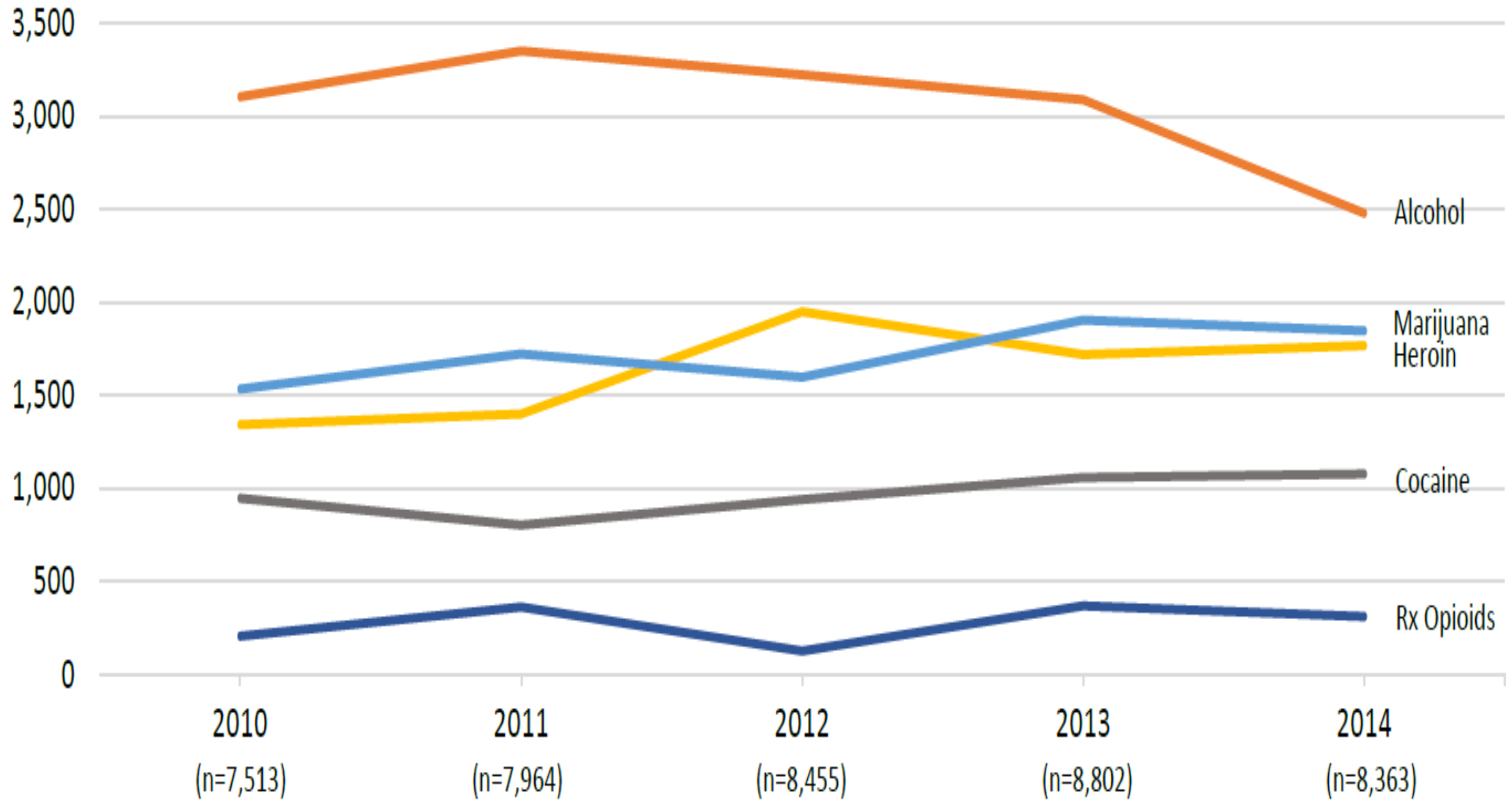
Year Substance Use Disorder and Major Depressive Episode for the Philadelphia-Camden-Wilmington Metropolitan Statistical Area (MSA), Pennsylvania, and the United States among Persons Aged 12 or Older (Except as Noted): Annual Averages, 2005 to 2010

Using 9.5% of the 1,278,738, est. Phila. 2010 census pop 12 and older to determine possible number of people needing D&A Tx = 121,480



2010 NOTE: For additional data, please see the tables available at http://www.samhsa.gov/data/NSDUHMetroBriefReports/index.aspx.a Difference between Philadelphia-Camden-Wilmington MSA estimate and Pennsylvania estimate is statistically significant at the .05 level.b Difference between Philadelphia-Camden-Wilmington MSA estimate and United States estimate is statistically significant at the .05 level. Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005 and 2006 to 2010 (Revised March 2012).

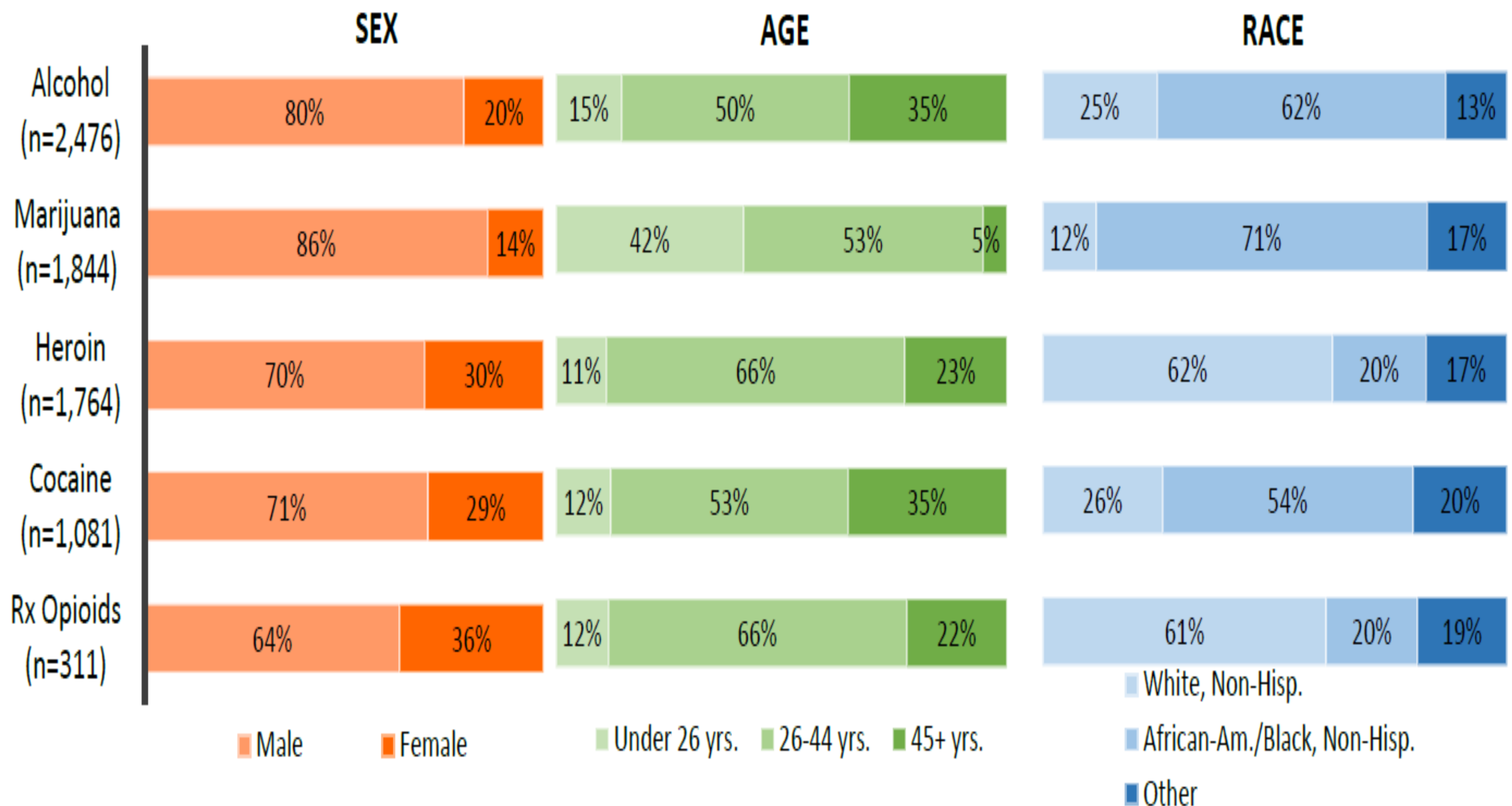
*National Survey on Drug Use and Health (NSDUH): Survey of U.S. Population**



Number and Percentage of Primary Drugs of Abuse at Treatment Admission by Uninsured and Underinsured Individuals in Philadelphia: 2013

Primary Drug of Abuse	Number of Treatment Admissions	Percentage of Total Admissions
Alcohol	2,476	29.6%
Heroin	1,844	22.0%
Marijuana	1,764	21.1%
Cocaine: Crack/Powder	1,081	12.9%
Other Opiates/Synthetics	311	3.7%
Benzodiazepine	80	1.0%
Methamphetamine & Amphetamine	15	0.2%
Other Drugs /Unknown	792	9.5%
SOURCE: Behavioral Health Special Initiative		

*National Survey on Drug Use and Health (NSDUH): Survey of U.S. Population**



*Treatment Admissions: Includes admissions for uninsured and underinsured individuals admitted to any licensed treatment programs funded through the Philadelphia Department of Behavioral Health. Percentages may not sum to 100 due to rounding.

Source: Data provided by the Philadelphia NDEWS SCE and the Philadelphia Department of Behavioral Health and Intellectual disAbility Services, Office of Addiction Services, Behavioral Health Special Initiative.

Number and Percentage of Primary Drugs of Abuse at Treatment Admission by Uninsured and Underinsured Individuals in Philadelphia: 2013

Primary Drug of Abuse	Number of Treatment Admissions	Percentage with Known Drugs of Abuse
Alcohol	3,087	36.8%
Heroin	**1,720**	**22.7%**
Marijuana	1,903	20.5%
Cocaine:Crack/Powder	1,058	12.6%
Other Opiates/Synthetics	**370**	**4.4%**
PCP	107	1.3%
Benzodiazepine	67	0.8%
Methamphetamine & Amphetamine	10	0.1%
MDMA	0	0.0%
All Other Known Drugs	58	0.7%

Heroin

- Those admitted to treatment reported oral ingestion as their preferred route of administration (69.7%), followed by injecting (30.2%).
- Those aged 26-44 were the most likely to be admitted for the primary heroin treatment.
  - (66.3% of all admitted cases)

National Drug Early Warning System (NDEWS), Philadelphia Sentinel Community Site Drug Use Patterns and Trends, 2015, Suet Lim, Ph.D.

HEROIN

- Data from Behavioral Health Special Initiative, Philadelphia Department of Behavioral Health and Intellectual disAbility Services shows that heroin use was responsible for 21.1% of primary treatment admissions in Philadelphia
  - This represents 1.6 pp increase from 2013, and 3.2 pp increase from 2010.
  - In 2014, males constituted 70.1% of primary heroin admissions.
  - Whites accounted for 62.4% of primary heroin treatment admissions
  - African Americans (20.1%) and
  - Asians and others (3.2%)
  - Hispanics constituted 14.3% of primary heroin treatment admissions.

PRESCRIPTION OPIOIDS

- The nonmedical use of prescription opioids was increasingly reported by individuals entering treatment.
  - As primary drug of choice, "Other Opiates" represented 3.7% of primary treatment admissions in 2014
    - There has been an almost threefold increase from 2012 in the proportion of primary treatment admissions for other opioids.
    - Of the 311 primary treatment admissions, 64.0% were male, 61.1% were White, 19.6% were African American, 3.2% were Asians and other races, and
    - 16.1% were of Hispanic ethnicity.
    - The largest age category for primary other opiates/opioids admissions was age 26-44 (66.2%).

Drug Threat Rankings for the Philadelphia Division, July-December 2014

Rank	Drug
1	Heroin
2	Pharmaceuticals
3	Cocaine
4	Crack Cocaine
5	Marijuana

Source: DEA Philadelphia Division

Drug Threat Rankings for the Philadelphia Division by Office, July-December 2014

Office	Number 1	Number 2	Number 3	Number 4	Number 5
Philadelphia Division Office	Heroin	Pharmaceuticals	Cocaine	Crack Cocaine	Marijuana
Pittsburgh District Office	Heroin	Pharmaceuticals	Cocaine	Crack Cocaine	Marijuana
Allentown Resident Office	Heroin	Cocaine	Pharmaceuticals	Methamphetamine	Marijuana
Harrisburg Resident Office	Heroin	Pharmaceuticals	Cocaine	Crack Cocaine	Marijuana
Scranton Resident Office	Heroin	Pharmaceuticals	Cocaine	Methamphetamine	Marijuana
Wilmington (DE) Resident Office	Heroin	Pharmaceuticals	Cocaine	Crack Cocaine	Marijuana

Heroin Prices by Unit Showing Both Low and High Amounts in US CurrencyJuly-December 2014 reporting period

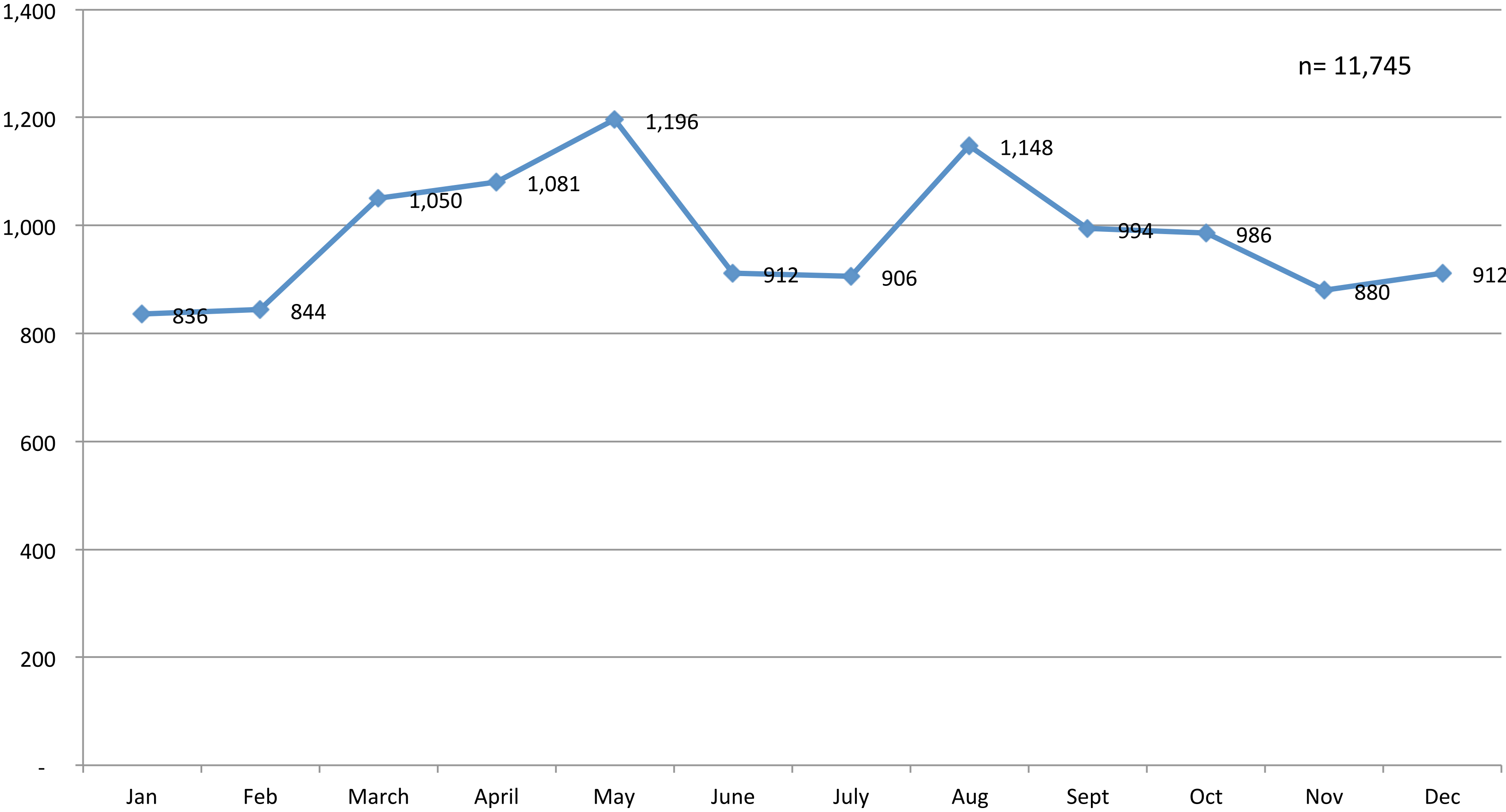
Office	Bag (.01-.03g)	Gram	Ounce	Kilogram
Philadelphia Division Office	$10	$50-$85	--	$55,000-$63,000
Pittsburgh District Office	$5-$15	$150	$2,000-$3,000	$50,000-$80,000
Allentown Resident Office	$10-$15	$65	--	$65,000
Harrisburg Resident Office	$10-$15	$100-$110	--	$55,000-$65,000
Scranton Resident Office	$5-$10	$60-$80	--	--
Wilmington (DE) Resident Office	$10	$75-$150	$2,100-$6,000	--

Source: DEA Philadelphia Division

Pharmaceuticals and their Prices by Unit Showing Both Low and High Amounts in US Currency
Philadelphia Office

Office	Type & Unit	Price
Philadelphia Division Office	Methadone 10 mg	$5-$15
	Morphine 15 mg	$3-$5
	Oxycodone 30 mg	$20-$30
	Oxycodone 10 mg	$10
	OxyContin® 80 mg	$20-$45
	Percocet® 10 mg	$10
	Percocet® 5 mg	$2.50-$5
	Percocet® 30 mg	$15-$20
	Suboxone 8 mg	$5-$15
	Vicodin® 7.5 mg	$7-$10
	Valium 5 mg	$2-$3
	Xanax® 2 mg	$2.50-$5
	Adderall® 20 mg	$10-$15

Emergency Medical Services Responses for Overdose/ Accidental Poisonings, 2014



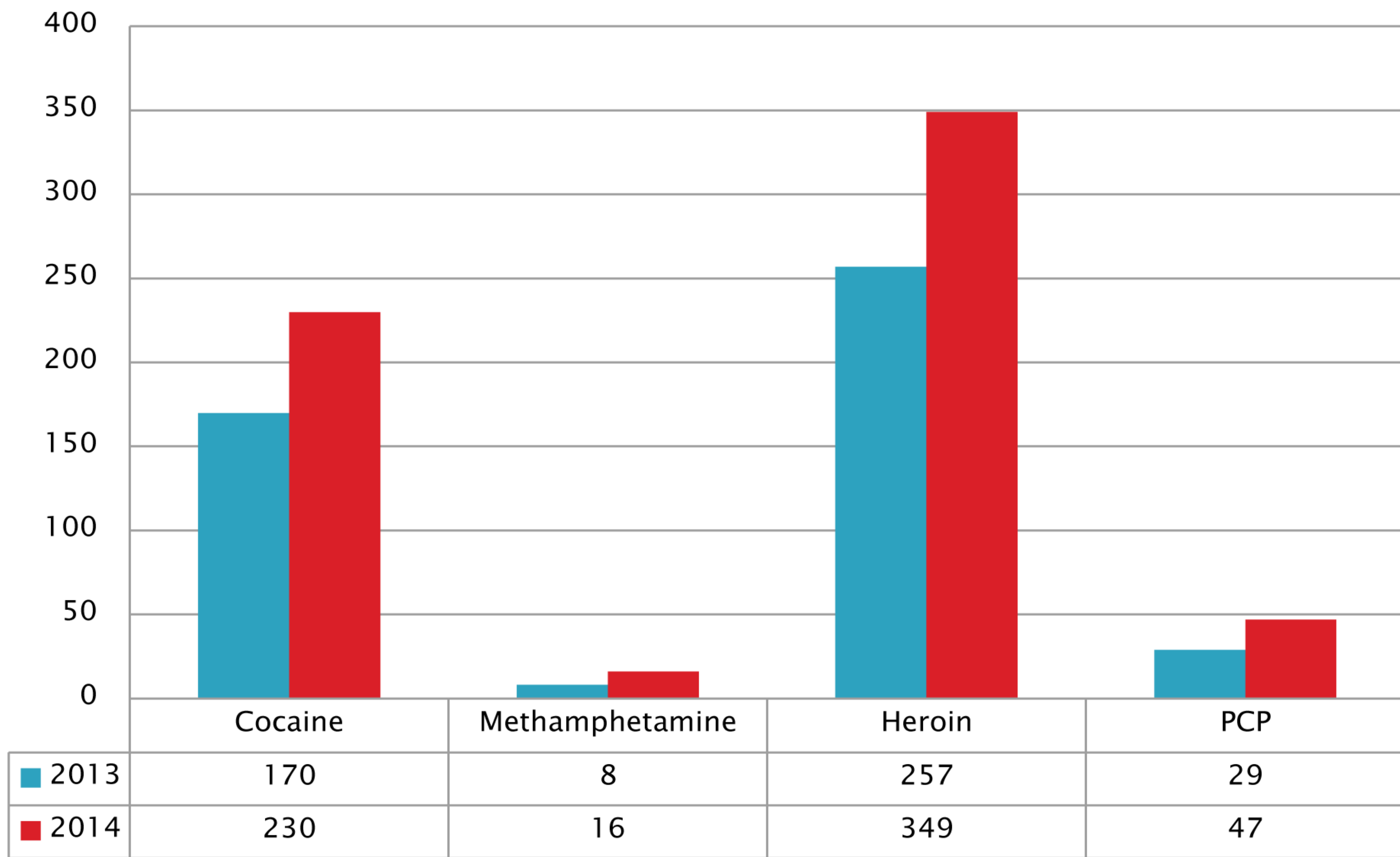
Source: Philadelphia Fire Department, EMS

Ranking of the Frequency of Drugs Present in Toxicology Test Results for Drug-Related Overdose Decedents, Philadelphia, 2012-2013-2014

Rank	Drug Detected 2014	#	%	Drug Detected 2013	#	%	Drug Detected 2012	#	%
1	Heroin	349	53	Heroin	257	52.0	Heroin/Morphine	287	57.7
2	Cocaine	230	35.0	Cocaine	170	34.0	Cocaine	256	51.5
3	Alprazolam	156	32.0	Alprazolam	156	32.0	Codeine	214	43.1
4	Fentanyl	99	15.0	Oxycodone	90	18.0	Aprazolam	150	30.2
5	Oxycodone	93	14.0	Oxazepam	65	13.0	Ethanol	145	29.2
6	Diazepam	83	13.0	Diazepam	58	12.0	Oxycodone	124	24.9
7	Oxazepam	79	12.0	Methadone	53	11.0	Diphenhydramine	77	15.5
8	Oxymorphone	64	10.0	Oxymorphone	45	9.0	Methadone	77	15.5
9	Methadone	62	9.0	PCP	29	6.0	Oxymorphone	72	14.5
10	PCP	47	7.0	Fentanyl	24	5.0	Nordiazepam	72	14.5
	TOTAL	1420			947		1474		

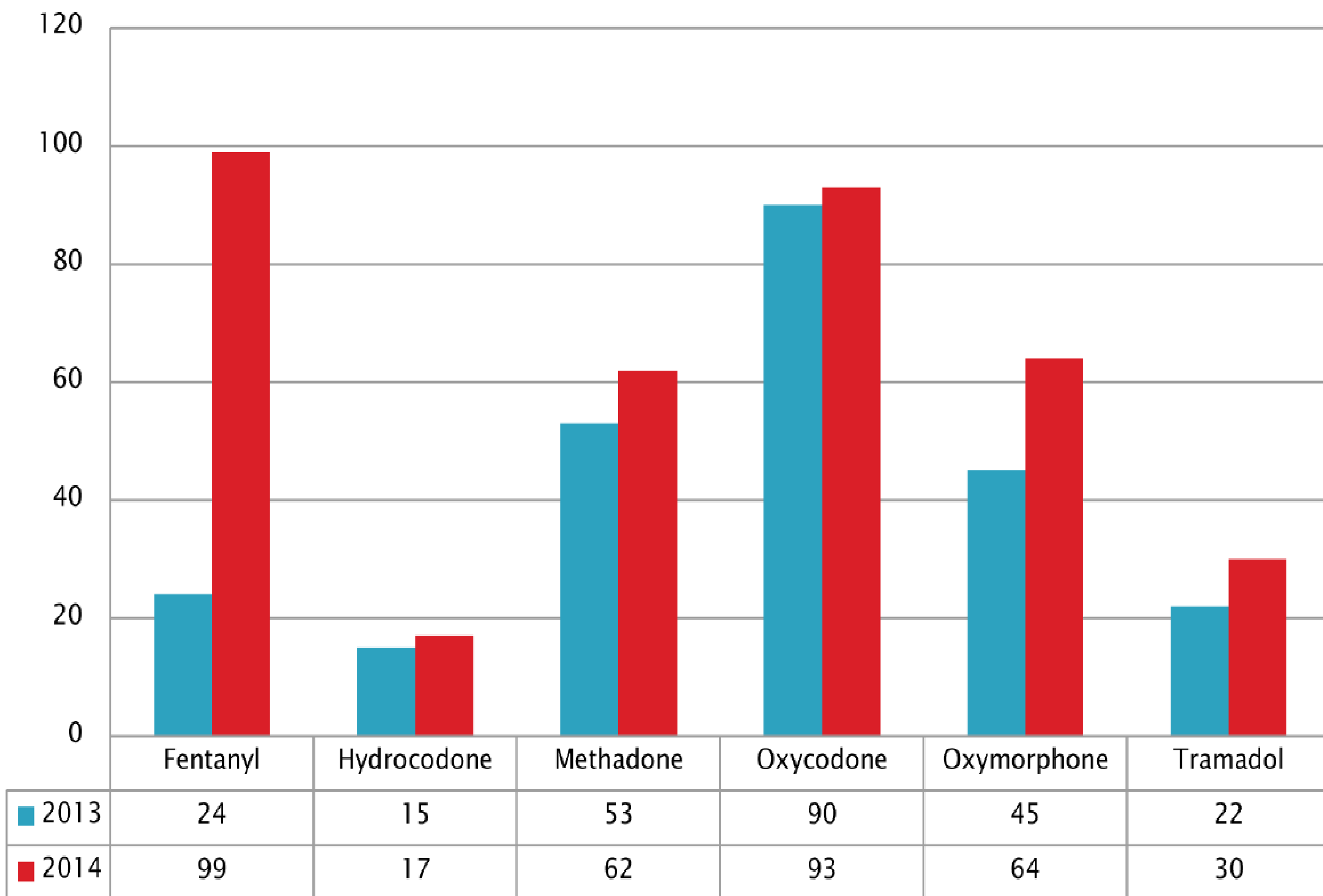
Source: Philadelphia Medical Examiner's Office

Figure 6: Illicit Drugs in Toxicology Test Results of Drug-Related Overdose Decedents, Philadelphia, 2013-2014



	Cocaine	Methamphetamine	Heroin	PCP
2013	170	8	257	29
2014	230	16	349	47

Opioids in Toxicology Test Results of Drug-Related Overdose Decedents, Philadelphia, 2013-2014



	Fentanyl	Hydrocodone	Methadone	Oxycodone	Oxymorphone	Tramadol
2013	24	15	53	90	45	22
2014	99	17	62	93	64	30

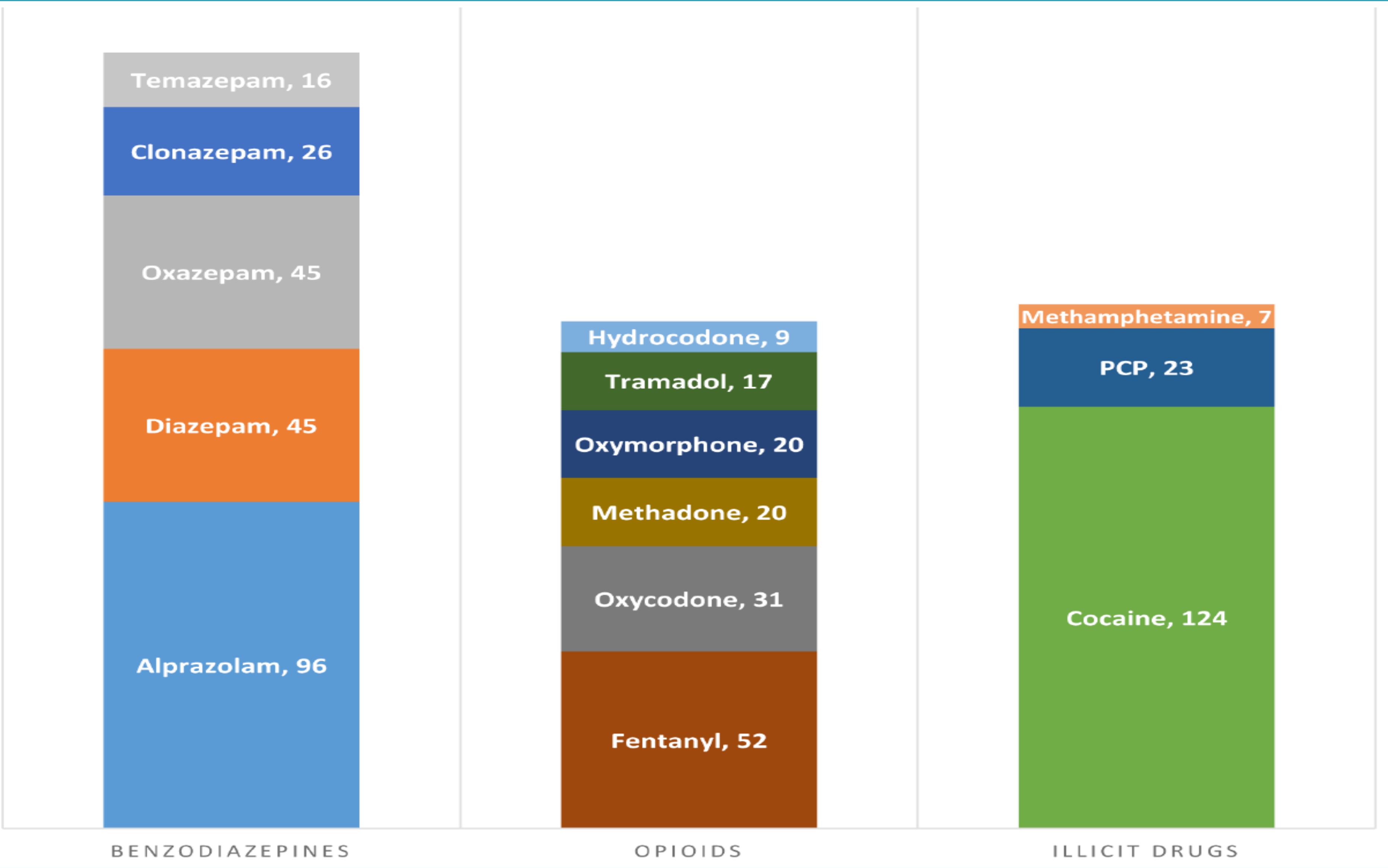
Source: Philadelphia Medical Examiner's Office

In 2014, there were 652 drug intoxication deaths certified by the Medical Examiner's Office (MEO)

- (627 accident, 1 homicide, 21 suicide, and 3 undetermined).
- Of those 652 deaths, toxicology testing was performed by the MEO on 635 cases. The ten drugs most frequently detected amongst the intoxication deaths are :
  - Morphine/heroin was detected in 350 cases,
  - Cocaine with 273.
  - Fentanyl was detected in 100 cases of intoxication deaths,
  - Oxycodone was detected in 93 intoxication deaths.
- Consistent with previous years, mortality cases with the presence of drugs are suggestive of high poly-drug use among the drug using population in Philadelphia.

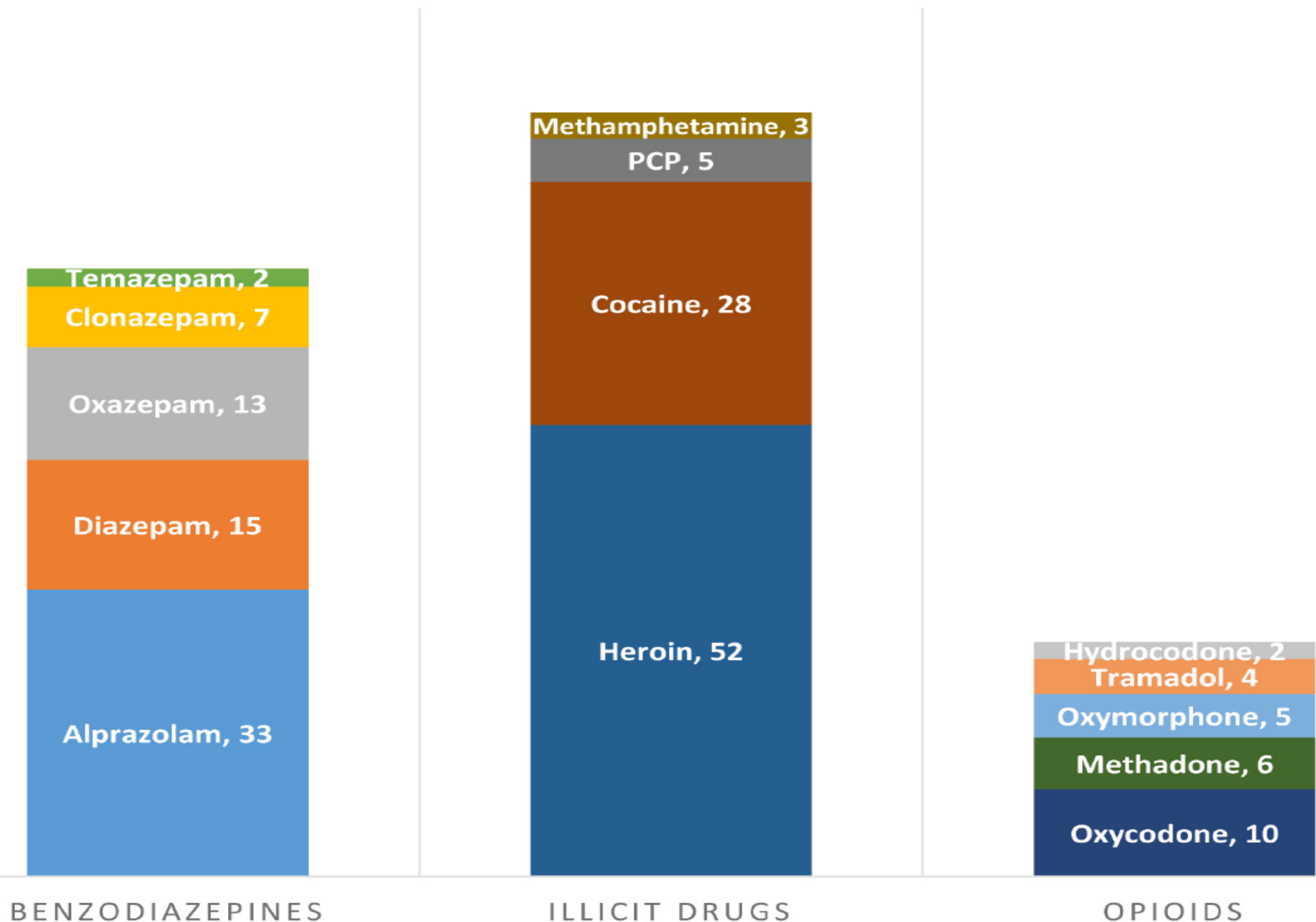
National Drug Early Warning System (NDEWS), Philadelphia Sentinel Community Site
Drug Use Patterns and Trends, 2015, Suet Lim, Ph.D.

Drugs Found in Combination with Heroin in Toxicology Test Results in Drug-Related Overdose Decedents, Philadelphia, 2014



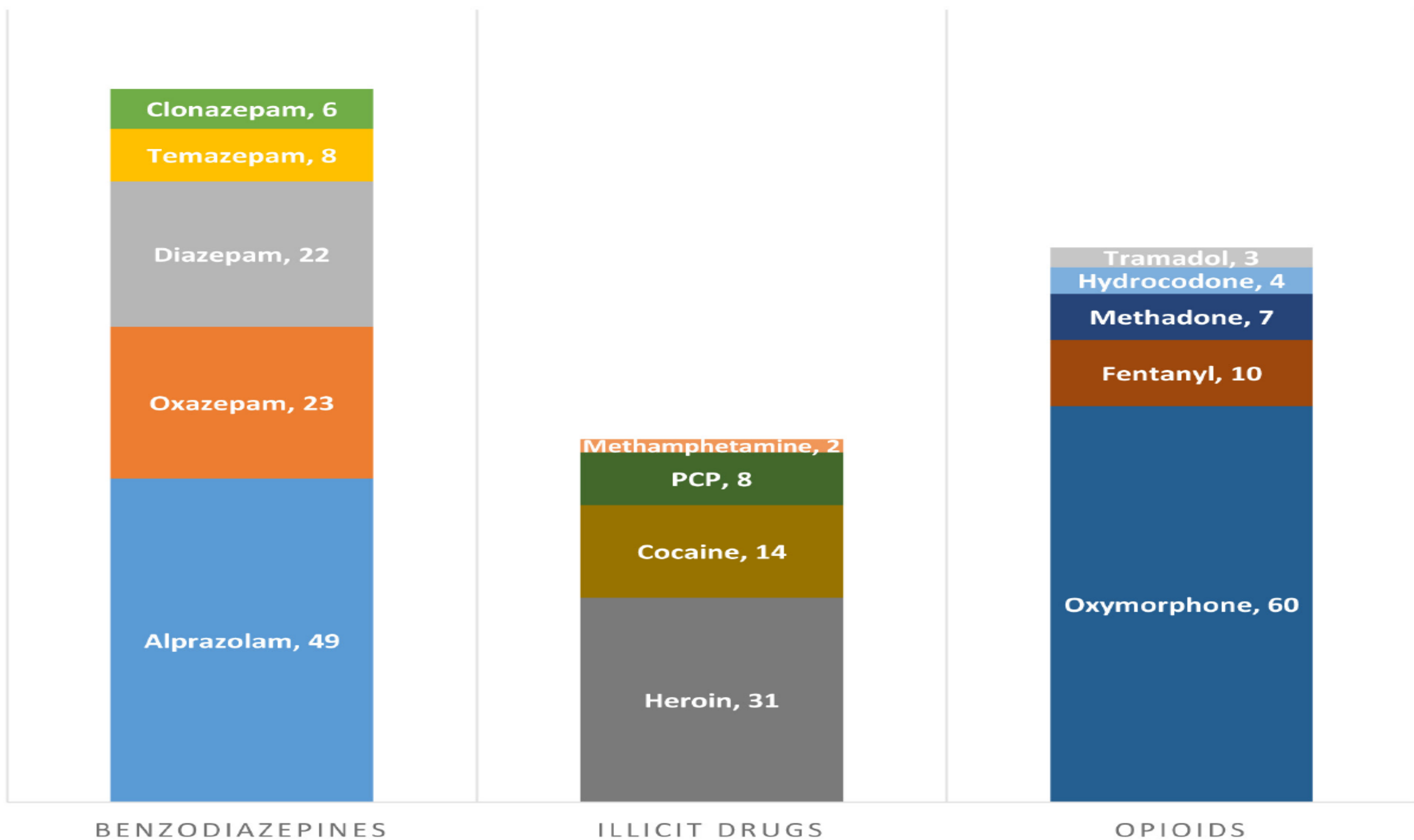
Source: Philadelphia Medical Examiner's Office

Drugs Found in Combination with Fentanyl in Toxicology Test Results in Drug-Related Overdose Decedents, Philadelphia, 2014



Source: Philadelphia Medical Examiner's Office

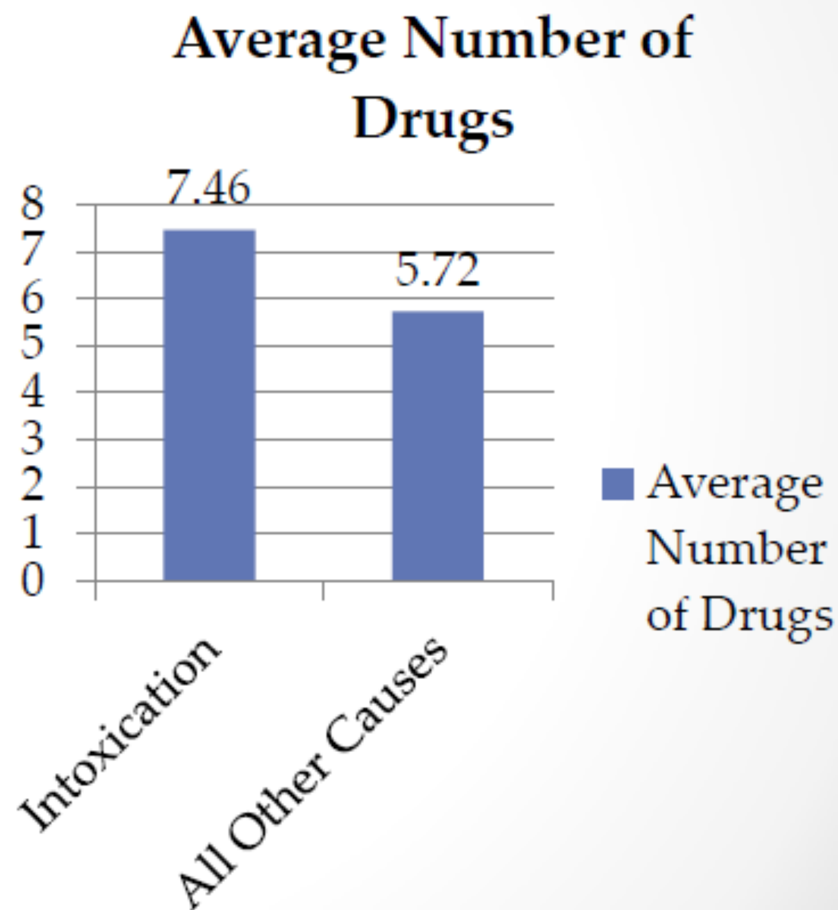
Drugs Found in Combination with Oxycodone in Toxicology Test Results in Drug-Related Overdose Decedents, Philadelphia, 2014



Source: Philadelphia Medical Examiner's Office

Alcohol and/or Drug Intoxication Deaths, Philadelphia, 2012

	No.	Percent
MEO cases w/ presence of drugs	972	
Alcohol and/or Drug Intoxication as Cause of Death	497	51.1%
All Other Causes	475	48.9%



- Source: Philadelphia Medical Examiner's Office

National Drug Early Warning System (NDEWS) Philadelphia Sentinel Community Site Drug Use Patterns and Trends, 2015

Suet Lim, Ph.D.

SCS Highlights

- Philadelphia experienced an outbreak of fentanyl-related intoxication deaths in 2014, with a major spike in March through mid-May; we observed a four-fold increase in fentanyl-related intoxication deaths from 2013.
- Numerous indicators suggest that heroin is a principal drug of abuse in Philadelphia. It is the drug most frequently detected amongst intoxication deaths in which a toxicology test was performed; treatment admissions for heroin as a primary drug of abuse have increased; and data from the National Forensic Laboratory Information System (NFLIS) show a higher percentage of drug items testing positive for heroin in 2014 than in 2013.
- Mortality indicator data shows that cocaine continued to be the 2nd most frequently detected drug amongst intoxication deaths; it was also the 2nd most identified drug in NFLIS items. In addition, there was a slight increase in primary treatment admissions for cocaine from 2013 to 2014.
- For prescription opioids, the mortality indicator and NFLIS reports identified oxycodone as the top ranked drug; treatment indicator showed little change in primary admissions for prescription opioids.
- Treatment admissions for benzodiazepines slightly increase from 2013 to 2014; mortality indicator data shows three benzodiazepines in the top ten drugs detected amongst intoxication deaths: alprazolam, clonazepam, and diazepam.
- Alcohol continues to be a top substance in primary treatment admissions and is the fourth most frequently detected drug among drug intoxication deaths with toxicology results.
- Marijuana continues to be in the top three primary treatment admissions; it is the most commonly identified substance in NFLIS.

www.ndews.org.

Deaths of the Homeless

- There were 296 deaths of individuals experiencing homelessness from 2009-2014,
  - in 106 the primary cause of death was drugs and/or alcohol;
  - in an additional 27 deaths, drugs and/or alcohol was a contributing factor.
  - This is the #1 cause of death for people experiencing homelessness in Phila.

Office of Supportive Housing City of Philadelphia

October 2014, The Good Samaritan legislation (Act 139)

- Established immunity for certain drug crimes and provided law enforcement new tools to reduce fatality rates during drug overdoses.
  - The new act provides for first responders (including law enforcement, fire fighters, EMS or other organizations) as well as individuals the ability to administer naloxone, a life- saving opioid-overdose antidote.
  - Act 139 provides immunity from prosecution for certain drug crimes for individuals who seek emergency medical help when a friend or companion overdoses on drugs
    - Act 139 will encourage people to quickly report overdoses to emergency personnel without fearing legal repercussions

Access To Care

TREATMENT SERVICES

Treatment Services Available (approx.)

In a city of over 1.5 mil people

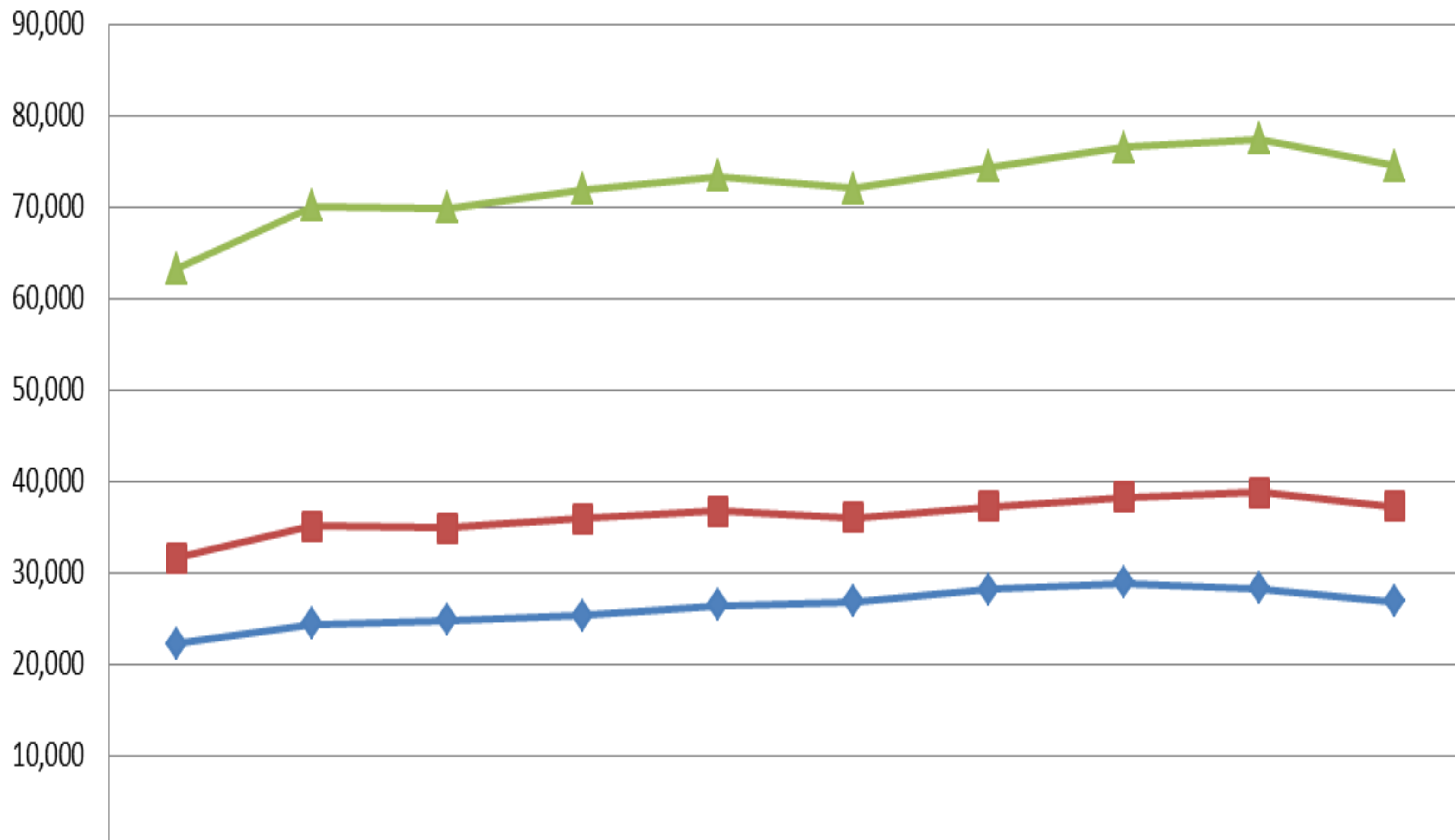
- **Detoxification (Medically Managed/Monitored) (10 facilities /200 beds approx.)**
- **Hospital-Based (Medically Managed) Residential Rehabilitation (4 facilities / 20 beds approx.)**
- **Non-Hospital (Medically Monitored) Residential Rehabilitation (62 facilities / 2058 beds approx.)**
- **Halfway House (6 facilities / 150 beds approx)**
- **Outpatient – Drug Free (72/ 8,000 slots approx.)**
- **Methadone (11 Providers operating 13 facilities/ 5,500 slots approx.)**
- **Intensive Outpatient (36 facilities /5,648 slots approx.)**

All Level of Care determinations are made by using the Pennsylvania Client Placement Criteria (PCPC) for adults. The American Society of Addiction Medicine (ASAM) tool is used for adolescents.

Programs providing any level of treatment services are licensed by the Pennsylvania Department of Health, Division of Drug and Alcohol Program Licensure.

Total D&A Served
2004 to 2013

Axis Title



	2004-CY	2005-CY	2006-CY	2007-CY	2008-CY	2009-CY	2010-CY	2011-CY	2012-CY	2013-CY
Total	31,639	35,075	34,939	35,970	36,723	36,034	37,229	38,276	38,751	37,271
Unique Clients - Paid BHSI	9383	10630	10097	10695	10323	9153	9099	9409	10493	10396
Unique Clients - Paid CBH	22,256	24,445	24,842	25,275	26,400	26,881	28,130	28,867	28,258	26,875

Challenge of the Chronically Homeless

- Some eight ago there were record numbers of those identified as chronically homeless reported on the streets of Philadelphia.
- Mayor’s Ten Year Plan to End Homelessness
- Many of those chronically homeless met the criteria for Medically Monitored Residential Treatment.
  - Were not going, not staying, being involuntarily discharged or being denied access.

The Challenge

Traditional Treatment Programs:

- Restrictive entry criteria
- Repressive initiations
- Treating crisis, images, behaviors not the person
- Often kicking “disruptive behavior out
- Banning from returning to care
- Would be authorized inadequate dosages of care

The Chronically Homeless

- Culture of the streets conflicts with generic residential treatment culture
- Recycling in acute levels of care
- Doe’s not respond well to authority
- Will need multiple opportunities to adjust
- Have real habilitation needs
- Will tend to gravitate to the predictable

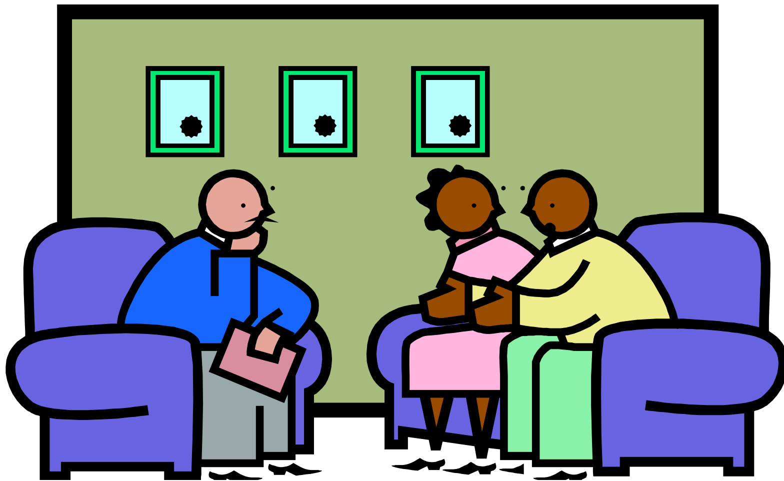
Journey Of Hope

Addiction Treatment For The Chronically Homeless

Recovery Oriented Response

- Chronically Homeless Residential Initiative
  - Reduce Access Barriers
  - Require that providers allow residents to return regardless previous AWOLS
  - Retrain staff to recovery oriented approach and encourage them to be Change Agents
  - Open-ended lengths of stay
  - Enhancement of housing options
  - Seek Federal Grant to expand program

The Journey of Hope Project



- Seven treatment programs have been transformed to provide comprehensive, recovery-oriented, substance abuse and co-occurring treatment services to individuals experiencing prolonged homelessness
- These seven programs are:
  - Horizon House Susquehanna Park
  - Horizon House Susquehanna Park II
  - North Philadelphia Health Systems (NPHS) Miracles in Progress II Sanctuary
  - North Philadelphia Health Systems (NPHS) Miracles in Progress I
  - RHD Womanspace Philadelphia
  - RHD New Start II
  - RHD New Start I (Halfway House)

Girard Behavioral Access Center (BAC)

Girard BAC – 8th and Girard

Assessment center for Journey of Hope programs

Horizon House Susquehanna Park

- Offer services to chronic homeless men
- 18 total beds
- Primary diagnosis of substance abuse / substance dependence
- Will accept clients who also present with mild to moderate mental health issues

Horizon House Susquehanna Park

- Long term, low demand residential program
- Approximate length of stay of 6 to 9 months (PCPC level 3-C)
- Will most likely step down to New Start I Halfway House

Horizon House Susquehanna Park II

- Designed for graduates of the Journey of Hope Project who may have relapsed and / or are struggling in their housing
- Allows for opportunity to regain foundation in recovery, re-connect with support network, and transition back to independent living before being evicted, etc.
- Approximate length of stay is 1 to 3 months

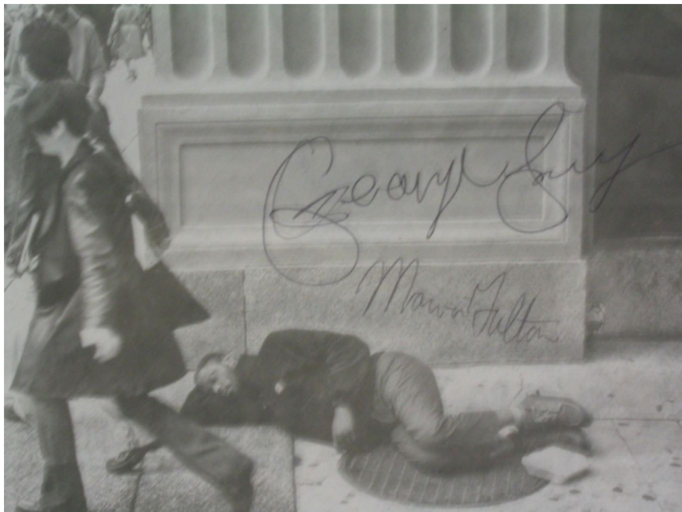
NPHS – Miracles In Progress Sanctuary Program

- Offer services to chronic homeless men
- 41 total beds
  - Originally 16 beds
  - Recent expansion of program and addition of 25 new beds
- Primary diagnosis of substance abuse / substance dependence
- Will accept clients who also present with moderate to high mental health issues

NPHS Miracles in Progress

- Long term, low demand residential program
- Approximate length of stay of 6 to 9 months (PCPC level 3-C)
- Will most likely step down to New Start I Halfway House

NPHS Miracles in Progress
Sanctuary Program



Womanspace Philadelphia

- 10 female beds
- Offers services to chronically homeless females with substance abuse / dependence and co-occurring mental health issues
- Transformed and re-opened to service chronically homeless population on May 1st, 2008

Womanspace Philadelphia

- Long Term, Low Demand Residential Substance Abuse Treatment
- Approximate length of stay of 6 months to 1 year

RHD New Start II

- 16 male beds
- Offers services to chronically homeless males with substance abuse / dependence and co-occurring mental health issues
- Re-opened on July 1st, 2008 to service chronically homeless individuals

RHD New Start II

- Long-term, low demand residential substance abuse treatment program
- Approximate length of stay of 6 to 9 months
- Will most likely step-down to RHD New Start I (Halfway House)

RHD New Start II

RHD New Start I Halfway House

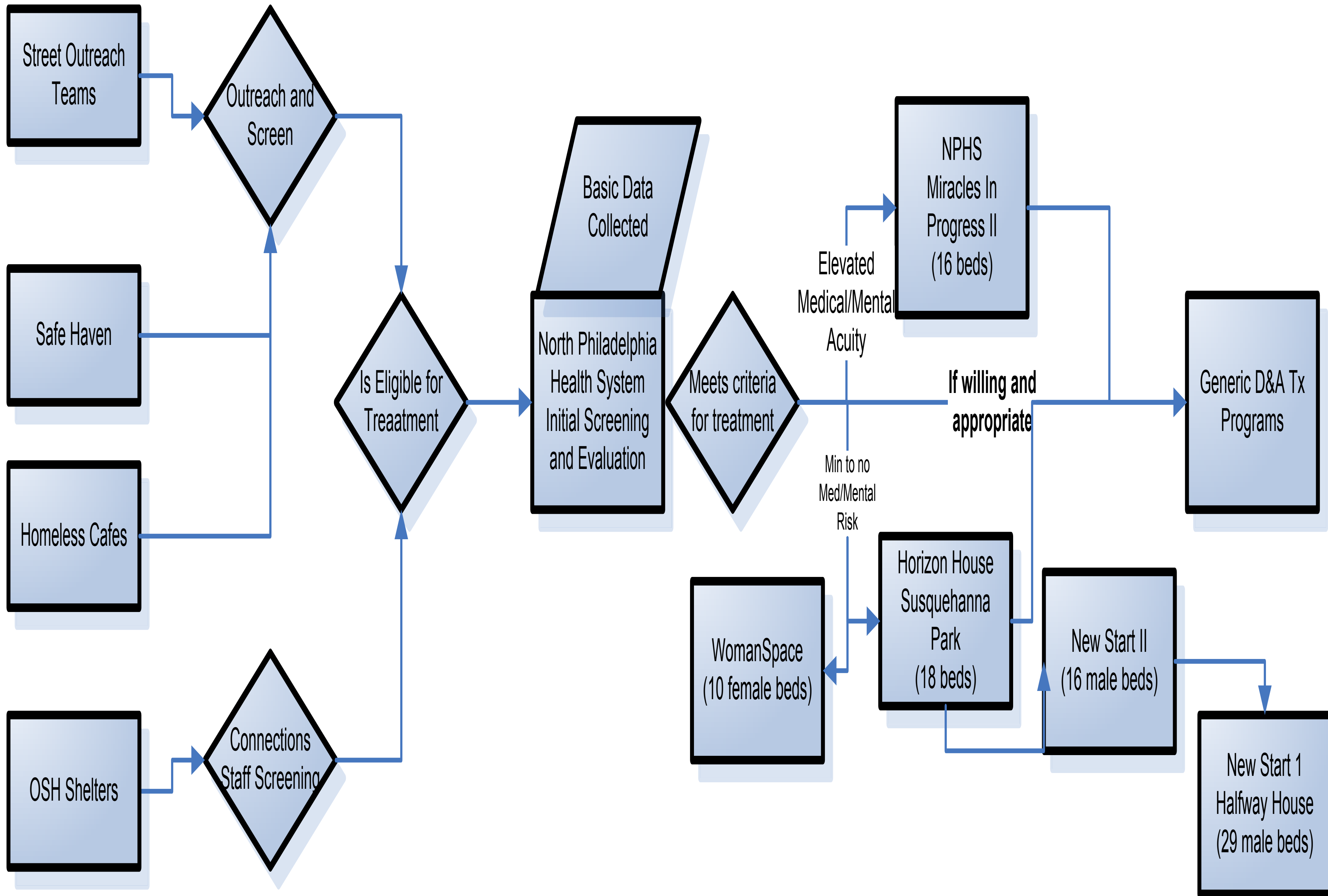
- Transformed program and re-opened on 10-5-09
- Licensed substance abuse treatment program
  - Not a recovery house
  - Not a transitional living facility
- PCPC Level 2-B Level of Care
- Long-term, low demand residential
- Approximate length of stay of 3 to 6 months

What is the difference between a halfway house and a recovery house?

- *Halfway Houses:*
- A halfway house is a licensed level of care
  - PCPC 2-B Level of Care
- Obtain this license via Department of Health (DOH) and Bureau of Drug and Alcohol Programs (BDAP)
- Licensed / credentialed treatment services are provided on site
- Contract with local funding agencies (i.e. CBH / BHSI) for client stay
- Client does not pay rent or client fees
- Examples:
  - RHD New Start I
  - Gaudenzia Re-Entry
  - Self-Help
  - Good Friends
  - Libertae
  - Gaudenzia Washington House

- *Recovery Houses:*
- There is no such thing as a "recovery house license"
- Clean and sober living arrangement
- Very little is needed to open a recovery house
  - Zoned for Rooming House or Boarding House
  - Rooming House/ Boarding House License
  - Certificate of Occupancy
- Individuals generally attend outpatient or intensive outpatient treatment while living in a recovery house
  - Outpatient (PCPC 1-A LOC)
  - Intensive OP (PCPC 1-B LOC)
- Little to no regulation in recovery house system

RHD New Start I Halfway House



Street Outreach Teams
Outreach and Screen
Safe Haven
Homeless Cafes
OSH Shelters
Connections Staff Screening
Is Eligible for Treaatment
Basic Data Collected
North Philadelphia Health System Initial Screening and Evaluation
Meets criteria for treatment
Elevated Medical/Mental Acuity
NPHS Miracles In Progress II (16 beds)
If willing and appropriate
Generic D&A Tx Programs
Min to no Med/Mental Risk
Horizon House Susquehanna Park (18 beds)
WomanSpace (10 female beds)
New Start II (16 male beds)
New Start 1 Halfway House (29 male beds)

Long Term, Low Demand Treatment

- What does long term treatment mean?
  - In this case it means 6 months to a year of continuous inpatient treatment
  - Generally not offered in substance abuse treatment in Philadelphia
  - Focuses on habilitation versus rehabilitation
  - “Includes 24-hour professionally directed evaluation, care, and treatment for addicted clients in chronic distress, whose addiction symptomatology is demonstrated by severe impairment of social, occupational, or school functioning” -PCPC 2nd ed.

- What does low demand mean?
  - In this case it means a much less structured, at least initially for most clients, than they may be accustomed to at other substance abuse treatment programs
  - “Meeting the client where they are at”
  - If the client wants to take it slow, we take it slow
  - Services offered in a “Menu” format – clients pick from the menu of services
  - Highly individualized treatment
  - Allowing clients time to become oriented to the treatment setting
  - Allowing for ambivalence to change

Comparisons Between Traditional Treatment and The Journey of Hope Project

Service Dimension	Treatment as Usual (as reported from past treatment)	Journey of Hope Project Sites
Attraction/Timing of Treatment Seeking	Passive: Response to medical/ psychiatric/legal crisis; use of addiction treatment for emergency housing	Assertive: Treatment/Recovery priming through prolonged outreach to people not initially interested in treatment/recovery
Access	Delayed: waiting lists; denial for lack of ID; denial based on multiple prior admissions	Immediate: Placed within 3-5 hours of expressed interest in treatment; no ID required for admission
Early Engagement	High attrition: high risk of leaving against staff advice (ASA) and administrative discharge (AD) for rule violations	Low attrition: Total focus on relational engagement; service partnership; personalization of degree of service structure; no discharge for alcohol/drug use (except use onsite); episode of use followed by increased supports; all ASA and AD discharges clinically staffed; newcomers visited by program graduates.

Assessment and Service Planning	Pathology-based: Focus on diagnosis, level of care placement and problems list as fulcrum for service planning; assessment an intake function; results in professionally-directed treatment plan; Program (service menu)-focused; addiction the primary focus	Aspiration- and asset-focused; continual assessment based on any change in clinical status or expressed service needs; more focused on lifestyle reconstruction than clinical pathology; client-directed recovery plans; highly individualized; focus on balanced resolution of multiple co-occurring problems
Composition of Service Team	Professionalized, multidisciplinary staff	Greater inclusion of recovering people (50-60%, including those with prior homelessness and staff who came through one of the pilot sites and were trained as peer specialists) and indigenous healers within the community (e.g., sponsors, clergy, alumni/volunteers); greater inclusion of staff with prior experience with homeless population
Service Relationships	Focus on professional authority (screen, assess, diagnose, treat, discharge)	Focus on long-term recovery partnership; emphasis on client choice; minimization of authority/rules unless requested by the client; coaching more than counseling; continuity of contact in a primary recovery support relationship (an individual or small recovery support team)
Service Dose	Ever-briefer acute episodes	6 months to1 year of active involvement

Service Scope	Limited ancillary supports	Broader services aimed at identity and lifestyle reconstruction, e.g., ID, clothing, medical/dental; permanent housing assistance, GED, employment coaching
Linkage to Communities of Recovery	Passive: verbal encouragement to attend; attendance at onsite meetings	Assertive: Personalized linkage to a person/group; emphasis on relationship with home group and sponsor; management of obstacles to participation; emphasis on participation in groups within the natural community; involvement in Philadelphia Recovery Community Center and local recovery celebration events; linkage to peer-facilitated recovery workshops
Post-treatment monitoring/ support and early re-intervention	Access to continued care contingent on "graduation"; continued care following formal treatment limited to weeks of scheduled groups or PRN counseling; responsibility for continued contact rests with the client.	Open door drop-in policy; regular alumni groups; 1 year of assertive post-treatment, in-home monitoring by case manager regardless of discharge status; responsibility for continued contact resides with the staff/volunteers; saturation of support during early community re-entry

What's Different?: Recovery Oriented Interventions

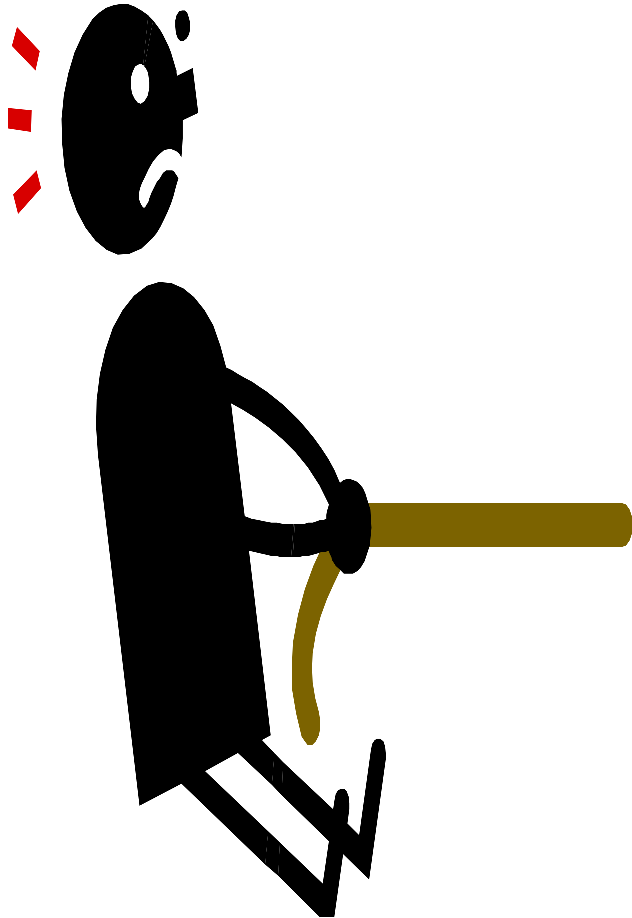
- Assertive outreach approaches utilized to encourage admission into treatment
- Low threshold for admission i.e. no I.D. required, no waitlist, limited assessment needed
- Highly individualized programming and treatment planning
- Allow for ambivalence to change
- Less structured program – "Menu" of services
- "Low demand, but not low expectations"
- Participants can pick what they want to attend and what they want to work on
- Participants are not discharged for relapsing
- Participants who leave program "AWOL" or "AFA / AMA" are allowed to be re-admitted to program; Outreach is contacted to re-engage participant in the street
- Programs embrace and support what is important to participant, including activities outside of the facility
- Longer length of stay in treatment allowing for stronger foundation in recovery and acquisition of coping skills
- Availability of housing resources / opportunities upon completion from project
- Strengths-based approach to treatment planning
- Participants write their own recovery plan
- Heavy emphasis on peer to peer support and use of Peer Specialists
- Emphasis on life skills/ skill building in preparation for permanent supportive housing
- Create opportunities for educational, vocational, and employment goals; resources for supported employment
- Enhanced medical services integrated into program and / or connection to medical services
- Use of evidence based practices i.e. Motivational Interviewing, CBT, Trauma Informed (TREM, Sanctuary), DBT, etc.
- Comprehensive support and follow up for participants when they complete the inpatient tx aspect of the project i.e. connections to IOP / OP, case management, peer specialist services, Mobile Psychiatric Rehabilitation Services (MPRS), tenant service liaison, alumni groups, recovery support groups, etc.

Key Concepts

- Motivational Interviewing
  - Building motivation for change
  - Resolving ambivalence
  - Strengthening commitment
  - Negotiating a treatment plan
- Recovery Management
  - Low Threshold for admission
  - Emphasis on pre-action stages of change
  - Strengths-based approach
  - Constituent driven recovery plan
  - Focus on service and support menus
  - High degree of individualization
  - Inclusion of peer specialists
- Modified Therapeutic Community
  - Community as the key agent of change
  - Interaction of staff and clients to influence attitudes, perceptions, and behaviors associated with D&A use

The Road to Self-Sufficiency

- Connections to case management services via both drug and alcohol and mental health systems for continued support
  - New Homeless Engagement Intensive Case Management Grant (HEICMs)
- Utilizing local recovery and transitional housing programs
- Utilizing subsidized supported housing programs
  - PHA Housing Choice Voucher Program
  - Shelter Plus Care
  - Project Home SIL / SRO Units
  - 1260 Housing
  - Other SIL / SRO Programs



Challenges

- Relapse
  - In a recovery-oriented environment, the immediate response is no longer discharge
  - But what is the most therapeutic response to relapse?
  - What occurs when what is therapeutic for the individual is not therapeutic for the community?
- AWOL's
  - Effect on the community (regardless of relapse)
- Resistance to Treatment
  - Maintaining staff morale
  - Working via Motivational Interviewing to move client across stages of change
- Medical complications
  - High degree due to length of time street homeless
- Lack of I.D.
  - Issues related to acquiring medical insurance and benefits

For Eligibility, Openings, Outcomes, and Status of the DBH Journey of Hope Project….

Please contact Timothy Sheahan at 215-599-5178 or Tsheahan@pmhcc.org
Or Dr. Marcella Maguire at 215-685-5419 or
Marcella.maguire@phila.gov

The Journey of Hope Project

- 121 beds
- 7 programs: RHD/Womanspace, RHD/New Start I and New Start II, NPHS/Miracles in Progress I and II, Horizon House/Susquehanna Park
- Cost: $4.7 million annually

The Journey of Hope Project: Outcomes

- National Treatment Completion rates are 41% for ANY addiction treatment admission, per TEDS data, 2006

- For CY 2008
  - 41% Treatment completion rate
  - Average length of stay= 135 days
- For CY 2009
  - 48 % Treatment completion rate
  - Average length of stay= 156 days
- For CY 2010
  - 51% Treatment completion rate
  - Average length of stay= 149 days
- For CY 2011
  - 53% Treatment completion rate
  - Average length of stay= 123 days
- For CY 2012
  - 70.1% Treatment completion rate
  - Average length of stay= 118 days
- For CY 2013
  - 67.2 % Treatment completion rate
  - Average length of stay=111 days
- For CY 2014
  - 80.5% Treatment completion rate
  - Average length of stay= 149 days