

This interview will be part of *Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care*, the second in a series of monographs on recovery management published by the Great Lakes Addiction Technology Transfer Center (ATTC).



# Frontline Implementation of Recovery Management Principles

*An Interview with Michael Boyle*  
By William L. White, MA

## INTRODUCTION

Many of the core recovery management principles and practices were piloted and refined within the Behavioral Health Recovery Management (BHRM) project. This was a collaborative effort of Fayette Companies in Peoria, Illinois; Chestnut Health Systems in Bloomington, Illinois; and the Center for Psychiatric Rehabilitation at the University of Chicago, was funded by the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse. Since the inception of the BHRM project, Fayette Companies has served as a model of recovery-oriented systems transformation in a community-based behavioral health organization. I conducted the following interview with Michael Boyle, President and CEO of Fayette Companies and Director of the BHRM project, September 29, 2006, on behalf of the Great Lakes Addiction Technology Transfer Center (Great Lakes ATTC).

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**GREAT LAKES ATTC:** Mike, could you begin by summarizing your background and how you came to your current position?

**MIKE BOYLE:** I've been with Fayette Companies and its predecessor organizations here in Peoria, Illinois my whole career. I started as a youth outreach worker and then ran an alcoholism treatment center that consolidated in 1976 with four other organizations to form what

is now the Human Service Center. Fayette Companies serves as the parent management corporation of a family of behavioral health service units that include the Human Service Center; White Oaks; Human Service Center Foundation, a 501(c)(2) property investment company; and Behavioral Health Advantages, providing Employee Assistance Programs and consultation services to businesses and industry.

Human Service Center (HSC) provides mental health treatment and recovery support services to about 1,600 people each year with serious mental illness. HSC also operates a methadone treatment program, a work release program, a transitional housing program for federal probation, and a long-term women's addiction treatment program. White Oaks offers a full array of addiction treatment services, from a medical detoxification unit to gender-specific residential programs for men and women, as well as gender-specific intensive outpatient and day programs serving over 2,000 people per year. We offer a specialized program for older adults who are in need of in-home substance use disorder (SUD) treatment services, and we have youth programs that provide both mental health and SUD treatment services, as well as prevention services. We presently have 18 service locations and more than 380 staff. Our programs are supported primarily through state contracts, Medicaid reimbursement, and corporate insurance. The mission of the Human Service Center is to "Engage people in a life of recovery and assist them to live their lives well."

Over the past 32 years, I have served as Vice President of Operations, as Executive Vice President, and currently as President and CEO. In recent years, I have focused on implementing an integrated vision of mental health and addiction treatment services and evidence-based treatment practices. I have also been fortunate to be a participant in the Network for the Improvement of Addiction Treatment (NIATx), which has taught me how to use process-improvement techniques to impact quality of care in addressing addictions.

**GREAT LAKES ATTC:** Describe how the behavioral health recovery management program came into existence.

**MIKE BOYLE:** Ten years ago, behavioral health leaders were scrambling to prepare for or implement managed care. During this time, I found myself drawn to national conferences on managed care that included presentations from primary care physicians on disease management. Organizations like Kaiser Permanente were often presenting on what they were doing to deal with chronic medical disorders. That's when I started thinking, "We say addiction and serious mental illness are chronic conditions; why are we using such an acute-care model to treat them?" I wondered why we were not using disease-management approaches like those that were emerging in primary medicine. Then in 1999, my local state representative approached me and asked if we had any legislative needs that he could help with. We began to discuss some of the needs of the field, and that led to writing legislation that would support the development of a disease-management approach to addictions and serious mental illness. We put together a legislative bill for a three-year project that would fund the development of this approach, and it passed the House and Senate and—with a little negotiation—was signed by the Governor.

We asked for a million dollars over a three-year period to support the project. In the course of moving the legislation through, the Secretary of the Illinois Department of Human Services became very interested in the project and offered to fund the idea if the legislation was passed. This was very helpful, since the bill would then not need an appropriation tied to it. As this came to fruition, I approached Chestnut Health System's Lighthouse Institute and recruited Bill White as an Associate Director of the project. David Loveland, now Director of Research at Fayette

Companies, became the other Associate Director, with a specialty in serious mental illness and co-occurring disorders. Pat Corrigan from the University of Chicago, Center for Psychiatric Rehabilitation later joined as a third partner in the Behavioral Health Recovery Management project.

**GREAT LAKES ATTC:** What distinctions were you making between recovery management and disease management as this project developed?

**MIKE BOYLE:** It was Bill White who came up with the concept of recovery management rather than disease management. I remember at the time, I said, “Well, everybody knows now what disease management is. It’s been around for a decade. No one has ever heard of recovery management.” And Bill said, “In three years, they will.” That was enough to sell me. Disease management (DM) has basically been built on the foundation of evidence-based practice—what science says will generate the best outcomes for specific chronic diseases. DM emphasizes science-based clinical guidelines for service practitioners, and DM also tries to actively engage each individual in managing his or her own illness rather than leaving everything to the physician and other health care professionals. Recovery Management (RM) incorporates the DM approach, but shifts the focus from the disorder to the person, from symptom management to building a life in recovery. RM approaches also place greater emphasis on natural supports within the family and community that can be aligned to enhance recovery initiation and maintenance. RM asks: “How can we build recovery support within the larger community? How can we assertively link the individual to such recovery support resources?” RM, because it focuses on the whole life rather than the disorder, is also broader in its scope, encompassing such areas as social and recreational activities, employment, education, housing, and life meaning and purpose. It is about making recovery a very enjoyable and positive experience.

**GREAT LAKES ATTC:** For readers unfamiliar with recovery management, could you briefly summarize how traditional clinical practices change in this model?

**MIKE BOYLE:** Thresholds of engagement are lowered, with a considerable emphasis placed on outreach services. Motivation is viewed as an important factor but seen as an outcome of treatment rather than a precondition for treatment admission. There is an emphasis on assessment processes that are global, continual, strengths-based, person- and family-centered, and culturally grounded. The service menu is broadened, and the eventual locus of services shifts to homes and neighborhoods. The service relationship is based on a partnership model that is much longer in duration and less hierarchical. Perhaps most distinguishing is the shift in emphasis from acute bio-psychosocial stabilization to long-term recovery monitoring and support; assertive linkage to communities of recovery; and, when needed, early re-intervention.

**GREAT LAKES ATTC:** Was the RM approach a natural progression in the overall development of Fayette Companies and its service units?

**MIKE BOYLE:** Actually, it’s really ironic. We formed our first organization, Human Service Center, by consolidating four mental health, drug, and alcohol treatment programs in the 1970s, but we had never really integrated care. So, in the late ‘90s, I started an initiative to fully integrate co-occurring disorders. We’d already been making some progress in trying to integrate the treatment of serious mental illness with primary healthcare by establishing a primary care clinic within our outpatient mental health center. We really needed to address the co-occurring substance use disorders and all mental illnesses, particularly serious mental illness. About half of the population that we serve have both disorders. People with serious mental illness were often abusing or addicted to substances, and our addiction programs were

filled with people suffering from serious mental illness, mood disorders, and anxiety disorders, including post-trauma effects and Posttraumatic Stress Disorder. We formed a quality improvement committee with multi-disciplinary representation across the functions of the organization, with the mission of fully integrating treatment services across the continuum of care. That's when, in 1998, we really started implementing evidence-based practices. The recovery management project shared that objective, and it was a natural evolution from the integration of treatment for co-occurring disorders to a more comprehensive vision of assisting people with the long-term recovery process. This moved us beyond thinking about biopsychosocial stabilization to the broader issues involved in recovery maintenance and enhancement of quality of life. Our focus began to shift toward long-term recovery and the role we could play in that.

**GREAT LAKES ATTC:** How did you begin to prepare staff for some of the changes that were implemented through this process?

**MIKE BOYLE:** Early on in our co-occurring project, we realized that we had to address staff's values and beliefs, their attitudes, and the different cultures of our mental health and addictions programs. We took all our clinical staff and divided them into small groups (12-15 staff each) that gathered in brown-bag lunch meetings every week. These meetings were facilitated by members of our co-occurring committee. We developed a list of statements we called "fire starters," to elicit and discuss beliefs and feelings about particular issues. Examples of our fire-starter statements include:

- Addictive and psychiatric disorders are both significant chronic conditions often characterized by episodes of exacerbation, remission, and relapse.
- All persons should be retained in service and treated with great respect in spite of non-adherence with treatment plan recommendations, including not taking prescribed medications or a return to use of the drug of choice.
- Addiction and mental illness are both no-fault disease categories.
- No behavioral health problem is so grave that an individual cannot be engaged in the recovery process.
- It is more important to convey caring and concern than to avoid being manipulated or conned—even at the cost of "enabling."
- Medication can be an effective strategy in the treatment of both disorders.
- Recovery begins with hope, not abstinence from drug use or reduction of psychiatric symptoms.

**GREAT LAKES ATTC:** Did this help "unfreeze" the cultures across programs?

**MIKE BOYLE:** It worked very well. We had intense debate over issues such as whether somebody who was on methadone treatment could be considered to be in recovery. One staff member would declare, "You couldn't be in recovery on methadone; You're still using an addictive drug!" That would trigger counter-responses from other staff: "Wait a minute. I've got people who are on methadone who are not using any alcohol or non-prescribed drugs. All the urine drug screens are clean. They have a family and a job, and they're doing great. What do you mean, they're not in recovery?" That type of interaction opened people's eyes and their minds. Here's another example. A person who worked in our detox program said, "People with addictions make a conscious choice to go back to using. They go to the bar. They go buy

some marijuana or cocaine, whereas people with serious mental illness really don't make a choice when they relapse." Mental health staff responded, "People make a conscious choice to not take their medications any longer. That's analogous to making a choice to drink or use a drug. Both populations know the risks and the likely events that will follow."

**GREAT LAKES ATTC:** Were there staff people who couldn't make this transition?

**MIKE BOYLE:** We made it clear to everyone, "We're going west, and the wagon train is leaving. We don't know exactly where we're going to end up. We're not sure if it's going to be in California or Oregon, but if you want to stay with this organization, you've got to get on board the train and make this journey with us." We made our expectations explicitly clear in written documents that outlined the attitudes, values, knowledge, and skills that we saw as the core of this shift toward recovery management and behavioral health service integration. Not all made it, but most did.

**GREAT LAKES ATTC:** Training seems to have been a crucial part of your system-transformation process.

**MIKE BOYLE:** Yes. All of this involved bringing outside trainers into the organization. In fact, we started the co-occurring initiative by bringing in Dr. Ken Minkoff to conduct a full day's training that was the largest clinical training in the history of the organization—with more than 120 staff. He does a great job of motivating people and getting them laughing at some of the stupid things we do. And then we followed up with a lot of evidence-based training for both mental health and substance abuse. We started with Motivational Interviewing (MI), which led to a major cultural change in our service units. That training was a milestone in shedding the culture of confrontation that had long-pervaded some of our service units. Rather than verbally beating people into superficial compliance, we redefined our jobs as helping people take a look at the pros and cons of the choices they have and the discrepancies between their life goals and their behaviors. That was probably the most important cultural change we made in both our mental health and addiction services.

We followed the MI training with a series of other trainings. The manualized treatments covered included Community Reinforcement training provided by Bob Meyers, Contingency Management training provided by Nancy Petry, Strengths-Based approaches by Leigh Steiner, Illness Management and Recovery from Kim Mueser, and Supportive Employment from Pat Corrigan and associates. We also provided basic training on recovery management principles. These trainings collectively moved us closer to evidence-based practice and toward a stronger recovery orientation. We also moved to person-centered care that required us to give up some of our delusions that we had control over people's individual decisions that impacted their lives. Rather than prescribing techniques, we had to engage individuals as partners in the pursuit of recovery.

**GREAT LAKES ATTC:** It seems like there was an interesting relationship between the BHRM project and Fayette, in which you used the service programs as a kind of laboratory to test out emerging ideas and approaches. Is that accurate?

**MIKE BOYLE:** That's very accurate. I'll give you one example. Four years ago, the local state-operated psychiatric hospital in Peoria closed. We took that opportunity to look at how we could improve services as some of the savings from the hospital closing were provided to us to expand our community-based services. One of the services we developed was recovery coaching. We said, "Wait a minute. If we're going to keep people coming through the front

door, we need to open a back door for sustained recovery support.” One of the evidence-based practices we were using at the time was assertive community treatment, the ACT model from Madison, WI. The ACT model, as it was widely implemented, was a life sentence of case management. We rethought that position. We hired two people to be recovery coaches, and we went through all of our case management caseloads to identify people who were doing well whom we could graduate from case management and put on this other team that would provide ongoing recovery support and monitoring. That was probably our first foray into recovery coaching and ongoing monitoring. Many are coming here only because they need to see the doctor every 90 days to continue to monitor their psychotropic medications. They don’t need anything else from us. So we’ve developed criteria, and we’re trying to link these people to primary care, particularly a federally qualified health center that we work with, and totally graduate them from the organization, saying, “If you ever have a return of symptoms, or you need help, we’ll always be here. Call any time. You are no longer a mental health client.” The primary care physician can monitor their psychotropic medication while he or she is treating other physical disorders like diabetes and hypertension.

**GREAT LAKES ATTC:** Mike, describe your changing philosophy about client access to services and the importance of retention.

**MIKE BOYLE:** Recovery management can increase access by lowering barriers to entry, but our access was pretty open even before the BHRM project, with one exception. We did have exclusionary criteria that resulted in our rejecting people with co-occurring disorders for both our mental health and addiction services. We had to work to eliminate these service-entry barriers, which we were able to do with considerable success. Our bigger issue was retention. We were fine bringing people back who had had previous treatment episodes, but we were throwing a lot of people out for lack of motivation or for petty rule violations. Particularly in addiction treatment, if people didn’t say the right things and do the right things, we were throwing them out or making them feel unwelcome enough that they’d leave. Our philosophy had been that they were not ready for recovery and that they needed to get back to the streets and accumulate some more pain in their lives. This is an area in which we saw dramatic change in staff attitudes.

**GREAT LAKES ATTC:** Elaborate on that change.

**MIKE BOYLE:** We started accepting people for where they were and respecting them for telling us the truth. Our new position was, “You don’t have to say that you’re here because you really want to stop using all drugs. It’s okay to be ambivalent. It’s okay to say, ‘I’m only here because the court’s forcing me to be here, or because I have to be here to get my kids back’.” Training on motivational interviewing changed the culture. We grew from blaming people for their lack of motivation to attempting to understand their current circumstances and desires. This change in philosophy was enhanced through our involvement over the past three years with the Robert Wood Johnson Foundation’s Network for the Improvement of Addiction Treatment. We have tried to make the environment in our treatment programs very welcoming, rather than conveying the feeling that you’re being processed into jail. In fact, we’re trying to use the term “engagement” rather than “retention.” You can retain people in jail or a locked psychiatric unit. Engagement implies the establishment of a relationship in which the person wants to be involved in the services. The whole atmosphere has changed.

**GREAT LAKES ATTC:** That must have generated a significant change in the nature of the service relationship.

**MIKE BOYLE:** One of the BHRM principles is development of a recovery partnership rather than a hierarchical dominance by the treatment program and the treatment professional over the individual. That has been a huge, huge change across the whole organization and reflects the strengths-based approach that Charles Rapp endorses for people with serious mental illness. Our messages are clear: We're here to work together. We want to understand what your goals are. What do you need to start and sustain your recovery? How can we help you achieve that? Our focus extended beyond treatment to each person's goals for his or her life. Often, a "non-treatment" goal will help the person realize that participating in treatment activities will assist them in reaching their goals. For example, obtaining and maintaining employment may be a primary goal, and taking psychiatric medications and reducing use of alcohol or drugs may be an important step toward meeting the goal of employment.

**GREAT LAKES ATTC:** You have argued that administrative discharge is a form of clinical abandonment.

**MIKE BOYLE:** A decade ago, we discharged people because they were violating our numerous rules and because we determined that they just weren't really ready to change. Our first step was to get rid of a lot of stupid rules that had little to do with someone's recovery. We've had to step back and ask, "Why are we doing this?" Many times, it's because we've always done it that way, and we can't even remember how the policy or practice started. I'll give you an example. We had a blackout period in our residential programs during which individuals weren't allowed to make phone calls or have visitors for a period of time. The clients were saying, "Hey, I really wanna call my kids and let them know how I'm doing." I remember a young woman who had a very close and supportive relationship with her father saying, "I really want to call my dad. I just want to talk to him." We finally said, "Okay. Let's do away with this blackout period. See what happens." The myth was that people would get homesick or hear the call of the streets and leave. Well, guess what? They stayed. Our average length of stay went up significantly as our AMA (leaving against medical advice) rate dropped after we changed this policy. In one of our programs, the AMA rate dropped from 30 percent to between 11 and 12 percent. And that happened by changing how we treated people. That's what it comes down to. Listening to our customers. Listening to what they want. Taking the strengths-based, Motivational Interviewing approach and avoiding confrontations and power struggles with our clients. We were often discharging people because we were picking fights with them. We had to abandon our philosophy of "It's our way or the highway." Our administrative discharge rate is now about 4 percent, a fraction of the national average, and usually results from someone bringing drugs into the program, or from violence.

**GREAT LAKES ATTC:** It seems you've found effective clinical alternatives to administrative discharge.

**MIKE BOYLE:** Today we're more likely to move someone to an alternative level of care than to sever the service relationship with the agency, and to stay involved with someone who wants to pursue a decision we think may not be a good one. Today, if someone says, "I don't want to stay longer in residential care," we work with them to find an outpatient alternative. We stopped dictating what people "should" do and started offering them choices at every step in the process. As a result, we're minimizing treatment dropout, and we've substantially increased the number of people involved in step-down care following residential treatment. For a recent 18-month period, the percentage of clients continuing in outpatient treatment following completion of residential care increased to 94 percent from 69 percent for the previous 18-month baseline period. Furthermore, participation in outpatient increased from 19 percent to 34 percent for those who didn't complete residential care.

A few years ago, if somebody used while they were in one of our outpatient programs, it would be an immediate administrative discharge. That whole attitude has changed. Now, if somebody comes in and says “I had a relapse over the weekend,” we work with that experience. What went wrong? How can you prevent that from happening again?

**GREAT LAKES ATTC:** The changes you describe in the service relationship are striking.

**MIKE BOYLE:** We’ve learned how very important it is to empower the individual. We’ve shifted from, “How do we keep this person out of the hospital?” to “How do we enhance this person’s quality of life in the community?”

**GREAT LAKES ATTC:** Another area of innovation in which you’ve invested considerable time and resources is the integration of primary healthcare and behavioral health treatment.

**MIKE BOYLE:** Another key recovery management principle is the importance of moving beyond the integration of mental health and addiction treatment toward the larger integration of behavioral health with primary healthcare. A large number of the individuals with serious mental illness and with severe drug and alcohol problems whom we serve have co-occurring physical health problems and needs. The medications we use, the new atypical antipsychotics, have side effects that can include weight gain. This may contribute to the potential development of hypertension, diabetes, and other weight-related disorders. For another example, on the addiction side, the attending physician for our women’s program tested all of the women for Hepatitis C and found that 25 percent were positive for Hepatitis C; but, of that population, only 40 percent who were positive knew they were positive. It’s time we started looking at the whole person—looking at global health.

**GREAT LAKES ATTC:** What strategies have you found effective to link people to primary healthcare in your programs?

**MIKE BOYLE:** We work very closely with a federally qualified health center (FQHC) that was established here in Peoria about 3 years ago. In fact, we were a sponsor in getting the organization started. They have assumed responsibility for the primary care clinic that is operated within our mental health center. Our goal is to enroll everyone in the FQHC who doesn’t have an ongoing primary care relationship. On the addiction side, we work closely with the FQHC to link clients to the FQHC, other clinics, or primary healthcare providers. We are also increasing our referrals to primary health care from our detox program. Also, with client consent, we have standard letters that we can use to inform someone’s primary physician of his or her admission to addiction treatment, letters that request the support of the physician in the patient’s ongoing recovery. Examples of these forms can be found on the BHRM web site at [www.bhrm.org](http://www.bhrm.org) in a guideline for linking addiction treatment with primary care. Our recovery coaches also play a major role in linking people to primary health care.

**GREAT LAKES ATTC:** How do you currently view the importance of recovery coaches in recovery management?

**MIKE BOYLE:** Let me describe what we’ve done with recovery coaching in our addiction treatment units. Two years ago, we took some existing funding and hired two women, both of whom were in addiction recovery, to pilot a recovery coaching program for women in our residential addiction programs. When women are within 4 to 6 weeks of completing treatment, we ask them if they would like to have a recovery coach, and we explain that the recovery

coach will work with them to develop their own personal recovery plan as part of their transition out of residential treatment. We have guidelines, and the forms we use are all on the BHRM website; people are welcome to adapt them to their own programs. The recovery coaches work with women on 8 domains:

- Recovery from substance use disorders
- Living and financial independence
- Employment and education
- Relationships and social support
- Medical health
- Leisure and recreation
- Independence from legal problems and institutions
- Mental wellness and spirituality

This plan is developed before they leave residential treatment, and recovery coaching remains available to them even if they leave AMA, or for any other reason before they complete treatment. When they do leave, the recovery coach transitions with them into the community, to help them implement their personal recovery plans and also to evaluate and modify their recovery plans as necessary.

What we found is that half of the women who accepted the recovery coach—and most do want it—were homeless upon leaving. One of the first efforts of the recovery coach is often linking our women to a local shelter or recovery home so that, on the date of discharge, they have a place to go that's safe and recovery-conducive. A lot of attention is also focused on helping clients gain employment, so they can get into their own apartment or sober living situation. Whatever their goals are, we help them pursue what they want.

At six-month follow-up, the results have been very encouraging. Seventy percent of the women have improved their living situations. At admission to drug treatment, only 4 percent of the women were employed. At six-month follow-up, we have 54 percent employed. Also noteworthy is the fact that 36 percent are involved in some type of educational activity. We're looking at adding some type of supportive education services to the recovery coach program that would help people with three levels of education: providing pre-GED, for people who need to improve their math and writing skills to get in a GED program; helping getting people enrolled in a GED adult diploma program; or helping people get enrolled in secondary education, particularly at our junior college. A big goal of many of the women we serve is to improve their education. We are also putting computer labs into our residential facilities so people can start building computer expertise while they're in residential treatment. This will also provide access to web-based resources and recovery supports that will expand significantly in the next few years. In fact, we're working on the development of these web-based recovery treatment and support interventions with the Innovations to Recovery project headed by Dr. David Gustafson at the University of Wisconsin.

**GREAT LAKES ATTC:** You've referenced some efforts to evaluate your shift toward a recovery management model. Could you describe some of these efforts in more detail?

**MIKE BOYLE:** In the past four years, there has been tremendous synergy between the implementation of Recovery Management and our participation in the Network for the Improvement of Addiction Treatment (NIATx). NIATx has taught us methods of process improvement for increasing access and retention, essential goals of Recovery Management.

One of the principles of BHRM is lowering the threshold to treatment. We have a central assessment unit for women that had an average length of one to fourteen days between the date of her calling and the date of her assessment. We simply did away with scheduling appointments and offered next-day assessment on demand. The time between the call and receipt of the first service dropped to an average of 2 to 3 days. Furthermore, the percentage of calls that resulted in a completed assessment increased from 50 percent to 70 percent.

Another BHRM principle is establishing a recovery partnership with those we serve. We used the NIATx rapid-change process to make treatment welcoming and engaging. For two women's residential programs, the rate of discharges against medical advice dropped from 30 percent or greater to 11-12 percent.

There is also a "business case" for these changes. For example, in one residential program, earnings increased by \$274,000 annually, compared to the baseline period one year earlier.

**GREAT LAKES ATTC:** One of the comments elicited from presentations on recovery management is, "Nobody will ever fund this. Who's going to pay?" How have you funded the innovations you have described?

**MIKE BOYLE:** For recovery coaching, we can bill those services either to the Division of Mental Health or to the Division of Alcoholism and Substance Abuse as case management services. Medicaid covers mental health case management services in Illinois. Unfortunately, case management services linked to addiction treatment are not funded in our state by Medicaid. As far as potential funding through insurance is concerned, we haven't approached that yet. I suspect it will be easier to sell this concept to corporations and insurance companies than to the public funders because of the former's experience with new approaches to the management of chronic medical disorders. Our recovery management project was only supposed to be three years in length, but the Division of Alcoholism and Substance Abuse was so impressed with the results that they extended the project for two more years and then converted the grant to a fee-for-service contract two years ago. We funded the recovery coaches by taking some of the former BHRM development money and using it to fund the salaries of the recovery coaches and then billing out those services.

**GREAT LAKES ATTC:** Do you have a vision of how funding changes will help support this transition from an acute care model to a recovery management model of addiction treatment in the next 10 years?

**MIKE BOYLE:** I think our first step is to prove that this model is effective and to study the cost implications and potential cost offsets and cost benefits. We need that data to approach the funders, both private and public. At this point in time, all we have is the pilot data that looks very good, but it is weak from a research perspective. We are getting indications that are confirming the value of this approach. These include positive impact on engagement and retention demonstrated through our work with the Network for the Improvement of Addictions Treatment and the well designed studies of the Assertive Continuing Care and the Recovery Management Check-ups that have been conducted by Lighthouse Institute. We need additional studies that confirm the value of post-treatment monitoring, support, and early re-intervention. We need formal studies of recovery coaching and its effects on relapse and recovery rates. We know anecdotally that recovery coaches provide a level of support that can help some people overcome a lapse without having to return to structured treatment. Our traditional response to relapse has been readmission for another treatment episode. Why do we continue to put people back through the same treatment they've been through multiple times and think this time

it's going to work? We need studies that illuminate how to deal with the problem of post-treatment relapse in the client's natural environment.

**GREAT LAKES ATTC:** What are some of the obstacles you've encountered in implementing the recovery management model, whether that's inside your agency; in the community; or at the federal, state funding, or regulatory levels?

**MIKE BOYLE:** There were several such obstacles. Let's start with the external ones. We've already referenced issues related to funding and regulatory compliance, but an obstacle we didn't anticipate was the attitudes of our referral sources. It took some time to orient them to what we were doing and why. On the criminal justice side, they like to mandate residential treatment whether people need it or not, and the same is often true of the child welfare system. It took us some time to demonstrate the value of less intensive services such as recovery coaching. As long as a person is staying engaged in a service process, our referral sources are supportive of our new service philosophies.

**GREAT LAKES ATTC:** Did the recovery management efforts that you've initiated open the doors to other projects and areas of innovation for the agency?

**MIKE BOYLE:** I believe the Recovery Management project was a key factor, along with our participation in the Network for the Improvement of Addiction Treatment, in our being selected for a United Nations project, the International Network of Drug Treatment Resource Centers. One of the four UN workgroups is focused on sustainable livelihoods for rehabilitation and reintegration, and the workgroup is using the principles of BHRM as well as Cloud and Granfield's concept of recovery capital as a foundation for the manuscript we're developing on how we can support recovery. The other project that ties in with our recovery management work is our involvement in the Innovations for Recovery project being developed by the University of Wisconsin, which involves the application of technology to treatment and recovery support. Its primary focus at the present time is on post-treatment recovery support, so this was a natural complement in the shift toward recovery management. Through this project, Dave Gustafson and his engineers are taking Alan Marlatt's relapse prevention schema and looking at technological applications we can use to help people when they're in various risk situations. For example, GPS technology might be used to identify people entering their high-risk environments and provide support through an avatar counselor on a PDA-type device. Our field is far behind other areas of health care in the use of new technologies to provide treatment. These technologies might make ongoing recovery support and monitoring affordable while providing an efficient means of ongoing outcome monitoring. We are even considering developing a recovery support "island" in a virtual world that can be accessed for support and information 24 hours a day.

**GREAT LAKES ATTC:** Are there pitfalls that other agency directors should be aware of who may want to consider implementing a recovery management philosophy at their agencies?

**MIKE BOYLE:** First and foremost is how to counter staff resistance or inertia. Recovery management challenges a lot of traditional service thinking and service practices, so there will be resistance. We worked through that by involving everyone in the process and through our training and supervision activities. An equally difficult challenge is the question of time. Many staff like the concept of recovery management and ongoing support, but they uniformly say, "We don't have time to do it. We'd love to be able to keep in contact with individuals when they leave and know how they're doing and provide them support, but we can't do it. As soon as somebody walks out the door, I've got somebody new on my caseload." That's a big barrier to

overcome. The time problems flow from the fact that funding streams are primarily designed to support the acute-care model.

In regards to funding, I believe providers will have to partner with funding and regulatory agencies to make necessary changes in the rules that control the provision and purchasing of addiction treatment services. This will have to occur on an individual basis with each state, due to the variations among states. Some states are already changing their funding mechanisms to support some aspects of a Recovery Management approach. In Arizona, for example, peer-delivered recovery support services are covered through their Medicaid funding stream.

**GREAT LAKES ATTC:** It does seem like the financial interests of addiction treatment programs work against providing long-term recovery support.

**MIKE BOYLE:** There are opportunities to incent service providers for providing such services. Pay-for-performance experiments in Delaware and Philadelphia are focusing on access and keeping people in treatment once they've begun. If we really move toward paying for recovery outcomes, that could change the whole world.

**GREAT LAKES ATTC:** What do you personally feel best about related to the work you've done in recovery management over the past six years?

**MIKE BOYLE:** The question probably should be, what do "we" feel best about, as BHRM has been a team effort of folks, obviously including Bill White, as well as folks like David Loveland, Pat Corrigan, and Mark Godley. What I feel best about is changing the entire culture of my organization for clients and staff. If somebody who worked here ten years ago walked in here today, they wouldn't recognize us as the same organization. Now everybody talks about using evidence-based practices. Our staff members' learning plans are based on evidence-based practices. Everybody's looking at recovery. I mean, recovery wasn't even a word we used on the mental health side ten years ago.

On a national level, it has been a thrill to watch more and more providers, states, and federal organizations become interested in Behavioral Health Recovery Management and start to apply RM principles and approaches. I think we are nearing the "tipping point," where we become a movement in making drastic changes to addiction recovery nationally, and even internationally. Recovery Management has been embraced by the United Nations project I've mentioned here.

Finally, I'm excited about the early positive results on research trials on recovery management approaches conducted by Mark and Susan Godley, Mike Dennis, Chris Scott, and others from Lighthouse Institute. The significant impact of Assertive Continuing Care for adolescents and Recovery Management Check-ups are very promising for promoting the outcomes of Recovery Management.

**GREAT LAKES ATTC:** Mike, what do you see as the next steps for your agency in the coming years?

**MIKE BOYLE:** I think the recovery concept and the recovery management model are very well ingrained here. I think the next three to five years will entail really finishing the total cross-training of all the staff in evidence-based practices for both mental health and addiction. All staff need to be well versed and well skilled in each of these practices and have their own personal toolboxes of techniques that they can use to support individuals and families in recovery. We're not there yet, even with our supervisors, but we're getting closer every day. I think we will also

be increasing our focus on what the community has to offer people in recovery. Let me give you an example. Our staff have put together a list of upcoming events that are free or that cost less than ten dollars, to encourage clients to become engaged in positive social interactions and entertainment in the community. I was reading some case notes the other day regarding an outpatient addiction treatment client who shared how bored he was all weekend. His whole weekend consisted of being bored, with the exception of going to three 12-Step meetings. Part of recovery management is finding ways to make recovery both fun and fulfilling. To do that, we have to get people into the life of the community.

**GREAT LAKES ATTC:** Your work with the faith community in recent years would seem to illustrate this.

**MIKE BOYLE:** We've done a lot the last few years to engage the faith-based community to help people become involved in church sampling. Recently, we've established the Peoria Area Alliance for Recovery, which includes many faith-based organizations providing recovery supports. The chemistry is amazing. For example, many women lack the Social Security card and number needed to obtain employment. The churches said they could provide funds to these women to purchase the birth certificates needed for obtaining their Social Security cards. Others in the group suggested the women could volunteer in church activities in exchange, thus empowering and engaging them in positive behaviors.

**GREAT LAKES ATTC:** How has your relationship with other local community institutions changed in the move toward recovery management?

There are many local organizations supporting recovery, and we realize we need one another to better assist those we serve. For example, the Peoria Area Alliance for Recovery is composed of representatives of organizations providing housing, employment, education, faith-based supports, community development, and other supports that people may need on their journey to recovery.

**GREAT LAKES ATTC:** Are you providing more services actually out in the community today than you were 10 years ago?

**MIKE BOYLE:** Absolutely. On the mental health side, 75 percent of our services are community based. On the addiction side, there's probably been less change. We've had our outreach component going for women involved with child welfare for 20 years now, but the recovery coaches are the major change there, moving toward more community-based services. I would love to have more recovery coaches. We did a focus group with people who are involved in our adult drug court in recovery coaching, asking whether or not they would find this beneficial and what types of services they would like from recovery coaching, and it turned out by chance that two of the people who were in the focus group had already been working with recovery coaches. By the end of the group, people in adult drug court programs were saying, "I hope I can stay in this drug court program long enough to get a recovery coach." To hear comments like that from mandated clients is testimony to the potential power of the recovery management model.