



Addiction Messenger

May 2008 Volume 11, Issue 5

Ideas for Treatment Improvement

Implementing Recovery Management Part 2 - Making the Philosophical Shift

This is the second in a series of interviews with leaders who envision a renewed emphasis on recovery within our nation's addiction treatment systems. Excerpted from a monograph by William L. White (2007) and published by the Great Lakes ATTC, this interview is with Michael Boyle, President and CEO of Fayette Companies and Director of the Behavioral Health Recovery Management (BHRM) project in Illinois. Mike is one of the founders of the movement to shift addiction services from an acute care to a more chronic care model with a focus on recovery. We hope you enjoy his insights.

Approximately ten years ago, while listening to physicians discussing how they approach the management of long term medical conditions and chronic diseases, Mike Boyle started thinking, "We say addiction and serious mental illness are chronic conditions; why are we using such an acute-care model to treat them?" He wondered why we were not using disease-management approaches like those that were emerging in primary medicine instead of the short-term doses of care that all too often ended prematurely, resulting in a return to the illness that precipitated the initial referral.

The notion that we need to shift both our philosophy and our practice started Mike on a journey that continues to this day. He has pioneered a movement that is gathering speed and momentum as policy makers, researchers and practitioners embrace his idea of providing care for chronic substance use and mental disorders with services consistent with the breadth and severity of those conditions. Bill White spoke with Mike in September, 2006.

BILL WHITE: Mike, 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.

"It is about making recovery a very enjoyable and positive experience."

~ Mike Boyle ~

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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.

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

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.

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

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:

- 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.
- 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.

WHITE: Did this help "unfreeze" the cultures across programs?

BOYLE: It worked very well. We had intense debate over issues such as whether somebody on methadone treatment could be considered to be in recovery. One staff member would declare, "You can'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.

WHITE: Mike, describe your changing philosophy about client access to services and the importance of retention.

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.

WHITE: Elaborate on that change.

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.

WHITE: You have argued that administrative discharge is a form of clinical abandonment.

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.

WHITE: It seems you've found effective clinical alternatives to administrative discharge.

BOYLE: Today we're more likely to move someone to an alternate 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?

WHITE: The changes you describe in the service relationship are striking.

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?"

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Sources

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