



# Addiction Messenger

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Ideas for Treatment

## Implementing Recovery Management Part 3 Recovery Coaching Pays Dividends

In this final article in our series on Recovery Management, Bill White continues his discussion with Mike Boyle, President and CEO of Fayette Companies in Peoria, Illinois. Mike emphasizes the impact of creating services that meet the specific needs of clients and how those services impact the organization as a whole. The interview has been edited from a monograph by William L. White, published by the Great Lakes ATTC in 2007.

**A** key component of Recovery Management is the individualization of a recovery plan for each and every client and the availability of a consultant to mentor the newly recovering person. When a recovery coach is available to build a supportive relationship with the client and facilitate the client's follow-through with the recovery plan, then great dividends can be reaped by the client, the family, the treatment agency and the community. Successful recovery benefits the entire community in so many ways. Talented people are returned to productive citizenship, families are restored, and illness is replaced with well-being.

Tangible improvements in the treatment system can accrue when focus is placed on meeting the needs of those entering early recovery. Bill White discussed those improvements and what they mean to treatment providers with Mike Boyle in September 2006.

**BILL WHITE:** 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

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*~ Mike Boyle ~*

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- 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.

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

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.

WHITE: 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?

BOYLE: I think our first step is to prove that this model is effective and to study the ...potential cost offsets and cost benefits. At this point, all we have is 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 Addiction Treatment, and the well designed studies of Assertive Continuing Care and Recovery Management Check-ups that have been conducted by Lighthouse Institute...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.

WHITE: Are there pitfalls that other agency directors should be aware of if they want to consider implementing a recovery management philosophy at their agencies?

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.

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

BOYLE: The question probably should be, what do "we" feel best about? 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.

WHITE: Mike, what do you see as the next steps for your agency in the coming years?

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...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.

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