Beyond Compliance:

Building a Phase Structure That Promotes Recovery

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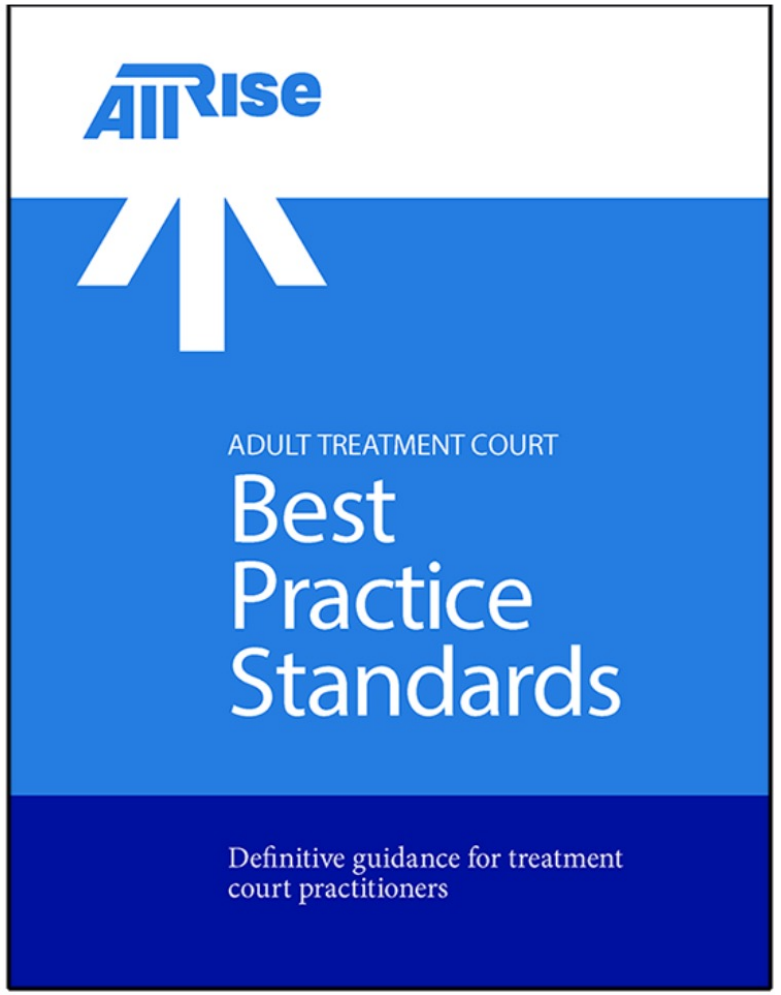
We Have Standards!

Noteworthy Clarifications in the 2nd Edition, Vol. I, Standard IV!

- Little direct research on phases but decades of research on effective behavior modification
- Standard IV provides a practical guide for building phases that promote success!
- **One-size-fits-all phase requirements are NOT best practice!**
- We focus on GOALS, needs and **proper sequencing** of services



Why Have Phases?

Phases provide a targeted approach to EFFECTIVELY address needs:

- **Provides structure, progressive measurable goals**
- A big, scary goal is more manageable in small bites!
- Builds a strong foundation for improvement
- **Instills confidence**: “I can do this!”

Why is Phase *Structure* Important?

- **High-risk/high-need individuals** have many needs.

•**Ratio Burden:** The foundation of recovery is built one step at a time.

•**Addressing needs in the wrong order can create confusion, waste resources, and even cause harm**.

•Arranging our phase structure to address participants' needs ***in a manageable sequence*** produces **better outcomes**.

•**How do we do that?**

EMBRACE!

USE SKILLS

ENGAGE!

PRACTICE SKILLS

PARTICIPATE

DO HOMEWORK

ATTENTIVE

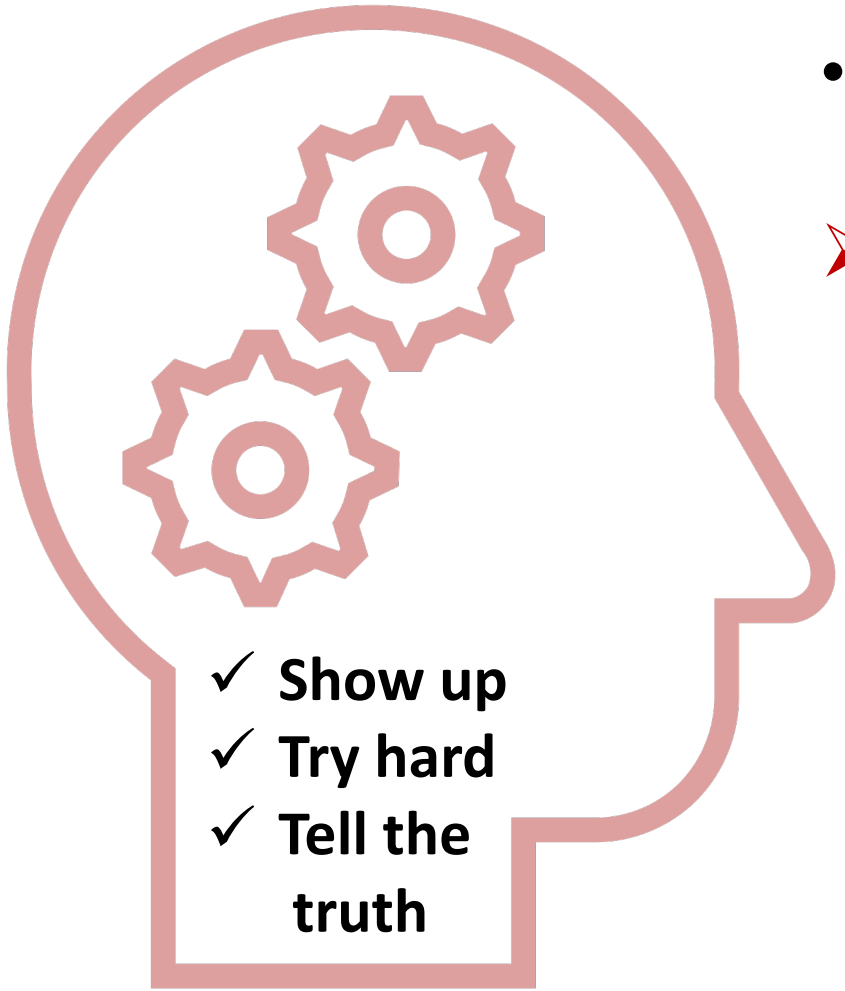
ON TIME

ENGAGE!

Proximal, Distal & Managed Goals

Proximal = Now/Near/Soon

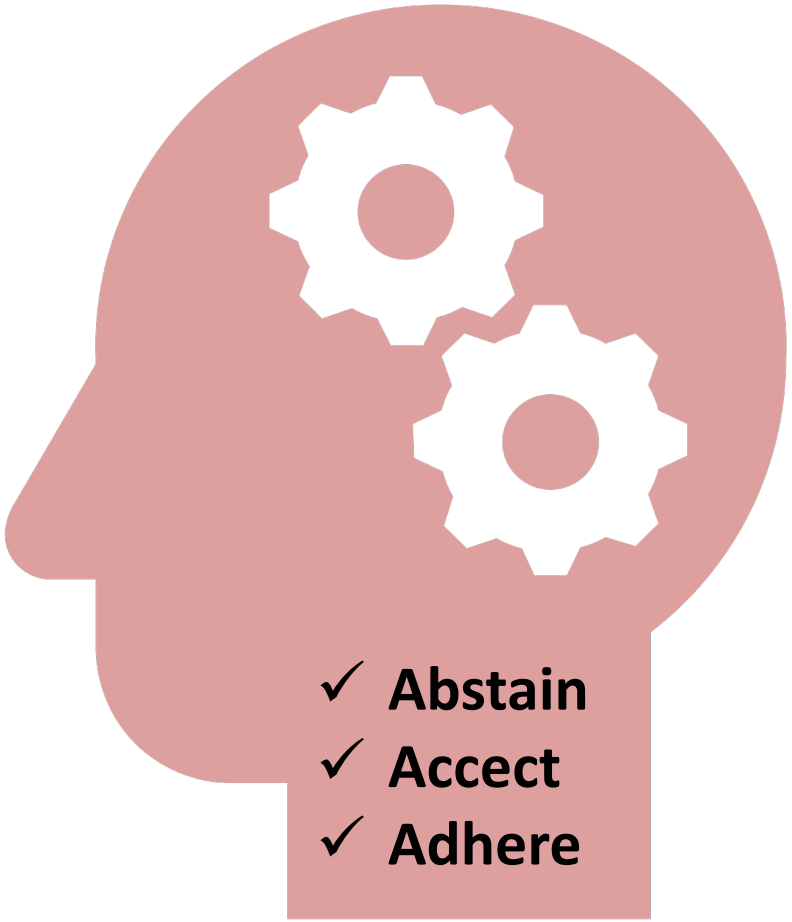
Proximal ≠ Easy



- **What the individual participant is capable of, and has the tools available to do, TODAY or soon**
  - **It's going to be different for everyone.**
    - Proximal at program start is **what we need them to do FIRST -- before we tackle bigger goals.**
    - When proximal goals can be maintained for an extended period, they are **"MANAGED"** goals.
    - Managed is **not "perfect". It's ~90%**
    - **Current phase must include proximal goals ONLY. When managed, phase-up**

What are Distal Behavioral Goals?

Distal = Distant, Later



- **What the individual participant is NOT capable of TODAY, but can be done later with HELP**
- **DO NOT put distal goals/requirements in their current phase!**
- **Skills must be learned and practiced a lot BEFORE distal goals can be achieved!**
- **There will be many mistakes before these things can be achieved**
- **Everything feels distal for most on Day 1. Be patient! Next phase has slightly more challenging goals.**

Standards: We're Moving to a Highly Individualized Approach

➢ **No one-size-fits-all approach:**

- Avoid mandatory **phase time lengths** (but ***do*** give approximations)
- Phase **abstinence goals** will vary
- **Recovery support groups** per week
- Supervision & treatment **contacts**

- Phase-up is NEVER tied to **treatment progress**: "Follow your treatment plan"

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How do your participants feel about your first phase?

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Do Your Early Phases Expect (Mandate!) Distal Behaviors?

- ❑ Excessive (>14 days) abstinence goals?
- ❑ Recovery support meetings? Sponsor?
- ❑ Employment? Payments?
- ❑ Community service?
- ❑ Prosocial activities?
- ➢ **That is NOT supported by research!**
- ➢ Too much, too soon kills confidence, causes frustration, disengagement & builds resistance. **It's HARMFUL.**

Watch Your Yardstick!

We can’t expect a car on blocks to perform like a Ferrari.
We can’t even get this car on the track until a lot of work is done.

So, why do we overload Ph. 1?

Our Go-To Old School Professional Judgement (NOT science): "Let's keep them so busy they won't have time to get in trouble."

Research: Phase requirements should be set by treatment professionals trained to:

- ✓ Assess individual participant needs
- ✓ Identify their proximal and distal goals
- ✓ **Sequencing goals** & monitoring progress
- ✓ Identify clinical in/stability.
- ➢ **THEY inform the team when participants have managed goals and are ready for phase-up**.
- ➢ **Goals are written, clear, objective & fair**
- ➢ **No team voting!**

Standards: Each Phase Has 4 or Less REASONABLE Proximal Goals

- Set 4 or fewer PROXIMAL goals for each phase based on what **this person should be able to do now or soon**.
- Each goal may require several small steps to achieve it.
- Once those goals are managed/ mastered– **phase up!**
- Set ***slightly*** more challenging goals in the next phase
- **We aren't alarmed or upset when participants are not able to achieve distal goals.**
- Our appropriate responses to behavior in each phase help them learn, grow, and engage.
  - **Where they are in the program (phase) and current skillset determines how we respond**

Building Your Phases

Phase 1: Acute Stabilization

“Getting Ready to Break Ground”

Standards' Suggested Phase 1 Goals: Phase-up occurs when these goals are managed by participant.

1. Crisis intervention—Stabilize, put out the fires causing acute distress or discomfort. (homeless, needs detox, medical care, food, transportation)

2. Orientation—a basic understanding of program policies, ~ a month of status hearings, counseling sessions, supervision sessions, and other services. Interact with all core team members and understands their roles

3. Comprehensive screening and assessment—use results to develop an evidence-based case plan in collaboration with the participant.

4. Create a collaborative, person-centered treatment plan—move forward, providing services that will help, building trust and alliance.

Putting the Phase 1 Plan into Action

Typically, brief (~ 30 to 60 days).

Goal: Positive and successful program entry. "We're here to help."

Abstinence: way distal & too soon! ASK Treatment!

Focus: Spot & reward the baby steps! Showing up is a "win" that we generously praise and reward with appropriate incentives.

➢ **Contacts in Ph. 1? Research:**

- No less than 1x/ two weeks for **court**. (Some Ph. 1 may require weekly)
- **Individual sessions** 1x/ week (in addition to group)
- **Testing:** 2x/ week min., 7 days/week, truly random
- **Home visits**? No research. 1x/ mo. Is recommended

WWYD: Change is Really Hard.

- Lucy (HR/HN, CSUD: meth) has been in Ph. 1 for **59 days**.
- Treatment reports that though she is **still experiencing intense cravings**, Lucy has **attended all but one treatment session** and is attentive and open.
- Though resistant at first, she understands what is expected of her and that the team is there to help her.
- Supervision reports in the past 30 days, she now is appearing on time for OVs, testing, and court despite a **rocky start**.
- Her **housing is stable**, no crises to address.
- She has discussed all the assessment results and is on board with the integrated treatment/supervision plan.
- Despite just producing her **3rd positive for meth in two weeks,** both say Lucy has settled in well.
- Lucy admitted use, saying, “I’m sorry. This is so hard for me. I’m trying. **I’m not sure I can do this**.”

Group Activity Time! Yay!!

- **Handouts:** Find Scenario #1: Lucy
- Work in small groups of 2-4
- Read scenario, DISCUSS & brainstorm.
- **Learning Objective: How can we help Lucy achieve Ph. 1 goals and prepare for Ph. 2?**
  - **What's going well? What's not?**
  - **How do we respond to her behavior:**
    - **Incentive, Sanction, Services? A combination?**

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What else is Lucy doing that we like?

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How Technological Options Can Help Achieve Ph. 1 Goals

1. Crisis intervention

2. Orientation

3. Comprehensive screening and assessment

4. Create a collaborative, person-centered treatment plan

Which of these is expected in Ph. 1?

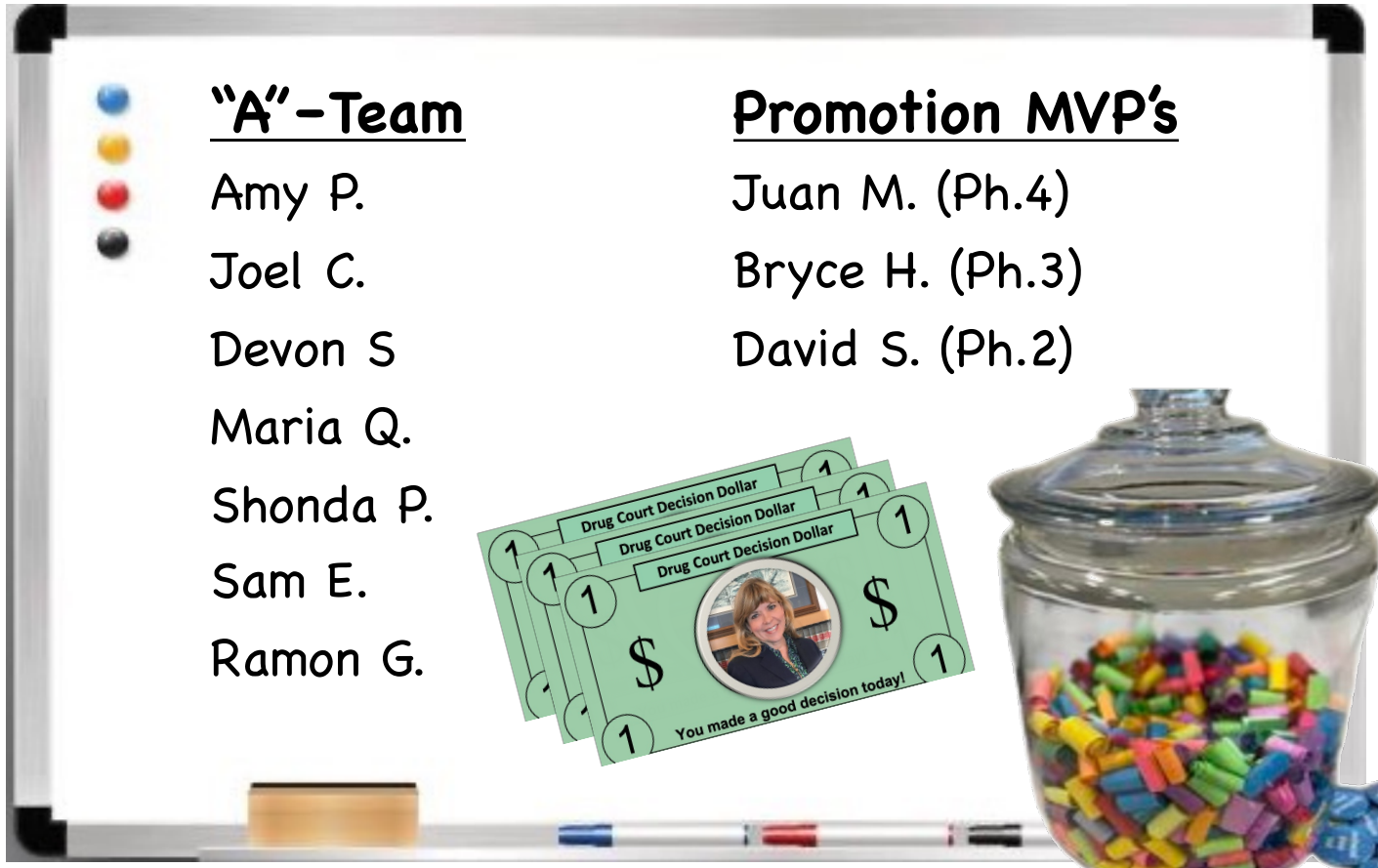
- Honesty?
- *Engagement* in treatment?
- Continuous pattern of abstinence/ neg tests?
- Stable, sober housing?
- Participation in criminal thinking classes, life skills?
- Prosocial activities?
- Employment, paying fines/fees, restorative justice?
- Choosing positive peers, attending peer recovery support meetings?
- Growing a recovery network, attaining a sponsor, mentor?
- Clinical stability: Symptoms resolved?

About Clinical Stability

No longer experiencing clinical symptoms of CSUD (withdrawal symptoms, cravings*, anhedonia, executive dysfunction, acute mental health symptoms like depression or anxiety) that interfere with their ability to attend sessions, benefit from interventions and avoid substance use.

- **90 days is assumed a MINIMUM threshold for clinical stability**, and some will take much longer (Do not tie this to time in program!)
- *Intermittent (as opposed to persistent, severe) cravings may continue even though the person has achieved clinical stability

Celebrating Phase Advancement is Essential



Why We Celebrate

- To **provide learning (to ALL**) that promotes engagement and motivates change
- **To remind ALL participants:**
  - ❑ **What was required** to complete the current phase
  - ❑ **What challenges and opportunities await** in the next phase.
  - ❑ **Their hard work paid off and they are getting better!**
- Celebrating phase advancement in group settings **reminds other participants** of how the program works and what they, too, can expect when they are successful. **Instills hope!**

Building Your Phases

Phase 2: Psychosocial Stabilization

“Pouring the Foundation”

Phase 2 Goals: Phase-up occurs when these goals are managed by participant:

1. Stable housing—living in safe, secure, and stable housing, and likely to continue in the foreseeable future.

2. Reliable attendance (~90%)—demonstrated the ability to attend services, court hearings, treatment & supervision sessions, and testing, regardless of the test results.

3. Therapeutic alliance—a collaborative working relationship with **at least one staff member** they're comfortable to share and ask for additional help/advice

4. Clinical stability—Treatment professionals are confident that the participant is **not experiencing debilitating symptoms that are likely to interfere with the person's ability to attend sessions or benefit from counseling interventions**.

Any big changes in Ph. 2?

~ 90 days to complete

Contacts: Same. Court no less than once every 2 weeks

Testing: still 2x/week, and service adjustments ***rather than sanctions*** for **substance use** until participants have achieved **early remission**, **which typically occurs by the end of the fourth phase.**

Abstinence goals: (still not a proximal goal), **brief periods of abstinence** (~several days or a few weeks)

Purpose: So clinicians can confirm that they are no longer experiencing withdrawal or cravings

Group Activity Time! Yay!!

- **Handouts:** Find Scenario #2: Joe
- Work in small groups of 2-4
- Read scenario, DISCUSS & brainstorm
- **Learning Objective: How can we help Joe achieve Ph. 2 goals and prepare for Ph. 3?**
  - **What's going well? What's not?**
  - **How do we respond to his behavior:**
    - **Incentive, Sanction, Services? A combination?**

WWYD: Joe Has Nowhere to Go

- Joe has been in Ph. 2 for **100 days.**
- He has a **great relationship with his counselor** and **never misses treatment**, though sometimes he's **unavoidably late** due to his chaotic living situation.
- Joe has been **couch-surfing** for the past year. Some of the places he's staying are not safe, and **none are drug-free**. Housing options for Joe are dismal.
- Despite this, Joe has been able to have periods of **abstinence up to 2-3 weeks at a time**, largely due to his use of MAT (**Suboxone)**, which has significantly helped him **manage his cravings**.
- Additionally, Joe has been **hanging out with the peer mentors** for Sober Basketball

WWYD: Is Joe ready for Phase 3?

1. Yes, though his housing is not ideal, he has met/exceeded other Phase 2 goals.
2. No, his housing situation must be resolved first.

Joe has not hit all target goals for Ph. 2 and is ready for Ph. 3

- ❑ Reliable attendance?
- ❑ Therapeutic alliance?
- ❑ Clinical stability?
- ☒ Stable housing?

Why are we concerned?

- ❑ Joe is not in a safe situation!
- ❑ Ph. 3 goals are demanding. A lot of new skills & behaviors to master!
- ❑ Ph. 3 contacts will be reduced
- ❑ How will we do home visits

How Technological Options Can Help Achieve Ph. 2 Goals

1. Stable housing

2. Reliable attendance (~90%)

3. Therapeutic alliance

4. Clinical stability

What we expect in Ph. 2: Psychosocial Stabilization

All of Phase 1 requirements, plus:

- Showing up is getting easier. Honesty, too.
- New goal: ***Participate*** in treatment
- Secure safe residence, supportive of recovery
- Address identified medical needs
- For most, at the end of Phase 2, begin self-help recovery activities (that they choose with treatment). **Explore!**
- Gradually increasing sobriety goals

What's NOT expected in Ph. 2?

- **Mostly the same as Phase 1**
- *Engagement* in treatment? Nope. **Participate!**
- Symptoms resolved, continuous pattern of abstinence/ neg tests? Nope!
- Participation in criminal thinking classes, life skills? (Ph. 3 & 4)
- Prosocial activities (Ph. 3 - 5)
- Choosing positive peers, attending peer recovery support meetings (Ph. 3 - 5)
- Growing a recovery network, attaining a sponsor, mentor (Ph. 3)
- Employment, paying fines/fees, restorative justice? (Ph. 4-5)

Building Your Phases

Phase 3: Prosocial Habilitation

“Framing Up”

Phase 3 Goals: Phase-up occurs when these goals are managed by participant:

1. Prosocial routine—Avoid negative peers. Seek daily interactions with prosocial persons & prosocial activities

2. Prosocial skills—Complete manualized CBT counseling curriculum focused on helping the person

3. Engage in treatment **--** Demonstrate use of treatment skills acquired from the curriculum.

4. Abstinence efforts—Apply efforts aimed at reducing substance use: Avoiding people/places where substance use is likely to occur

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What are some ways we increase prosocial behavior & promote recovery in this phase?

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How Technological Options Can Help Achieve Ph. 3 Goals

1. Prosocial Skills

2. Prosocial Routine

3. Abstinence Efforts

4. Engage in Treatment!

Big Service Changes in Ph. 3!

Typically, ~90-120 days. Contacts: Begin reducing court hearings (& other contacts) to **1x/ month Testing:** 2x/ week. Use service adjustments ***rather than sanctions*** for **substance use** until **early remission**, **which typically occurs by the end of the fourth phase.**

Abstinence goals: Varies. **Ask treatment.**

Lots of new programming goals!
Client is clinically stable. Now focus on using those skills, **increasing prosocial activities, and building recovery capital**!

Group Activity Time! Yay!!

- **Handouts:** Find Scenario #3: Jean
- Work in small groups of 2-4
- Read scenario, DISCUSS & brainstorm
- **Learning Objective: How can we help Jean achieve Ph. 3 goals and prepare for Ph. 4?**
  - **What's going well? What's not?**
  - **How do we respond to her behavior:**
    - **Incentive, Sanction, Services? A combination?**

WWYD: Jean

- Jean has been in **Ph. 3** for **135 days**.
- She has **65 consecutive days of abstinence** and is **very engaged in treatment**, often **coming early to help** set up.
- She **works part time** at a local quilting shop, mostly managing inventory in back.
- Suffering from **social anxiety**, she shuns traditional meetings, but has found a group of women in **recovery** who meet **online regularly**. She engages with this group no less than **3 times a week**.
- She also does a **YouTube yoga class** in her home. Jean is a homebody.

WWYD: Is Jean ready for Phase 4?

1. Yes, though her approach is nontraditional, she has met her Ph. 3 goals.
2. No, she needs to improve her social recovery capital with in-person support.

Has Jean hit all target goals for Ph.3 and is ready for Ph. 4

- ❑ Prosocial routine?
- ❑ Prosocial skills?
- ❑ Engaged in treatment?
- ❑ Abstinence efforts?

Why is Jean's way okay?

- ❑ Research: Online support can be just as impactful as in-person—even more so for some!
- ❑ Giving Jean agency increases the likelihood she will continue these activities post program

What we expect in Ph.3: Prosocial Habilitation Putting Skills into Practice!

All of Phase 1-2 requirements, plus:

- Maintain attendance at peer recovery groups **chosen by client**, with treatment's help
- Start building a recovery network (For some, find a sponsor/mentor)
- Start life skills classes, build healthy habits
- Begin criminal thinking program
- Engage in prosocial activity
- Greater sobriety efforts: 3-4 weeks at a time

➢ **<u>Mistakes will STILL occur.</u> Addiction is a chronic disease with a HIGH relapse rate.**

What's NOT expected in Ph. 3?

- Extensive, continuous pattern of abstinence/ neg tests? Nope!
- **Getting easier:** Choosing positive peers, attending peer recovery support meetings (Ph. 3 - 5)
- **Coming soon**: Employment, paying fines/fees, restorative justice (Ph. 4-5)
- Addressing life skills? Not yet (Ph. 4)

Many formerly distal behaviors are becoming proximal, but there is still a long way to go!

Progress, Not Perfection!

Building Your Phases

Phase 4: Adaptive Life Skills

“We’re Well Under Way”

Phase 4 Goals: Phase-up occurs when these goals are managed :

1. ***Life skills curriculum***—Complete a life skills curriculum focusing on preparatory skills needed for a long-term adaptive role *desired by the person*. (GED, employment, parenting, budgeting, time management)
2. ***Adaptive Role***—Engaged in an adaptive role (school, household, work) **For best outcomes: 90 days prior to discharge.**
3. ***Early Remission:*** **At least 90 days without clinical symptoms** (withdrawal, persistent substance cravings, anhedonia, cognitive impairment, acute mental health symptoms like depression/anxiety) **and abstinent ~ 90 days.**

How Technological Options Can Help Achieve Ph. 4 Goals

1. *Life skills curriculum*
2. *Adaptive Role*
3. *Early Remission*

Any big service changes in Ph. 4?

Typically, ~90-180 days.

Contacts: Still no less than monthly = better outcomes.

Testing: Reduce **only when treatment determines** participant is in **early remission**, typically by the end of Ph. 4

Programming? We are preparing to launch!

- ❑Client is clinically stable.
- ❑Now we will focus on life beyond the program and maintaining recovery capital!

Group Activity Time! Yay!!

- **Handouts:** Find Scenario #4: Toby
- Work in small groups of 2-4
- Read scenario, DISCUSS & brainstorm
- **Learning Objective: How can we help Toby achieve Ph. 4 goals and prepare for Ph. 5?**
  - **What's going well? What's not?**
  - **How do we respond to his behavior:**
    - **Incentive, Sanction, Services? A combination?**

1 Step Forward, 2 Steps Back

- Star client, Toby, achieved all the Ph. 4 goals and was approved to graduate.
- The night after graduation, Toby **bought beer and drank it alone**. It was his deceased mom's birthday.
- Though he knew it would be a tough day, he **did not reach out to his support system**.
- Called next morning and **told CM everything.**
- Treatment says this was a "slip". Toby is stable but **deeply fears he can't be successful without the court's support**.

WWYD: Toby's Slip

In addition to an appropriate sanction and/or service response, would you?

1. Have Toby restart Ph. 4
2. Let Toby proceed to Ph. 5, but keep a careful eye on him

What do we want to know about Toby?

- **Does "a slip" mean Toby is clinically unstable?**
- No all cravings rise to the level of clinical instability. Get clarity from treatment.
- **Did we miss something big?**
  - Grief counseling, trauma?
  - Assessing & growing recovery capital,
  - Relapse prevention, continuing care plan
  - Toby fears he can't be successful on his own after graduation!
- **How strong *<u>is</u>* his recovery capital?**
  - What do we know about his "support system"?

About Demotions… Don't!

Research: Requiring perfect or continuous abstinence is associated with demoralization, negative self-image.

- **Demotion/ forced restart** conveys "your hard work was wasted and easily undone by a mistake."
- **Best practice:** Talk to Toby. Does *he* want to restart the phase? Some do. We take our cues from treatment.
- We will keep Toby in the safety net of the program until he stabilizes.

➢What do we do in situations where **egregious** behavior occurs?

➢When do we terminate?

Best Practice for Late Phase Slips/Recurrence

Work together and determine the ”why”:

- If **clinically unstable**, provide **service adjustments & supports** to get the person back on track.
- **If infractions are willful (criminal thinking), use appropriate sanctions.**

Program completion should be delayed until the participant:

- **Reestablishes clinical stability for at least 90 days**
- **Achieves abstinence for approximately 90 days (without requiring perfection)**
- **Is reliably engaged in recovery management activities to sustain abstinence after discharge.**

What Part of the Brain Do You Use When Things Go Wrong?

- Our folks lie, manipulate, push our buttons, frustrate, disappoint, shock, anger, and scare us!
- The prefrontal cortex operates slowly and is **logical and precise**.
- The limbic system works fast and is dominated by **emotion and impulse**.

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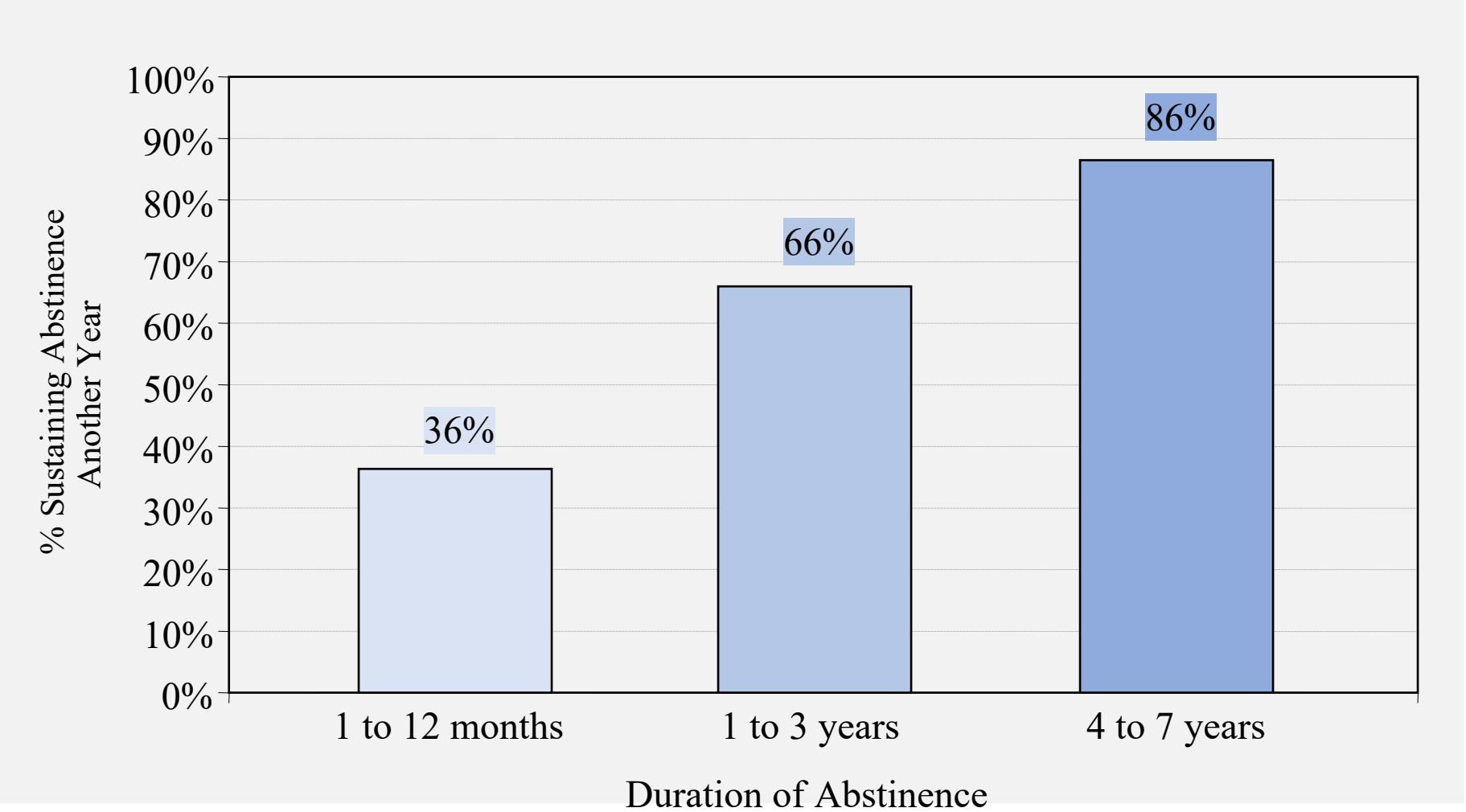
What we expect in Ph.4: Adaptive Habilitation

- Things that were DISTAL become proximal & managed!
- Address any ancillary needs: parenting classes, etc.
- Find employment, vocational training or school

What's NOT expected in Ph. 4 or 5? Perfection

- Mistakes & setbacks occur
- This is a chronic disease with a high rate of recurrence.
- Even with treatment, even with program completion, our folks are still in the earliest stages of recovery



Source: Dennis, Foss & Scott (2007)

Building Your Phases

Phase 5: Recovery Maintenance

“Move in & Maintain”

Phase 5 Goals: Completion occurs when these goals are managed by participant:

1. ***Recovery-management activities***—active peer support community, interacts regularly with those who offer relevant informed advice, empathy, support, and companionship.
2. ***Continuing-care or symptom-recurrence prevention plan***—regularly attending continuing-care services or has a workable prevention plan
3. ***Abstinence maintenance***—demonstrates the ability to sustain abstinence.
4. ***Restorative justice activity***—instructive community service, paying affordable fees or restitution, making amends.

What do we expect in Ph. 5? Recovery Management

<u>Typically</u>, ~90 days. As always, treatment's input is CRUCIAL

Before we tackle these goals, participants must be:

- ❑In **early remission** (~90 days)
- ❑**Practicing** prosocial skills
- ❑**Engaged** in an adaptive life role

How Technological Options Can Help Achieve Ph. 5 Goals

1. *Restorative justice activity*
2. *Recovery-management activities*
3. *Continuing-care or symptom-recurrence prevention plan*
4. *Abstinence maintenance*

Restorative Justice: Timing is Everything

Restorative justice activities produce significantly better outcomes in the criminal justice system:

- Performing instructive community service
- Paying off treatment fees or restitution
- Apology, Victim impact panels, etc.

- **Require these activities too soon**, before participants have the skills and resources needed to complete or benefit from the activities **is a waste of time and can cause resistance.**

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Ph.5: Recovery & Maintaining Connection

- Recall: Our folks are in the earliest stages of recovery with a 40-60% chance of recurrence.
- Don’t freak out. Help. Provide support & services.
- **Maintain connection:** the first 90 days are crucial.
- If they reoffend take them back again & again.

Always keep the doors open & provide access to recovery support services:

- ✓ Treatment boosters
- ✓ Alumni group
- ✓ Prosocial activities
- ✓ Peer support
- ✓ Community/ Court events

Questions

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Diane's Presentations

May 23rd :

9:30-10:45: *Effective Communication: Magic # Minutes*

2:00-3:15: *Gender Matters: Female Parti*cipants (with Hon. Denise Bradley)

3:30-4:45: *Avoiding Ethical Pitfalls* (with Hon. Denise Bradley))

- **May 24th :**

8:00-9:15: *Have You Done Everything to Avoid Termination?* (with Dr. Shannon Carey)

9:30-10:45: *2024 Incentives on a Dime!*