# Discovery, Dropout Prevention versus Recovery, Relapse Prevention: Doing Treatment and Change, not Doing Time

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# Models of Stages of Change

- 12-Step model - surrender versus comply; accept versus admit; identify versus compare

- Transtheoretical Model of Change - Pre-contemplation; Contemplation; Preparation; Action; Maintenance; Relapse and Recycling; Termination

- Readiness to Change - not ready, unsure, ready, trying, doing what works

# A Word About Terminology
## *Treatment Compliance vs Adherence*

Webster's Dictionary defines:

- "comply": to act in accordance with another's wishes, or with rules and regulations

- "adhere": to cling, cleave (to be steadfast, hold fast), stick fast

# Changing the Concept of Resistance

- In the Glossary on page 412: "Resistance – A term previously used in Motivational Interviewing, now deconstructed into its components: sustain talk and discord."

- Notice "previously used" means: "Resistance" as a term and concept will no longer be used as in previous editions- "Rolling with Resistance"; "Responding to Resistance"

# Concept of Resistance (cont.)

Here's a quote from page 197: "*…our discomfort with the concept of resistance has continued to grow, particularly because it seems to place the locus and responsibility for the phenomenon within the client. It is as though one were blaming the client for "being difficult." Even if it is not seen as intentional, but rather as arising from unconscious defenses, the concept of resistance nevertheless focuses on client pathology, under-emphasizing interpersonal determinants.*"

# Concept of Resistance (cont.)

DELETE “resistance”

Focus on “sustain talk” and “discord”

# What is Sustain Talk?

- It is "the client's own motivations and verbalizations favoring status quo." (p. 197). Person not interested in changing anything; I am OK with keeping things way they are – status quo, sustain what I have already got or where I already am.

- "There is nothing inherently pathological or oppositional about sustain talk. It is simply one side of the ambivalence. Listen to an ambivalent person and you are likely to hear both change talk and sustain talk intermingled." (p. 197). "Well maybe I have a drug problem and should do something about it if I don't want to be arrested again." (Change talk). "But it really isn't as bad as they say, they're just overacting." (Sustain talk).

# What is Discord?

## RESISTANCE minus SUSTAIN TALK = DISCORD

(disagreement, not being "on the same wavelength," talking at cross-purposes, or a disturbance in the relationship. (p. 197).

- "You can experience discord, for example, when a client is arguing with you, interrupting you, ignoring, or discounting you." (p. 197).

# What is Sustain Talk versus Discord?

- "Sustain talk is about the target behavior or change" – drinking or drugging, over-eating, gambling etc.

- "Discord is about you or more precisely about your relationship with the client – signals of discord in your working alliance." – Are you on same page as your client? Are you more interested in abstinence and recovery than they are? Are you doing more work than them about going to AA or taking medication?

# Engage the Client as Participant

## Treatment Contract

What?
Why?
How?
Where?
When?

# Identifying the Assessment and Treatment Contract

| | Client | Clinical Assessment | Treatment Plan |
|---|---|---|---|
| WHAT? | What does client want? | What does client need? | What is the treatment contract? |
| WHY? | Why now? What's the level of commitment? | Why? What reasons are revealed by the assessment date? | Is it linked to what client wants? |
| HOW? | How will s/he get there? | How will you get him/her to accept the plan? | Does client buy into the link? |
| WHERE? | Where will s/he do this? | Where is the appropriate setting for treatment? What is indicated by the placement criteria? | Referral to level of care |
| WHEN? | When will this happen? How quickly? How badly does s/he want it? | When? How soon? What are realistic expectations? What are milestones in the process? | What is the degree of urgency? What is the process? What are the expectations of the referral? |

# Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Marijuana Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he hasn't used anything. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack, which Carl says he is holding for a friend.

# Carl (cont.)

1. What does Carl want that will drive engagement, collaborative treatment planning and treatment adherence?

2. How would you word one Problem Statement in Carl's treatment plan that would make sense to him?

# Discovery, Dropout Prevention vs Recovery, Relapse Prevention

| Discovery, Dropout Prevention | Recovery, Relapse Prevention |
| --- | --- |
| ■ List three reasons the court sent you to treatment.<br>■ Identify what happens if you don't comply with probation requirements and report to group.<br>■ List the positive and negative aspects of substance use.<br>■ Attend at least one AA meeting and see if you can identify with anyone's story.<br>■ Verbalize anything that would make you want to quit treatment earlier than recommended.<br>■ Discuss what would help you stay in treatment and not give up and dropout. | ■ For the next incident of rage and anger, fill in the date, trigger, physiological signs and your behavior; and then discuss how you could deescalate the rage.<br>■ Share in group what has been working to prevent relapse and get more suggestions.<br>■ Explore early childhood history of violence through individual therapy once per week. Focus on what kind of role models the client had. |

# Discovery, Dropout Prevention vs Recovery, Relapse Prevention (cont.)

| Discovery, Dropout Prevention | Recovery, Relapse Prevention |
|---|---|
| ■ Gather the data and evidence to prove you don't have an addiction, parenting or anger problem<br><br>■ Role play an angry situation with a fellow client in group and show everyone how good your anger management skills are.<br><br>■ Ask for a difficult parenting situation and demonstrate to the group how to handle that in a non-violent, calm way using your parenting skills that you believe to be very good. | ■ Write down the most recent incidents involving alcohol and other drugs; and what you can learn from those.<br><br>■ Find someone at an AA meeting who has the kind of life you want and see if they will be your sponsor.<br><br>■ Practice progressive relaxation to know how to deal with anxiety and cravings to use and delay any impulsive behavior.<br><br>■ Explain what attitudes, thoughts and behaviors you do that threaten the public safety.<br><br>■ Say which of those you are trying to change. |

# Revised Constructs for Dimension 5

A. Historical Pattern of Use or Mental Health Problems
   1. Chronicity of Problem Use or MH problems
   2. Treatment or Change Response

B. Pharmacologic Responsivity
   3. Positive Reinforcement (pleasure, euphoria)
   4. Negative Reinforcement (withdrawal discomfort, fear)

(*The ASAM Criteria*, 2013, pp..403 - 407)

# Revised Constructs for Dim. 5 (cont.)

C. External Stimuli Responsivity
   5. Reactivity to Acute Cues (trigger objects and situations)
   6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses
   7. Locus of control and Self-efficacy

# Revised Constructs for Dim. 5 (cont.)

D. Cognitive and behavioral measures of strengths and weaknesses (cont.)

8. Coping Skills (stimulus control, other cognitive strategies)
9. Impulsivity (risk-taking, thrill-seeking)
10. Passive and passive/aggressive behavior

# Recovery and Psychosocial Crises

- Slips/using substances while in treatment
- Suicidal – impulsive or wanting to use
- Loss or death – cravings or impulsive
- Disagreements, anger, frustration with fellow clients or therapist

(*The ASAM Criteria*, 2013, pp.407 - 409)

# Policy and Procedure

Implements principle of re-assessment and modification of treatment plan:

1. Face to face or telephone appointment ASAP.

2. Attitude of acceptance; listen for patient's point of view, rather than lecture, enforce "program rules"; or dismiss their perspective.

3. Assess safety and immediate needs in all six ASAM assessment dimensions.

(*The ASAM Criteria*, 2013, pp.407 - 409)

# ASAM Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

*The ASAM Criteria* (2013) Pages 43-53

# Policy and Procedure (cont.)

4. Discuss circumstances surrounding the crisis, develop a sequence of events/precipitants.

5. Modify participatory treatment plan to address new or updated problems.

6. Reassess treatment contract and what patient wants if any lack of interest in modifying Tx. Plan.

7. Determine if modified strategies need same level of care; or more or less intense level.

(*The ASAM Criteria*, 2013, pp.407 - 409)

# Policy and Procedure (cont.)

8. If patient recognizes the problem/s; understands need to change, but still chooses no further treatment, then discharge.

9. If patient is invested in treatment, then Tx. continues.

10. Document crisis and modified treatment plan or discharge in the medical record.

(*The ASAM Criteria*, 2013, pp.407 - 409)

# What to Do with Poor Outcomes - ACCEPT

**A** ssess – what is working and *not* working

**C** hange treatment plan to improve outcomes

**C** heck treatment contract if reluctant to modify the Tx. plan

**E** xpect effort in a positive direction –"do treatment" not "do time"

**P** olicies that permit mistakes and honesty; not zero tolerance

**T** rack outcomes in real time – functional change (attitudes, thoughts, behaviors) not compliance

# ACCEPT – Applied to Lying and Dishonesty

| Treatment Provider | Treatment Court Team |
|---|---|
| **ASSESS**<br>▪ Why did you lie? What was going on that you chose to lie rather than be honest?<br>▪ Do you and I understand how lying is an indication that something has gone wrong in the therapeutic alliance?<br>▪ When has lying and lack of integrity manifested itself in your life before and how has it gotten you into more trouble?<br>▪ Do you even see dishonesty as an issue you need to work on? If so, why; and if not, why?<br>▪ What can we do to make it easier for you to be honest and open?<br>▪ What are you fears or obstacles if you were to be honest? | **ASSESS**<br>▪ Collaborate with the treatment provider (in the Pre-court meeting) to assess if the participant is working in good faith treatment or not.<br>▪ Does the treatment provider recommend a sanction for a participant who is not taking treatment seriously and is just "doing time"?<br>▪ Does the treatment provider recommend that the judge admonish the participant (sanction) that lying is not acceptable, but then praise them (incentive) for the new treatment plan s/he has embraced to work on lying. |

# ACCEPT – Applied to Lying and Dishonesty (cont.)

| Treatment Provider | Treatment Court Team |
|---|---|
| **CHANGE**<br>▪ What are you going to do in your treatment plan to address dishonesty?<br>▪ How could you use individual or group sessions to work on a tendency to lie and con?<br>▪ Change goals or strategies in the treatment plan in a positive direction e.g., practice being totally honest for one day in treatment and see what feels good or bad about that and report back to group; e.g., when someone asks "How are you?" practice pausing and answer honestly rather than a quick automatic "Fine".<br>▪ Changing the treatment plan about lying is a learning opportunity to be embraced and expected of the participant. | **CHANGE**<br>▪ The judge gives a clear message to the participant that lying is not acceptable in a court of law nor in treatment if it is to be effective.<br>▪ However the judge also engages in a dialogue with the participant to determine if they are clear on the expectation and can articulate what s/he is working on in an updated treatment plan to address lying.<br>▪ If the participant is not changing the treatment plan in a positive direction and working on lying as a treatment priority, then escalated sanctions will be forthcoming. |

# ACCEPT – Applied to Lying and Dishonesty (cont.)

| Treatment Provider | Treatment Court Team |
|---|---|
| **CHANGE**<br>▪ What are you going to do in your treatment plan to address dishonesty?<br>▪ How could you use individual or group sessions to work on a tendency to lie and con?<br>▪ Change goals or strategies in the treatment plan in a positive direction e.g, practice being totally honest for one day in treatment and see what feels good or bad about that and report back to group; e.g., when someone asks "How are you?" practice pausing and answer honestly rather than a quick automatic "Fine".<br>▪ Changing the treatment plan about lying is a learning opportunity to be embraced and expected of the participant. | **CHANGE**<br>▪ Treatment providers, probation/parole and other court team members should work together and share any information on the participant's functioning in the community e.g., continued active association with justice-involved people or people who are known substance-users. Such behaviors inform needed changes in the treatment plan.<br>▪ All treatment court team members reaffirm the message delivered by the judge (lying is not acceptable in a court of law nor in treatment if it is to be effective) as appropriate and during their on-going, day-to-day interaction with the participant. |

# ACCEPT – Applied to Lying and Dishonesty (cont.)

| Treatment Provider | Treatment Court Team |
|---|---|
| **CHECK**<br>▪ If you are doing more work than the client e.g., putting more energy in urging the client to be honest than they are; chasing the client to be sure they follow through with treatment plans while they watch you passively, as they just go through the motions.<br>▪ The participant should be as active in figuring out changes in the treatment plan as you are.<br>▪ If they are not, then check whether they are really committed to do treatment or not. | **CHECK**<br>▪ The treatment court team checks that the participant is actively working in treatment not passively complying with court mandates.<br>▪ The participant should be active in figuring out changes in the treatment plan to address lying; and be able to explain to the judge and probation or parole officer what they are doing to prevent or decrease lying and dishonesty. |

# ACCEPT – Applied to Lying and Dishonesty (cont.)

| Treatment Provider | Treatment Court Team |
|---|---|
| **EXPECT**<br>▪ Continued treatment after lying or conning is dependent on whether the participant is changing their treatment plan in a positive direction and putting in a good faith effort.<br><br>▪ If, after using Motivational Interviewing and Motivational enhancement treatment, the participant continues passive involvement in treatment, that is "doing time" not "doing treatment and change". An escalated sanction is then recommended to the Court team. | **EXPECT**<br>▪ A judge could ask a participant:<br>**"To what extent have you assessed with your treatment provider what went wrong that you ended up lying?"**<br><br>▪ "What are you working on in your treatment plan to address lying?"<br><br>▪ If the participant is unable to answer such questions, check whether the treatment provider has done an adequate assessment and changed the treatment plan to address lying. Is it a treatment provider's lack of skill? Or is the client not working in good faith? |

# ACCEPT – Applied to Lying and Dishonesty (cont.)

| Treatment Provider | Treatment Court Team |
|---|---|
| **POLICIES**<br>▪ Examine policies that inadvertently encourage dishonesty that disincentivizes participants to be open and honest with mistakes, substance urges and actual use; and pushes illicit use by themselves and others underground.<br><br>▪ Fellow participants are then more focused on "snitching" and antisocial, criminogenic behavior to scam the system than on learning how to be honest and confronting others when they see lying. | **POLICIES**<br>▪ Examine policies that inadvertently encourage dishonesty that disincentivizes participants to be open and honest with mistakes, substance urges and actual use; and pushes illicit use by themselves and others underground.<br><br>▪ Examine how the judge and probation/parole address lying. Do they reinforce the need for the participant to take responsibility and work on this in treatment? Or just impose an immediate sanction? |

# THANK-YOU

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