Discovery, Dropout Prevention versus Recovery, Relapse Prevention: Doing Treatment and Change, not Doing Time (ACCEPT)

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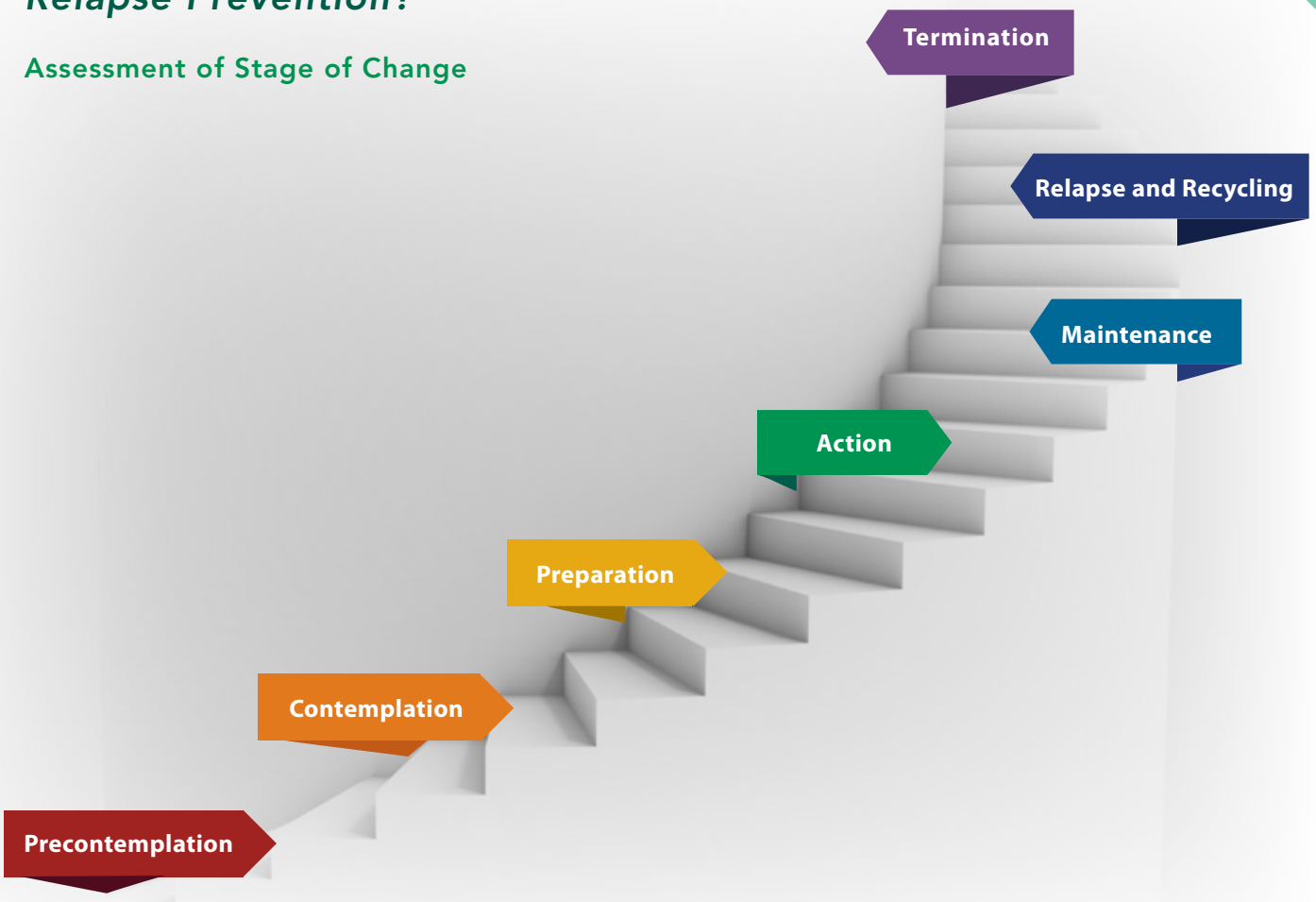
Who Needs Discovery, Dropout Prevention, versus Recovery, Relapse Prevention?

Assessment of Stage of Change



Definitions of Compliance and Adherence

Webster's Dictionary defines **comply**: to act in accordance with another's wishes, or with rules and regulations. It defines **adhere**: to cling, cleave (to be steadfast, hold fast), stick fast.

Changing the Concept of Resistance

Miller, W.R., & Rollnick, S. (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY. Guilford Press.

In the Glossary, 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 (e.g., "Rolling with Resistance," "Responding to Resistance").

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."

So if you start deleting "resistance" from your clinical vocabulary and focus on "sustain talk" and "discord," you are now in a better position to attract a person into recovery than responding to them as a resistant, non-compliant person in denial.

What is sustain talk?

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

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

What is discord?

- "If we subtract sustain talk from what we previously called resistance, what is left? The remainder… more resembles disagreement, not being "on the same wavelength," talking at cross-purposes or a disturbance in the relationship. This phenomenon we decided to call discord" (p. 197).
- "You can experience discord, for example, when a client is arguing with you, interrupting you, ignoring or discounting you" (p. 197).

Discord is about you – or more precisely about your relationship with the client, signals of discord in your working alliance.

Are you on the same page as your client?
Are you more interested in abstinence and recovery than they are?
Are you doing more work?

Developing the Treatment Contract

(The ASAM Criteria 2013, page 58)

	Client	Clinical Assessment	Treatment Plan
WHAT	What does client want?	What does client need?	What is the Tx contract?
WHY	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what the client wants?
HOW	How will s/he get there?	How will you get him/her to accept the plan?	Does the 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 Cannabis Use Disorders, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms. But then, he really doesn't think he has a problem. 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 18 months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he was not using 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 18 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 said he is holding for a friend.

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	Recovery, Relapse Prevention
List three reasons the court sent you to treatment.	For the next incident of rage and anger, fill in the date, trigger, physiological signs and your behavior. Then discuss how you could deescalate the rage.
Identify what happens if you don't comply with probation requirements and report to group.	Share in group what has been working to prevent relapse and get more suggestions.
List the positive and negative aspects of substance use.	Explore early childhood history of violence through individual therapy once per week. Focus on what kind of role models you had.
Attend at least one AA meeting and see if you can identify with anyone's story.	Write down the most recent incidents involving alcohol and other drugs, and what you can learn from those.
Verbalize anything that would make you want to quit treatment earlier than recommended.	Find someone at an AA meeting who has the kind of life you want, and see if they will be your sponsor.
Discuss what would help you stay in treatment and not drop out.	Practice progressive relaxation to deal with anxiety and cravings to use, delaying any impulsive behavior.
Gather the evidence to prove you don't have an addiction, parenting or anger problem	Explain what attitudes, thoughts and behaviors you have that threaten the public safety.
Role play an angry situation with a fellow client in group and show everyone how good your anger management skills are.	Express which of those (above) you are trying to change.
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.	Get the names and numbers of ten people in long-term recovery who you can call at any time to socialize with or get help when necessary.

Relapse/Continued Use/Continued Problem Potential - Dimension 5

(The ASAM Criteria 2013, pp 401-410)

Historical Pattern of Use

1 **Chronicity of Problem Use**
Since when and how long has the individual had problem use or dependence and at what level of severity?

2 **Treatment or Change Response**
Has s/he managed brief or extended abstinence or reduction in the past?

Pharmacologic Responsivity

3 **Positive Reinforcement (pleasure, euphoria)**

4 **Negative Reinforcement (withdrawal discomfort, fear)**

External Stimuli Responsivity

5 **Reactivity to Acute Cues (trigger objects and situations)**

6 **Reactivity to Chronic Stress (positive and negative stressors)**

Cognitive and behavioral measures of strengths and weaknesses

7 **Locus of Control and Self-efficacy**
Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?

8 **Coping Skills (including stimulus control, other cognitive strategies)**

9 **Impulsivity (risk-taking, thrill-seeking)**

10 **Passive and passive-aggressive behavior**
Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and psychosocial crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

- Slip, using alcohol or other drugs while in treatment
- Suicidal, feeling impulsive or wanting to use alcohol or other drugs
- Loss or death, disrupting the person's recovery and precipitating cravings to use/impulsive behavior
- Disagreements, anger, frustration with fellow patients or therapist

The following procedures provide steps to help implement the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.

2. Convey an attitude of acceptance. Listen and seek to understand the patient's point of view rather than lecture, enforce "program rules" or dismiss the patient's perspective.

3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

   - **Acute intoxication and/or withdrawal potential**
   - **Biomedical conditions and complications**
   - **Emotional/behavioral/cognitive conditions and complications**
   - **Readiness to change**
   - **Relapse/continued use/continued problem potential**
   - **Recovery environment**

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to it. If the crisis is a slip, use the six dimensions as a guide to assess causes. If the crisis appears to be willful, defiant non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan and reasons they did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. If there appears to be a lack of interest in developing a modified treatment plan in step 5 above, reassess the treatment contract and what the patient wants out of treatment. If it becomes clear that the patient is mandated and "doing time" rather than "doing treatment and change," explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care – or a more or less intensive level of care in the continuum of services, or different services such as co-occurring disorder enhanced services. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem and understands the need to change the treatment plan to deal with newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve treatment in a positive direction. Such a patient may also demonstrate lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not an overwhelming Dimension 5 issue to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute reoccurrence of signs and symptoms breaks continuity of care at precisely the crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on their breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change the treatment plan. Concerns about "triggering" others in the group are handled no

differently from if a patient was sharing trauma issues and sobbing, and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills. In addition, it jeopardizes the safety of the patient at the very time they need more support and guidance rather than rejection, discharge or transfer.

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

What to Do With Poor Outcomes as Applied to Lying and Dishonesty

(https://tipsntopics.com/may-2019/)

First, an overview of ACCEPT:

A ssess what is and is not working in the treatment plan

C hange the treatment plan to address identified problems or priorities

C heck the treatment contract if the participant is reluctant to modify the treatment 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 with a program

ACCEPT as applied to lying and dishonesty:

Treatment Provider	Treatment Court Team
ASSESS	
• Why did you lie? What was going on that you chose to lie rather than be honest? • Do you and I understand how lying is an indication that something has gone wrong in the therapeutic alliance? • When has lying and lack of integrity manifested itself in your life before, and how has it gotten you into more trouble? • Do you see dishonesty as an issue you need to work on? If so, why? And if not, why? • What can we do to make it easier for you to be honest and open? • What are you fears or obstacles if you were to be honest?	• Collaborate with the treatment provider (in the pre-court meeting) to assess if the participant is working in good faith treatment or not. • Does the treatment provider recommend a sanction for a participant who is not taking treatment seriously and is just "doing time"? • 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 they have embraced to work on lying?
CHANGE	
• What are you going to do in your treatment plan to address dishonesty? • How could you use individual or group sessions to work on a tendency to lie and con? • Change goals or strategies in the treatment plan in a positive direction. For example, practice being totally honest for one day in treatment and see what feels good or bad about that. Then report back to group. Or, when someone asks, "How are you?" practice pausing and answering honestly rather giving than a quick and automatic, "Fine." • Changing the treatment plan to address lying is a learning opportunity to be embraced and expected of the participant.	• 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. • However, the judge also engages in dialogue with the participant to determine if they are clear on the expectation and can articulate what they are working on in an updated treatment plan to address lying. • 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. • 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. • 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 during their ongoing, day-to-day interaction with the participant.

Treatment Provider	Treatment Court Team
CHECK	
• Check if you are doing more work than the client (e.g., chasing the client to be sure they follow through with treatment plans), while they watch you passively and just go through the motions. • The participant should be as active in figuring out changes in the treatment plan as you are. • If they are not, then check whether they are really committed to do treatment or not.	• The treatment court team checks that the participant is actively working in treatment, not passively complying with court mandates. • The participant should be active in figuring out changes in the treatment plan to address lying. They should be able to explain to the judge and probation or parole officer what they are doing to prevent or decrease lying and dishonesty.
EXPECT	
• 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. • 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.	• A judge could ask a participant, ***"To what extent have you assessed with your treatment provider what went wrong that you ended up lying?"*** • *Or, "What are you working on in your treatment plan to address lying?"* • 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?
POLICIES	
• Examine policies that inadvertently encourage dishonesty and disincentivize participants to be open and honest with mistakes, substance urges and actual use. This pushes illicit use. • If this is the case, fellow participants may be more focused on "snitching" and antisocial, criminogenic behavior to scam the system than learning how to be honest and confront others when they see lying.	• Examine policies that inadvertently encourage dishonesty and disincentivize participants to be open and honest with mistakes, substance urges and actual use. This pushes illicit use. • 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, do they just impose an immediate sanction?

Treatment Provider	Treatment Court Team
TRACK	
• Track whether participants are actually working on attitudes, thoughts and behaviors that have contributed to lying and dishonesty. • Track whether outcomes are improving. Is there is less lying or successful full honesty? • If participants aren't able to explain what attitudes, thoughts and behaviors they are working on to avoid further lying, then they are not doing treatment in good faith.	• Track whether participants are making progress on lying and improving their active participation in good faith effort. • Collaborate in the interdisciplinary team of judge, attorneys, probation/parole, treatment providers and law enforcement to gather all data on level of function in the community. • Is the participant improving in attitudes, thoughts and behaviors that threaten public safety and lying not at all or less frequently?

References and Resources

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Notes:

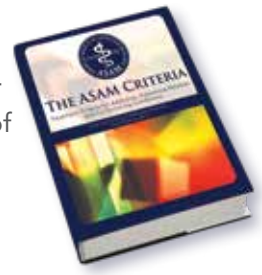
ASAM eLearning Modules

The ASAM eLearning modules introduce *The ASAM Criteria* and provides opportunities to practice multidimensional assessment, service planning and level of care placement.

Module 1: Multidimensional Assessment
Module 2: From Assessment to Service Planning and Level of Care
Module 3: Introduction to *The ASAM Criteria*
www.changecompanies.net/etraining/

The ASAM Criteria

The ASAM Criteria, Third Edition, is the most comprehensive set of guidelines for assessment, service planning, placement, continued stay and transfer/discharge of individuals with addiction and co-occurring conditions.
www.changecompanies.net/asam



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