Doing Time or Doing Treatment and Change

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A. Understanding How People Change and How to Facilitate Change

1. Natural Change and Self-Change

(DiClemente CC (2006): "Natural Change and the Troublesome Use of Substances – A Life-Course Perspective" in "Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It" Ed. William R Miller and Kathleen M. Carroll. Guildford Press, New York, NY. pp 91; 95.)

The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But "treatment is an adjunct to self-change rather than the other way around." "The perspective that takes natural change seriously…shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change." (DiClemente, 2006)

2. What Works in Treatment - The Empirical Evidence

- Extra-therapeutic and/or Client Factors (87%)
- Treatment (13%):
- 60% due to "Alliance" (8%/13%)
- 30% due to "Allegiance" Factors (4%/13%)
- 8% due to model and technique (1%/13%)

(Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.
Miller, S.D., Mee-Lee, D., & Plum, B. (2005). Making Treatment Count. In J. Lebow (ed.). *Handbook of Clinical Family Therapy. New York: Wiley).*

3. Three aspects of the Therapeutic Alliance (Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY. Guilford Press.p. 39):

(a)

(b)

(c)

4. Stages of Change

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

* Transtheoretical Model of Change (Prochaska and DiClemente):

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of a possible "problem" and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a "problem" or needs to change; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong discord and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to specific steps to be taken to solve the problem in Action stage; increasing confidence in the decision to change; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission.

* Readiness to Change - not ready, unsure, ready, trying, (doing what works) (Miller and Rollnick)

B. **Engaging the Participant in Collaborative Care**

1. Developing the Treatment Contract and Focus of Treatment

	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 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?

2. Doing Time or Doing Change – the Importance of Collaboration

The mandated client can often present as hostile and resistant because they are at "action" for staying out of jail; getting people off their back; getting housing or a job; or getting their children back. In working with mandating agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Unfortunately, clinicians/programs often blur the boundaries between "doing time" and "doing treatment".

For everyone involved with mandated clients, the 3 C's are:

- Consequences – It is within justice services, problem solving courts and dependency and neglect systems' mission to ensure that participants take the consequences of their illegal or abusive behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the person, family or youth and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

- Compliance – The participant is required to act in accordance with the court, or mandating agency's orders; rules and regulations. From a justice or mandating agency's perspective court personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

- Control –Mandating agencies and courts aim to control, if not eliminate, illegal or abusive behavior that threaten the public, children, youth and families. While control is appropriate for the courts, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated and to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of courts or mandating agencies to carry out mandates determined for reasons other than clinical.

Thus, working together and engaging the identified client into treatment involves all of the principles/concepts to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care. The issues are:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create and provide incentives and supports for change
- Communication and conflict resolution - committed to common goals of public safety; safety for children and families; responsibility, accountability, decreased legal recidivism and lasting change; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

C. **The Power of Language and Terminology**

1. From Pathology to Participant

- Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician
- "Resistance" may be as much a problem with knowledge, skills and attitudes of clinicians as it is a "patient" problem

As a first step to moving from pathology to participant, consider our attitudes and values about resistance. It is often perceived as pathology that resides within the client, rather than an interactive process or even a phenomenon induced and produced by the clinician.

2. Changing the Concept of Resistance

- In the Glossary (Miller & Rollnick, 2013. 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".

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."*

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 – 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"?

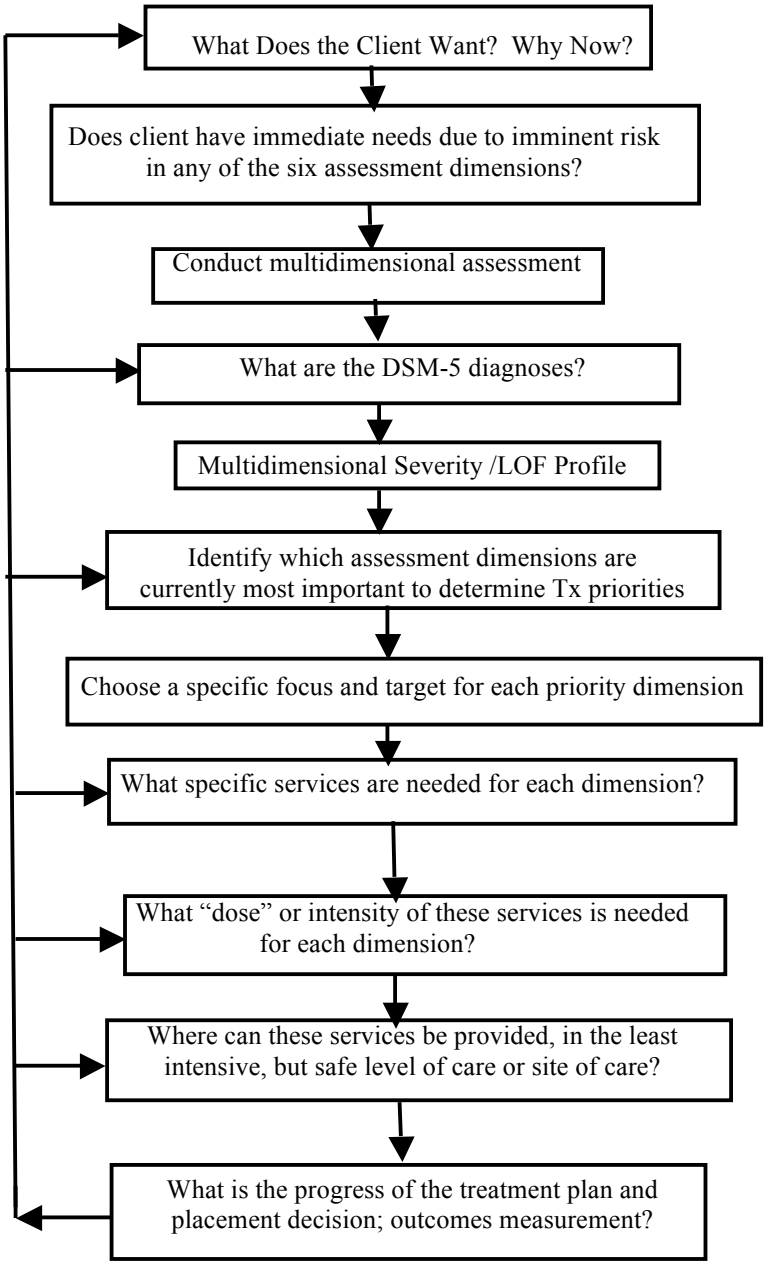
- "If we subtract sustain talk from what we previously called resistance, what is left? The remainder …more resembles disagreement, not being "on the same wavelength," talking at cross-purposes, or a disturbance in the relationship. This phenomenon we decided to call discord." (p. 197).
- "You can experience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

"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 the 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?

3. Compliance versus Adherence

Treatment or medication *compliance* is a term that has had long use in the health care field in general and the addiction and mental health sectors in particular. Webster's Dictionary defines "to comply" as "to act in accordance with another's wishes, or with rules and regulations." By contrast, it defines "adhere" as "to cling, cleave (to be steadfast, hold fast), to stick fast."

D. How to Organize Assessment Data to Focus Treatment



(The ASAM Criteria 2013, p 124

E. What Court and other Mandating Agencies Should Expect from Treatment Providers

Participants mandated to treatment are varied and can present with addiction, mental health and physical health complexity. These diverse clinical presentations highlight the need for individualized approaches that treatment providers should be pursuing with the client:

1. Assessment of each client's multidimensional needs as per The ASAM Criteria six dimensions. So assessing if a person is developmentally disabled and suffers from an intellectual developmental disorder (previously called Mental Retardation) is important compared with a person who has antisocial personality disorder or lifestyle and is very institutionalized and used to incarceration. The intellectually developmental disordered person has deficits in reasoning, problem solving, abstract thinking, judgment, learning from instruction and experience etc. The institutionalized antisocial person experiences sanctions like water on a duck's back.

2. Assessment and methods to enhance treatment engagement and good faith effort of the client in treatment. Participants with co-occurring mental and addiction issues will have more difficulty with engagement and have needs that require awareness of their multiple vulnerabilities. Treatment plans need to be assessment-based and person-centered not program and compliance based. Because of different client learning styles and their array of needs, any manualized and evidence-based curriculum may require adaptation to fit each client's problems and progress/outcomes.

This calls for a level of clinical sophistication to use Evidence-Based Practices (EBPs) in a person-centered and outcomes driven manner rather than a compliance and one-size-fits-all manner. Interactive Journaling is an evidence-based method to facilitate self-change using Motivational Interviewing, stages of change work and CBT. The Change Companies has a Drug Court journal that can be used along with other journals designed for criminal justice populations used by Federal Bureau of Prisons and many others.

3. Outcomes-driven treatment. Is the client making progress in real accountable change? Are they demonstrating improved functioning that will increase public safety, decrease legal recidivism and increase safety for children and families? Active credible treatment is not just about compliance with attendance and negative drug screens. Is the client invested in a change process at a pace that fits their assessed abilities and vulnerabilities? Or is the client merely passively complying, which does not translate into lasting change and increased safety? How do we impact the revolving door of repeated episodes of treatment and incarceration, or child protective services involvement, which wastes resources and does not produce the outcomes we all want?

F. **Moving from Punishment to Accountability for Lasting Change – Implications for Sanctions and Incentives**

(Tips and Topics, Volume 12, No. 6, September 2014. www.changecompanies.net; click on Blogs; click on Tips and Topics and go to the Archives on left hand side.)

1. Sanction for lack of good faith effort and adherence in treatment based on the clinical assessment of the person's needs, strengths, skills and resources. Don't sanction for signs and symptoms of their addiction and/or mental illness in a formulaic manner that is one-size-fits-all.

2. The treatment provider is responsible for careful assessment and person-centered services and to keep the court apprised of any risk to public safety. The court should be informed about the client's level of good faith effort in treatment; and whether the client is improving in function at a pace consistent with their assessed needs, strengths, skills and resources. The provider should not just report on passive compliance with attendance and production of positive or negative drug screens - passive compliance is not functional change.

3. If the client is not changing their treatment plan in a positive direction when outcomes are poor e.g., positive drug screens, attendance problems, passive participation, no change in peer group activities and support groups like AA etc., then the client is "doing time" not "doing treatment and change." Providers need to then inform the judge that the client is out of compliance with the court order to do treatment. The client consented to do treatment not just do time and should be held accountable for their individualized treatment plan. If the client is substantively modifying their treatment plan in a positive direction in response to poor outcomes; and adhering to the new direction in the treatment plan, then the client should continue in treatment and not be sanctioned for signs and symptoms of their illness(es).

4. Incentives for clients can be explored and matched to what is most meaningful to them. For example, incentives that allow a client to choose a gift certificate or coupon for a restaurant may be meaningful for

some clients. But others may find assistance in seeing their children; or receiving help with housing; or advocacy to change group attendance times to fit better their work schedule to be more meaningful incentives to be used. This requires an individualized approach recommended to the court by providers who should know their client's needs, skills, strengths and resources. It is too much to expect the judge can work all this out in a busy schedule of court appearances.

5. A close working relationship between the client, judge, court team and treatment providers is needed to actualize this approach.

These ideas come from my clinical bias and experience, but they are offered with awareness:

- That we need more discussion to make this work in the world of courts and criminal justice.
- That to achieve the public safety outcomes we all want, we have to move treatment from a passive compliance and a 'jumping through the hoops' mentality that allows many clients to "do time" in treatment instead of "doing treatment and change".
- That treatment providers will need to rise to the occasion and improve assessment and person-centered treatment planning that values outcomes-driven services.
- That judges and court personnel can expect treatment providers to design and deliver individualized care; and to keep them well-informed on any threats to public safety. Reports need to be on functional improvement not just compliance with attendance and drug screens.

LITERATURE REFERENCES AND RESOURCES

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