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## Engaging People Into Collaborative Treatment

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### A. Understanding Motivation and Resistance

#### 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.

### B. 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)

#### 1. What Works in Treatment - The Empirical Evidence

(a) Extra-therapeutic and/or Client Factors (87%)

(b) 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).

## 2. Definitions of Compliance and Adherence

Webster's Dictionary defines "**comply**" as follows: 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.

### C. Assessing Readiness to Change

#### 1. Models of 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 and 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; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance 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 the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; 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 in readiness to change.
  - 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; comprehensive, multidimensional assessment to explore all reasons for relapse.
  - 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 through maintenance strategies.
- \* Readiness to Change - not ready, unsure, ready, trying, (doing what works): Motivational interviewing (Miller and Rollnick)

## 2. The Spirit of Motivational Interviewing

(Miller, William R; Rollnick, Stephen: “Motivational Interviewing - Preparing People for Change” Second Edition, New York, NY., Guilford Press, 2002. p.35)

Fundamental approach of motivational interviewing	Mirror-image opposite approach to counseling
<p><b>Collaboration.</b> Counseling involves a partnership that honors the client’s expertise and perspectives. The counselor provides an atmosphere that is conducive rather than coercive to change.</p> <p><b>Evocation.</b> The resources and motivation for change are presumed to reside within the client. Intrinsic motivation for change is enhanced by drawing on the client’s own perceptions, goals, and values.</p> <p><b>Autonomy.</b> The counselor affirms the client’s right and capacity for self-direction and facilitates informed choice.</p>	<p><b>Confrontation.</b> Counseling involves over-riding the client’s impaired perspectives by imposing awareness and acceptance of “reality” that the client cannot see or will not admit.</p> <p><b>Education.</b> The client is presumed to lack key knowledge, insight, and/or skills that are necessary for change to occur. The counselor seeks to address these deficits by providing the requisite enlightenment.</p> <p><b>Authority.</b> The counselor tells the client what he or she must do.</p>

### D. Engaging the Patient as Participant

	<u>Client</u>	<u>Clinical Assessment</u>	<u>Treatment Plan</u>
<u>What?</u>	What does pt. want?	What does client need?	What is the Tx contract?
<u>Why?</u>	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
<u>How?</u>	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
<u>Where?</u>	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
<u>When?</u>	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. The Coerced Client and Working with Referral Sources

The mandated client can often present as hostile and resistant because they are at “action” for staying out of jail; keeping their driver’s license; saving their job or marriage; or getting their children back. In working with referral 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.

Criminal justice professionals such as judges, probation and parole officers untrained in addiction and mental health run the risk of thinking that mental health and addiction issues can be addressed from a criminal justice model. They can see mandated treatment for addiction and mental health problems as a criminal justice intervention e.g., mandate the client to a particular level of care of addiction treatment for a fixed length of stay as if ordering an offender to jail for a jail term of three months.

Unfortunately, clinicians and programs often enable such criminal justice thinking by blurring the boundaries between “doing time” and “doing treatment”. Clinicians say that they cannot provide individualized treatment since they have to comply with court orders for a particular program and level of care and length of stay. For everyone involved with mandated clients and think this way, the 3 C’s are important:

### 3 C’s

- **Consequences** – It is within criminal justice’s mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender 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 offender is required to act in accordance with the court’s orders; rules and regulations. Criminal justice 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** –The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. 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 rather than feeling disempowered 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 the law or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles and concepts above 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 now at this point in time. The issues span the following:

- 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 incentives for change and provide supports to allow change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize “No one succeeds unless we all succeed!”

### Carl

Carl is a 15 y.o. young man who you suspect meets DSM criteria for Alcohol Abuse and Marijuana Abuse, 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 denies use. 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 claims he is holding for a friend.

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