
What to Do When Participants Aren't Really Participating

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A. 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; 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.

Clinicians/programs can enable criminal justice and mandating agencies’ thinking by blurring the boundaries between “doing time” and “doing treatment”. For everyone involved with mandated clients, the 3 C’s are:

- ⤴ **Consequences** – It is within mandating agencies and criminal justice’s mission to ensure that participants take the consequences of their illegal or unsafe behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the participant 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’s orders; rules and regulations. Mandating agencies and 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** –Mandating agencies and the criminal justice system aim to control, if not eliminate, illegal acts that threaten the public or safety to children and families. While control is appropriate for the courts and child protective services, 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 child protective services 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/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; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize “No one succeeds unless we all succeed!”

B. Compliance vs Adherence – The Role of Treatment

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

(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).

C. What is Addiction?

Addiction is a brain disease and biopsychosocial-spiritual in nature.

(a) American Society of Addiction Medicine (ASAM) definition of addiction

There is a "short version" definition of addiction (shown below), as well as a "long version" definition (available at <http://www.asam.org/for-the-public/definition-of-addiction>).

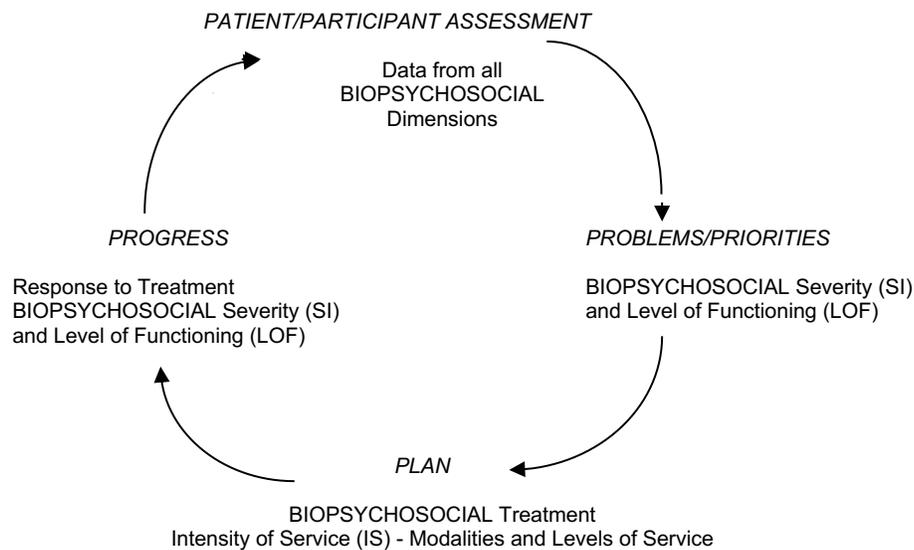
- Short Definition begins: "Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry." (August 15, 2011)
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- Pathologically pursuing reward and/or relief by substance use and other behaviors.

(b) Biopsychosocial in etiology, expression and treatment

D. Multidimensional Assessment & Individualized Treatment(*The ASAM Criteria* 2013, pp 43-53)

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in 5 levels of care & preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage use motivational enhancement strategies. If ready for recovery, expand action for change.
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention plans. If still at early stages of change, focus on "discovering" consequences of continued use or problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

1. Individualized, Clinically-driven Treatment



2. What to Do with Poor Outcomes - ACCEPT

Assess what is and is not working

Change treatment plan to improve outcomes

Check treatment contract if participant reluctant to modify the treatment plan

Expect effort in a positive direction – “do treatment” not “do time”

Policies that permit mistakes and honesty; not zero tolerance

Track outcomes in real time – functional change (attitudes, thoughts, behaviors) not compliance

3. Assess Substance Use and Flare-ups to Fix What Went Wrong

Relapse/Continued Use/Continued Problem Potential - Dimension 5 (*The ASAM Criteria* 2013, pp 401-410)

A. 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 he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity

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

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
 - 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 Substance Use in Treatment

(The ASAM Criteria 2013, pp 407-409)

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:

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

The following procedures provide steps to assist in implementing 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.
 1. Acute intoxication and/or withdrawal potential
 2. Biomedical conditions and complications
 3. Emotional/behavioral/cognitive conditions and complications
 4. Readiness to Change
 5. Relapse/Continued Use/Continued Problem potential
 6. Recovery environment
4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-compliance 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 s/he 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. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. 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/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her 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 overwhelming Dimension 5 issues 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 a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her 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 his/her treatment plan.

Concerns about “triggering” others in the group are handled no differently from if a patient was sharing trauma issues, 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.

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

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

(Tips and Topics, Volume 12, No. 6, September 2014. Tipsntopics.com)

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, all stakeholders and treatment providers is needed to actualize this approach.

Some judges are rightly concerned that treatment providers are not watching for public safety concerns closely enough so take treatment into their own hands. This can result in sanctions or mandates that are not assessment based e.g., mandating 90 days of residential level of care; or 90 AA meetings in 90 days; or ordering sanctions that may be ineffective in producing improved treatment engagement and real client functional change.

REFERENCES & RESOURCES

“A Technical Assistance Guide For Drug Court Judges on Drug Court Treatment Services” - Bureau of Justice Assistance Drug Court Technical Assistance Project. American University, School of Public Affairs, Justice Programs Office. Lead Authors: Jeffrey N. Kushner, MHRA, State Drug Court Coordinator, Montana Supreme Court; Roger H. Peters, Ph.D., University of South Florida; Caroline S. Cooper BJA Drug Court Technical Assistance Project. School of Public Affairs, American University. May 1, 2014.

Bureau of Justice Assistance (BJA) training video on The ASAM Criteria that can be viewed by creating an account and going to the Adult Drug Court Lessons. The system can be found at www.treatmentcourts.org and this video was initiated by Dennis Reilly at the Center for Court innovation.

Critical Treatment Issues Webinar Series, Bureau of Justice (BJA) Drug Court Technical Assistance Project at American University Feb. 10, 2016 – May 3, 2016
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