Discharge, Suspend or Sanction? Improving Skills and Systems to Deal with Relapse, Continued Use and Continued Problems

David Mee-Lee, M.D. Davis, CA
(530) 753-4300; Mobile (916) 715-5856
davidmeelee@gmail.com davidmeelee.com tipsntopics.com

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A. 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

B. Definitions of Terms

Addiction Treatment	Mental Health Treatment
Slip or Lapse – A single incident of substance use that may or may not result in a relapse, depending on how the client (and practitioner) responds. A slip can be viewed productively as a mistake and an opportunity for further learning. (NIDA, 1993)	Lapse – Recurrence of a symptom of a disorder (Evans and Sullivan, 1990). Infrequent symptoms without significant interference in functioning
Slides – Slips and lapses that may be heading towards a full-blown relapse. Slides provide an opportunity to prevent treatment dropout and arrest further regression into relapse.	Lapsing – Continuing symptoms intermittently that may be heading towards a full-blown relapse. Lapsing provides and opportunity to prevent treatment dropout and stabilize further regression in to relapse
Continued Use – A person who has not committed to recovery may continue to use as they work through ambivalence and either try to control substance use or decide on abstinence.	Continued Problems – A person who has not committed to treatment may continue to have emotional, behavior or cognitive problems as they work through their ambivalence
Relapse – An unfolding process in which the resumption of substance use is the last event in a long series of maladaptive responses to internal or external stressors or stimuli. (NIDA, 1993). A full-blown relapse is not necessarily accompanied by the full resumption of a drug abuse lifestyle, but may result in a client's seeking renewed treatment. For this reason, relapse must be further distinguished from a client's total regression back to drugs. Some view "dry drunk" as a recovering person's wanting total abstinence and sobriety, but still having cravings and attitudes that they consider to be still in relapse. Another definition is "any violation of a self-imposed rule regarding a particular behavior". (Marlatt, 1995)	Relapse – (1) to exhibit again the symptoms of a disease from which a patient appears to have recovered; (2) recurrence of a disease after apparent recovery ("Mosby's Pocket Dictionary of Medicine, Nursing and Allied Health", Second Edition, 1994). • Responding to lapses with old solutions likely to result in a return to pretreatment status (Evans and Sullivan, 1990)

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

1. 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)

2. Stages of Change

* Transtheoretical Model of Change (Prochaska and DiClemente):

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; not actively interested in change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of possible "problem" & 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 being satisfied with the status quo; 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 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.

D. **Dimension 5 - Relapse/Continued Use/Continued Problem Potential**

(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 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:

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 the person's recovery and precipitating cravings to use or 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-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 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. 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 he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

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

E. **When people are not skilled at getting their needs met, don't call them names**

"Manipulative", attention-seeking" flow easily from the tongue. But reframing the person's behavior as unskilled attempts to get their needs met, you can be empathic and help them develop more effective ways to get their needs.

(a) "Manipulative"

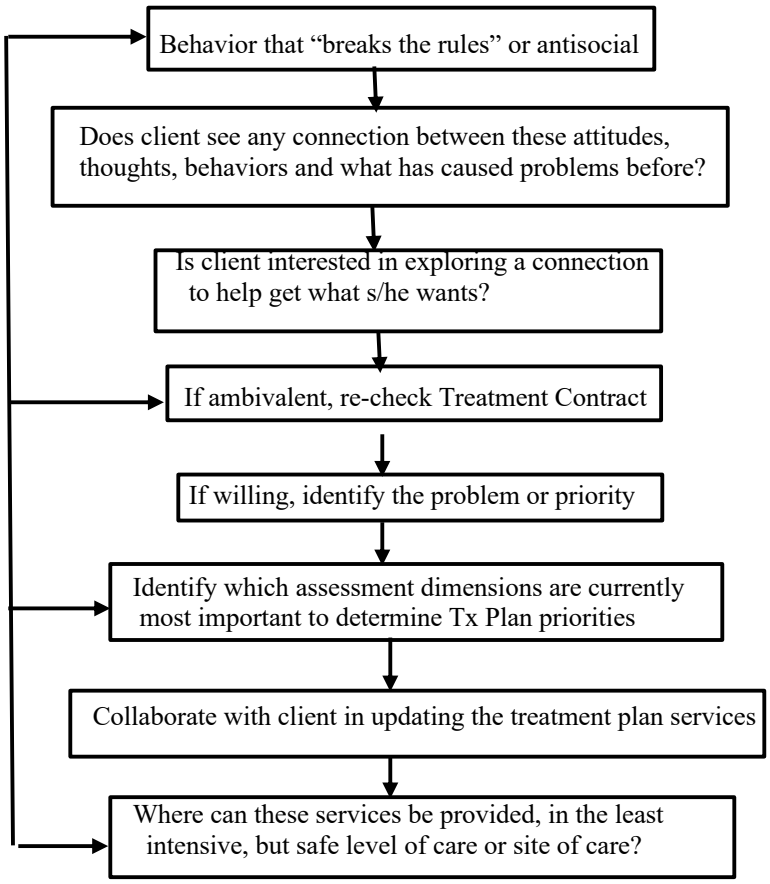
- If you are skilled at asking for what you want and persuading people to meet your needs and collaborate and cooperate with you, we call you "assertive", or an effective leader", or "a person of influence". But if you are not skillful in asking for what you want; try to get what you want from one person and then if that doesn't work, attempt to get someone else to meet your need, we call you "manipulative" especially if you go about it in an annoying persistent manner.

(b) "Attention seeking"

* We all have the need for attention to some extent. Nobody wakes up every day and says to themselves: "I hope no-one notices I am around, ignores me and treats me as if I am a nobody." So if you are skilled at getting noticed, respected and do that in ways that contribute positively to others' lives, we call you a "celebrity" or "movie or rock star" or "politician" or "trainer and consultant"!

* If you are not skilled at getting noticed and regarded and go about seeking that in annoying, intrusive ways, then now you are "attention seeking". Such people are crying out to be respected and taken seriously, but need skills training on how to get those needs met effectively, instead of calling them names and rejecting them.

F. **Behavior Control or Treatment Plan Change**



G. **What to Say to Orient Participants**

"Thank-you for choosing to enter join Drug Court. The reason you have been given the opportunity to get treatment rather than be incarcerated is that you have addiction that is related to your charges. We believe that if you get addiction treatment and establish recovery, this will not only be good for your life, but society will benefit from increased public safety, decreased crime and spending resources on treatment rather than incarceration, which is much more expensive.

But you are accountable for doing treatment, not time; for working on changing your attitudes, thinking and behavior; not just complying with a program and graduating."

H. **What to Say to Check on Progress**

"Tell me about your treatment plan." (Pause to see what the participant says and monitor if they are working on anything in particular to improve functioning for public safety; or whether they are just "doing time" e.g., "I just have to be here and have another three months.")

"What you are working on to change your attitudes, thinking or behavior that has gotten you into trouble with crime, restricted your freedom and threatened public safety?"

I. What to Say to Track Treatment Engagement

"What would you like to do in this session or in group today to advance your treatment plan?" (Pause to see what the participant says and monitor if they are working on anything in particular to improve functioning for public safety; or whether they are just "doing time" e.g., "I just have to be here" Or "What do you want me to say?") What you would hope they would say is: "I don't have an anger problem, but I am trying to get off probation so I'm going to ask someone to role play with me an angry situation. Others would get into a fist-fight but not me. I have good anger management skills and am going to demonstrate to the group how to handle that in assertive but nonviolent way. You will note that down and let my PO know that I am doing well."

J. What to Say to about Positive Drug Screens

"In addiction treatment, it's not OK to use any unauthorized substance. But if this didn't happen and everyone had perfect control over using, they wouldn't have addiction and wouldn't need treatment. You can learn skills and use supports to never have to use again, so it is not inevitable that you will have a flare up and use.

But if it happens to you or anyone else in treatment with you, it is your responsibility for your safety and your fellow participants to immediately address any attitudes, thinking or behavior building up to any use substance use; or any actual use. Reach out to a team member just like you would if experiencing a heart attack. They will then work with you to find out what went wrong and how to improve your treatment plan to prevent another flare-up.

If substance use happens in a residential setting there will be a community meeting ASAP to help anyone who used with you. If you or anyone else is not interested in finding what went wrong and how to fix it, then anyone has the right to choose no further treatment and take the legal consequences of their criminal offense."

K. What *not* to say to about Positive Drug Screens

"In addiction treatment, it's not OK to use any unauthorized substance. You are mandated to be abstinent and if you use and it is found on a drug screen, you will be sanctioned and could be set back a phase in your treatment program. If it happens more than once, you could be incarcerated for a brief period and it may even be grounds for discharge from the drug court program.

In order to advance through the phases of the Drug Court program and eventually graduate, you must demonstrate full abstinence. If you do not, there are escalating sanctions, but there are also incentives for those who do stay abstinent."

"Now be honest, did you use or not?!!"

L. What to Say in Individual, Group, or an Emergency Community Meeting

"Please share what happened that led up to and triggered the substance use so we can figure out what went wrong and help you get back on track. If others used with you, please identify them so we can do the same process with them ASAP.

If you are willing to change your treatment plan and work on fixing the mistakes with commitment and effort in good faith, then treatment continues. If you are not interested in doing that, you have a right to choose no further treatment and be discharged from the program."

M. What to Say to a Person who says they don't want to go to Alcoholics Anonymous

It is not unusual for a client to object to having to attend AA or other such groups. Here is how to address such clients:

"There are AA meetings and groups that appeal to different members in different ways. If you haven't tried a number of different groups, it may be that just haven't yet found the meeting that works for you.

Now if you are saying you just don't want to go to AA for whatever reason, I don't want to push that on you. Maybe you have another self/mutual help group that works better for you. But before you give up on AA, let's discuss where else can you find a support group where:

1. You can have access to regular meetings every day and even more than once a day if you really need them – and all for free?
2. You can have a coach like an AA sponsor, who is ready to have you call them at all hours of the day and week if you really need them?
3. You can be with a whole group of people and have sober fun while there are temptations and triggers all around you on New Year's Eve, Mardi Gras, or St. Patrick's Day?
4. You can have many friends who have been exactly where you have been with addiction; understand what you are going through from deep personal experience; and will be there for you if you reach out?

Maybe you have a group like that at your church, synagogue, community of faith, or some other group. If you get support from that group with all the same effective features of what AA has to offer, then by all means embrace that group. This is about getting you the ongoing support and guidance you need to establish and maintain recovery and well being, not pushing AA on you."

N. **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.

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