What to Do When Participants Aren't Really Participating

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Plenary: May 8, 2019 – 1 PM – 2:30 PM Wisconsin Dells, WI
2019 WATCP State Conference – Kalahari Resort and Conference Center

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).*

3. Definitions of Compliance and Adherence

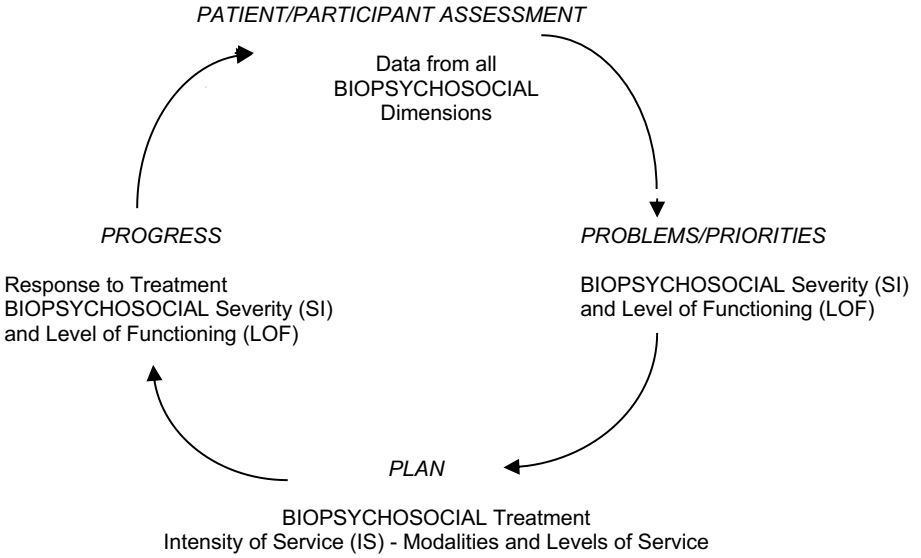
Webster's Dictionary defines "**comply**" as follows: to act in accordance with another's wishes, or with rules and regulations. It defines "**adhere**": to cling, cleave (to be steadfast, hold fast), stick fast.

C. **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?

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

1. Individualized, Clinically-driven Treatment



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

3. Biopsychosocial Treatment - Overview: 5 M's

* Motivate - Dimension 4 issues; engagement and alliance building
* Manage - the family, significant others, work/school, legal
* Medication – withdrawal management; HIV/AIDS; anti-craving anti-addiction meds MAT; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
* Meetings - AA, NA, Al-Anon; SMART Recovery, Dual Recovery Anonymous, etc.
* Monitor - continuity of care; relapse prevention; family and significant others

4. Treatment Levels of Service *(The ASAM Criteria* 2013, pp 106-107)

0.5 Early Intervention
1 Outpatient Services
2 Intensive Outpatient/Partial Hospitalization Services
3 Residential/Inpatient Services
4 Medically-Managed Intensive Inpatient Services

E. **What to Do with Poor Outcomes – ACCEPT** © David Mee-Lee 2019

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

F. **Case Discussions**

- 25 yo man in Drug Court with four drug-related charges and Methamphetamine and Cannabis Use Disorders in the first month of the Intensive Outpatient Program.
- Says he won't use marijuana while in the program, but when he graduates he will likely smoke marijuana again as he sees nothing wrong with marijuana and has a medical marijuana card anyway for chronic pain.
- Attends all prescribed activities and groups, but sits passively with little active input.

How do you manage this?

1. Give him more time to get used to the program and to come around to get engaged in treatment.
2. Increase drug testing to ensure he is not smoking marijuana.
3. Thank him for being in treatment, but explore with him what is most important to him that made him decide to join the Drug Court Program.

Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorder, 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 says he has not been using any drugs. 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 says he is holding for a friend.

Angela, a 28 y/o, pregnant (1st trimester), mother of 2 and is being referred to drug treatment by Child Welfare and Probation.

The referral states Angela was arrested for driving under the influence while her children were in the car (2 y/o, 4 y/o). Angela's children were unrestrained, unkept, and not clothed appropriately for the cold weather. When Angela was pulled over, she was arrested due to a previous warrant and the children were immediately removed and placed in foster care. Angela's toxicology screen at the time of her arrest was positive for alcohol and methamphetamine. Angela spent 30 days in jail and is reporting abstinence since her release 4 days ago.

Child Welfare reports that the client has a history of psychiatric hospitalizations and does not want to take her Bipolar medications because of the pregnancy. Prior to her arrest, she and her children were homeless for 2 months.

During your intake, Angela reports feeling that substances are not an issue for her and she does not need a drug treatment program. Client states, "I was clean in jail and since getting out I have not used."

Questions:

1. What does Angela want that will drive the assessment and treatment process?

2. To assess severity in each of the 6 ASAM Criteria assessment dimensions, what clinical information for each dimension do you need, if missing in this vignette? Indicate which dimension has missing information and specify what more information you want.

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
https://www.youtube.com/watch?v=AuUEP52z1Xk

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Mee-Lee, David with Jennifer E. Harrison (2010): "Tips and Topics: Opening the Toolbox for Transforming Services and Systems". The Change Companies, Carson City, NV

Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Third Edition. Carson City, NV: The Change Companies.
To buy: changecompanies.net

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