Skill Building in Engagement and Alliance: Changing Compliance into Collaboration

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A. Review of Motivational Interviewing (MI) and Stages of Change

1. Understanding Motivation and Resistance - 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. 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)

3. 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)*.

4. 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.

5. **<u>Working with Ambivalence</u>**

- Ambivalence is a normal and common component of many psychological problems and a central phenomenon in addictive behaviors
- The elements of a conflict for any one client are unique. You should not assume that you already know the costs and benefits in a particular client's situation, or the relative importance that the client assigns to these factors
- Discovering and understanding these motivations is an important part of individual assessment
- How an officer or counselor responds to ambivalence is crucial. Ambivalence is not wholly rational. In focusing on motivational ambivalence, it is important to remain attuned to the client's feelings, values, and beliefs
- Working through ambivalence is only part of the process. Motivational interviewing promotes the client's readiness to change and to strengthen motivation to proceed with change on their own

6. **<u>Client-Therapist Relationship</u>** - Solution-Focused Therapy (Berg):

- <u>Visitor-type relationship</u>: patients see their involvement in treatment as voluntary with therapeutic tasks, goals, and solutions being imposed on them against their wishes; labeled and behave as if they are "unmotivated" or "resistant"; the "real problem: is "having to come" to treatment.
- <u>Complainant-type relationship</u>: this relationship involves persons who have goals for others, but not for themselves; parents, spouse, employer or probation officer etc., present another person's substance use as a problem to the complainant; these persons often labeled "co-dependent", "caretaker" and "unhealthy".
- <u>Customer-type relationship</u>: patients express a treatment goal that is related to themselves and demonstrate many ways in which they are ready to change their behaviors of their own volition; for most addiction patients, this is not the usual presentation and very few have "hit bottom", nor should be expected to for treatment eligibility.

7. **<u>Principles of Motivational Interviewing (MI)</u>** - Miller and Rollnick:

- Motivational Interviewing is a particular way to help people recognize and do something about their present or potential problems
- It is particularly useful with people who are reluctant to change and are ambivalent about changing
- Some are able to move onto change once unstuck. For others, MI is only a prelude to treatment which creates an openness to change, which paves the way for further therapeutic work
- In MI, the counselor does not assume an authoritarian role. Responsibility for change is left with the individual
- Strategies of MI are more persuasive than coercive, more supportive than argumentative. The counselor seeks to create a positive atmosphere that is conducive to change
- When such an environment is created, it is the client who presents the arguments for change, rather than the therapist

*   **Express empathy** - "accurate empathy" (Carl Rogers) and acceptance.

*   **Develop discrepancy** - between present behavior and goals of what the patient wants.

*   **Avoid argumentation** - avoid head-to head confrontations. (This principle has been folded into the next principle in Second Edition "Motivational Interviewing - Preparing People for Change, 2002)

*   **Roll with resistance** - "psychological judo" (Jay Haley); patient as a valuable resource in finding solutions; perceptions can be shifted.

*   **Support self-efficacy** - client is responsible for choosing and carrying out personal change; belief in the possibility of change is powerful motivator.

8. **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
Collaboration. 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.	*Confrontation*. 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.
Evocation. 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.	*Education*. The client is presumed to lack key knowledge, insight, and/or skills that are necessary for change to occur. The counselor seeks to address theses deficits by providing the requisite enlightenment.
Autonomy. The counselor affirms the client's right and capacity for self-direction and facilitates informed choice.	*Authority*. The counselor tells the client what he or she must do.

B. **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.

<u>Maintenance</u>: 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._

<u>Relapse and Recycling</u>: 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.

<u>Termination</u>: 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.

*   <u>Readiness to Change</u> - not ready, unsure, ready, trying, (doing what works): Motivational interviewing (Miller and Rollnick)

C. <u>**Skill-Building in Collaborative Care - Developing the Treatment Contract**</u>

	<u>Client</u>	<u>Clinical Assessment</u>	<u>Treatment Plan</u>
<u>What?</u>	What does client 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?

1. <u>Development of the alliance is the highest priority in the opening phases of therapy</u>
In the last thirty years there have been over 2,000 research publications and papers on the concept of the alliance. Here are some of the conclusions about developing the alliance that can help in your therapeutic practice with clients:

- **Develop a strong alliance early in treatment** – "Early" is relative to the length of therapy. But there is a convergence of evidence that points to sessions 3 to 5 as a critical window. In some ways this is not surprising if you have ever gone to therapy yourself. Would you likely go back to a therapist who you didn't feel was helping; and whose methods and fit with your style seemed ineffective? Would you really be interested in hanging in for five or more sessions? Of course if you have excellent retention rates, then you can ignore this point as you must be doing this well already.

- **The client's experience of being understood, supported, and provided with a sense of hope is linked with the strength of the alliance in early stages of therapy** – clinicians need to be curious about the client's perception of what you are doing to generate empathy, support and hope. The client's interpretation of what you do, especially early on in treatment, can be quite different from what you intended. Message sent may not be the same as message received. Just because you think you are great at engaging people doesn't mean that the client experiences it that way at this point in time with you. In other words, you may be a great clinician, but not necessarily for this particular individual at this time, doing the kind of work you do, which leads to the next conclusion.

- **Progressively negotiate the quality of the relationship as an important and urgent challenge** – You can anticipate that your initial assessment of the client's relational capacities, style, preferences and quality of the alliance may differ from the client's. It is the *client's* perception of the alliance that is most influential, not yours. If they feel no hope or confidence in what you have to offer, they are the ones who stop coming to treatment either physically and/or energetically (if mandated or incarcerated). Thus it is important to specifically check out their perceptions on whether the relationship in treatment is working for them or not.

- **Techniques and models contribute less to outcome in early stages of treatment than the quality of the alliance** - The alliance should be forged first. This includes a collaborative agreement about the goals of treatment and the important strategies to be used as part of the therapeutic work. Only then can various models and techniques be usefully implemented

The bottom line: Developing a good working alliance with the client is not just a nebulous, generic nice thing to work on over weeks and months. It is a specific, early, clinical priority to evaluate and measure.

<u>**Reference**</u>:
"Psychotherapy Relationships That Work – Therapist Contributions and Responsiveness to Patients" (2002) Ed. John C. Norcross. Oxford University Press, New York. pp 11-14.

Horvath AO, Bedi RP (2002): "The Alliance" in "Psychotherapy Relationships That Work – Therapist Contributions and Responsiveness to Patients" (2002) Ed. John C. Norcross. Oxford University Press, New York. pp 37-69.

2. Change Talk and Resistance

(Miller and Rollnick (2002)"Motivational Interviewing – Preparing People for Change" 2nd Edition. Pp 46 - 51)

(a) Resistance

*   Client behaviors occur in the context of and are influenced by interpersonal interaction
*   Client resistance behavior is a signal of dissonance (different agendas, different aspirations) in the counseling relationship (p.46, Miller and Rollnick (2002)"Motivational Interviewing – Preparing People for Change" Second Edition.)
*   Client resistance is a meaningful signal – it predicts that the person will not likely follow through
*   Research demonstrates that client resistance behavior is under the experimental control of the counselor – it can be increased or decreased, depending on how the counselor responds to it
*   Resistance represents and predicts movement *away* from change

(b) Change Talk

*   "Change talk" is opposite to resistance behavior just as consonance is opposite to dissonance
*   Change talk is what has been referred to as" self-motivational statements"
*   Four categories of change talk: **disadvantages of the status quo; advantages of change;; intention to change; optimism for change**
*   Change talk reflects movement of the person *toward* change

Change talk	**Resistance**
Disadvantages of status quo	Advantages of status quo
Advantages of change	Disadvantages of change
Intention to change	Intention not to change
Optimism about change	Optimism about change

D. **Building Motivation for Change**

1. Opening strategies and traps that increase resistance

(a) The Question-Answer Trap
*   In tone, the "expert" counselor controls the session by asking questions, while the client merely responds with appropriate short answers
*   Negative aspects: it teaches the client to give short, simple answers, rather than the kind of elaboration you will need for MI; it implies an interaction between an active expert and a passive patient – if you ask enough questions, then you will have the answer; it affords little opportunity for the client to explore and offer self-motivational statements
*   A subtler form of this trap is to ask open-ended questions without reflective listening of the answer. The use of several open-ended questions consecutively can have a similar effect to that of a series of closed-ended questions. A general rule is to avoid asking three questions in a row.

(b) The Confrontation-Denial Trap
- This is the most important and common trap to avoid
- Therapists fall into it through their own good intentions and through a faulty understanding of motivational processes
- The counselor detects some information indicating the presence of a "problem" e.g., alcoholism and begins to tell the client that he/she has a serious problem, and prescribes a certain course of action.
- The client expresses some reluctance about this and responds usually along two lines: "My problem really isn't that bad", and "I don't really need to change that much."
- Because most people enter treatment ambivalent, they feel two ways about their situation. If the counselor argues for one side of the ambivalence, the client will give voice to the other side.
- By taking responsibility for the "problem-change" side of the conflict, the therapist elicits oppositional "no-problem" arguments from the client

(c) The Expert Trap
- The enthusiastic counselor can unwittingly fall into this trap by conveying the impression of having all the answers
- This can edge the client into a passive role and inhibits the client's opportunity to explore and resolve ambivalence for themselves
- There is a time for expert advice, but first build the client's motivation for change

(d) The Labeling Trap
- Diagnostic labels can carry stigma in the public mind. Counselors can believe that it is most important that a client accept the counselor's labeling ("You're an alcoholic", "You're in denial")
- This may be a power struggle or an attempt to assert control and expertise, or judgmental communication
- The labeling struggle evokes unnecessary resistance – respond to questions about diagnosis or labels with reflection and reframing e.g., "So it sounds like implying you are an addict is a worry for you, is it?"

(e) The Premature-Focus Trap
- Resistance may result if the client and therapist wish to focus on different topics
- A struggle can ensue if the counselor wants to focus on the "real" problem while the client wants to focus on a broader or different range of concerns
- Avoid the struggle about the proper topic for early discussion, starting with the client's concerns, rather than those of the counselor

(f) The Blaming Trap
- A client can be concerned about blaming – whose fault is the problem? Who's to blame?
- Needless time and energy can be wasted on defensiveness. Blame is irrelevant
- This can usually be dealt with by reflecting and reframing e.g., "It sounds like you are worried about who is to blame. Counseling has a 'no fault' policy where we are interested in what is troubling you and what you can do about it."

2. Early Strategies to Avoid Traps

(a) Ask Open-Ended Questions
   • Establish an atmosphere of acceptance and trust, in which the client will explore hir or her problems
   • The client should do most of the talking and the counselor listening carefully and encourage expression

(b) Listen Reflectively
   • The crucial element is not just keeping quiet and hearing what someone has to say. It is how the counselor responds to what a client says
   • Any response that has the effect of blocking, stopping, diverting, or changing direction create a roadblock – 12 kinds of responses that are *not* listening (Thomas Gordon, 1970):

   (1) Ordering, directing, or commanding
   (2) Warning or threatening
   (3) Giving advice, making suggestions, or providing solutions
   (4) Persuading with logic, arguing, or lecturing
   (5) Moralizing, preaching, or telling clients what they "should" do
   (6) Disagreeing, judging, criticizing, or blaming
   (7) Agreeing, approving, or praising
   (8) Shaming, ridiculing, or labeling
   (9) Interpreting or analyzing
   (10) Reassuring, sympathizing, or consoling
   (11) Questioning or probing
   (12) Withdrawing, distracting, humoring, or changing the subject

(c) Affirm
   • Affirm and support your client during the counseling process in the form of compliments and statements of appreciation and understanding e.g., I appreciate how hard it must have been for you to decide to come here; That's a good suggestion; It must be difficult for you to accept a day-to-day life so full of stress.

(d) Summarize
   • Summary statements can be used to link together material that has been discussed
   • Such periodic summaries reinforce what has been said and show that you have been listening carefully. They prepare the client to move on.

(e) Elicit Self-Motivational Statements or Change Talk
   • This helps a client resolve ambivalence. Opposite to the confrontation of denial approach, in MI the client is the one who presents the arguments for change. It is the counselor's task to facilitate the client's expression of these self-motivational statements:

   (1) Problem recognition – I guess there's more of a problem than I thought
   (2) Expression of concern – I'm really worried about this
   (3) Intention to change - I've got to do something about this
   (4) Optimism - I think I can do it

E. **Dealing with Resistance**

1. Forms and Functions of Resistance

Forms of Resistance	**Corresponding Functions**
Client:	
Resistance to admitting a problem	Denial of the extent or consequences of a problem helps client deal with internal conflicts e.g., concerns over deteriorating values; or internal or external stressors e.g., school, work or marriage threatened (Precontemplation)
Overt refusal to comply with recommendations	Productive or counterproductive assertiveness that indicates an inadequate therapeutic alliance, assessment and/or treatment contract
Passive agreement, but failure to act	Inadequate assertiveness, responsibility and/or honesty and avoidance of conflict, or fear of rejection. Indicates inadequate change environment and therapeutic alliance
Forms of Resistance	**Corresponding Functions**
Therapist/Counselor:	
Resistance is seen as "denial," a trait characteristic requiring confrontation to "see the light"	Avoids analysis of client's ambivalence, internal conflicts and stage of change. Labels client with set pathology that avoids individualized assessment and treatment. Avoids therapist's internal conflicts over acknowledgement of different paths for change
Comments inflammatory to client or that reduce the credibility of the client's ideas and position	As above, but also may be misguided attempt to reassure the client e.g., a pessimistic comment by client is met with a "cheer leading", upbeat reassurance of success. Avoids exercise of empathetic skills
Goals of treatment and strategies for change are prescribed for the client by the therapist; client is seen as "in denial" or incapable of making sound decisions	Pathology-oriented perspective that orients therapist to paternalistic and patronizing interactions rather than participatory, person-centered treatment planning. Maintains therapist's position of power and client's dependent status with therapist

(Rothschild, Debra (1995): "Working with Addicts in Private Practice: Overcoming Initial Resistance" " In AM Washton (Ed.), "Psychotherapy and Substance Abuse - A Practitioner's Handbook" New York, NY., Guilford Press. p.193; Miller, William R; Rollnick, Stephen (1991): "Motivational Interviewing - Preparing People to Change Addictive Behavior" New York, NY., Guilford Press. p.53; Fisch, R; Weakland, JH; Segal, L (1982): "The Tactics of Change – Doing Therapy Briefly" San Francisco, Jossey-Bass Publishers p.99)

2. Responding to Resistance

(Miller, William R; Rollnick, Stephen: "Motivational Interviewing - Preparing People for Change" Second Edition, New York, NY., Guilford Press, 2002. pp 98-110)

(a) *Simple reflection* - a good general principle is to respond to resistance with nonresistance. Acknowledgement of the person's disagreement, feeling, or perception can permit further exploration rather than continued defensiveness

- e.g., <u>Client</u>: I just don't want to take pills. I ought to be able to handle this on my own
  <u>Interviewer</u>: You don't think medications would work for you. <u>OR</u>
     You don't want to rely on a drug. It seems to you like a crutch.

(b) *Amplified reflection* – reflect back what the person has said in an amplified or exaggerated form – to state it in an even more extreme fashion. This is done emphatically, but not in a sarcastic tone or too extreme an overstatement as it may elicit a hostile or other resistance reaction.

- e.g., <u>Client</u>: I couldn't just give up drinking. What would my friends think?
  <u>Interviewer</u>: You couldn't handle your friends' reaction if you quit.

- e.g., <u>Client</u>: I can take care of myself. I don't need my parents always checking up on me.
  <u>Interviewer</u>: So you might be better off, really, without parents.

- e.g., <u>Client</u>: My wife is always exaggerating. I haven't ever been that bad.
  <u>Interviewer</u>: It seems to you she has no reason for concern.

(c) *Double sided reflection* – capture both sides of the ambivalence. Acknowledge what the person has said and add to it the other side of his or her own ambivalence (not yours).

- e.g., <u>Client</u>: I now that what you're trying to do is help me, but I'm just not going to do that!
  <u>Interviewer</u>: On the one hand, you know that there are some real problems here I'm trying to help with, and, on the other, what I suggested is just not acceptable to you.

(d) *Shifting Focus* – shift the person's attention away from what seems to be a stumbling block in the way of progress. Go around barriers rather than to climb over them. First defuse the initial concern and then direct attention to a more readily workable issue.

- e.g., <u>Client</u>: OK, the judge said I had to come here, so tell me what I have to do.
  <u>Interviewer</u>: I don't know enough about you yet for us to even start talking about what it makes sense for you ro do. What we need to do right now is….

(e) *Reframing* – acknowledge the validity of what the person's raw observations but offer a new meaning or interpretation for them. The client's information is recast into a new form and viewed in a new light that is more likely to be helpful and to support change.

- e.g., <u>Client</u>: I've tried so many times to change, and failed.
  <u>Interviewer</u>: You're very persistent, even in the face of discouragement. This change must really be important to you.

- e.g., <u>Client</u>: My husband is always nagging me about taking my medicine. He's always reminding me to take my insulin and telling me to watch what I eat.
  <u>Interviewer</u>: It sounds like he really cares about you, and is concerned for you. I guess he expresses it in a way that you're angry about, and maybe we can help him learn to tell you in a better way that he loves you and is worried about you.

(f) *Agreeing with a Twist* – offer initial agreement, but with a slight twist or change of direction. This is basically a reflection followed by a reframe.

- e.g., <u>Client</u>: Nobody can tell me how to raise my kids. You don't live in my house. You don't know how it is.

        <u>Interviewer</u>: The truth is that it really is up to you how your kids are raised and what they learn. You're in the best position to know which ideas are likely to work and which aren't, and I can't just be prescribing things for you. You need to be a full partner in this process.

(g) *Emphasizing Personal Choice and Control* – when people perceive that their freedom of choice is being threatened, they tend to react by asserting their liberty e.g., "I'll show you; nobody tells me what to do!" Assure the person that it is the client who determines what happens.
-    e.g., <u>Client</u>: The judge told me that I have to come here. I don't have any choice about it.
        <u>Interviewer</u>: Actually you do, in several ways. You chose to come here instead of taking your chances with the judge. Also, if you find that you don't want to come here, I can work with you and the court to find a different program for you, on you might like better.

(h) *Coming Alongside* – if taking one side of the argument causes an ambivalent person to defend the other, then the process ought to work both ways. This is a special case of amplified reflection. Coming alongside as the client argues against change is just another way of defusing the argument and eliciting change talk.
-    e.g., <u>Client</u>: That's about it, really. I probably drink too much sometimes, and I don't like the hangovers, but I don't think it's much of a concern, really.
        <u>Interviewer</u>: It may just be worth it to you to keep drinking as you have, even though it causes some problems. It's worth the cost.

F. <u>**Strengthening Commitment to Change**</u>
(Miller, William R; Rollnick, Stephen: "Motivational Interviewing - Preparing People for Change" Second Edition, New York, NY., Guilford Press, 2002. pp 133--139)

(a) <u>Negotiating a Change Plan</u>

A process of shared decision making and negotiation that involves:

1. Setting Goals – motivation is driven by discrepancy between a person's goals and his or her perceived present state. A first step in instigating change is to have clear goals toward which to move. Based on and driven by "what the client wants".

2. Considering change options – consider possible methods form achieving the chosen goals. Involve the client directly in this process of brainstorming and evaluating possible change strategies, drawing on his or her own ideas.

3. Arriving at a plan – negotiation of a plan for change. Elicit this plan by having the person voice it.

4. Eliciting commitment – look for the client's approval of and assent to the plan. "Is this what you want to do?" Commitment to a plan can be enhanced by making it public.

(b) <u>A Change Plan Worksheet</u>

The most important reasons why I want to make this change are:

My main goals in making this change are:

I plan to do these things in order to accomplish my goals:

Specific action   When?

Other people could help me with change in these ways:

Person   Possible ways to help

These are some possible obstacles to change, and how I could handle them:

Possible obstacles to change   How to respons

I will know that my plan is working when I see these results:

G. **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!"

Rosemary

This 31 year old, Latina. married, unemployed, female, referred by her caseworker on the Mental Health Service Team where she is being treated for paranoid schizophrenia, reports an 8-year habit of weekend crack cocaine use in the amount of 5 rocks on each occasion. This client has 3 children, ages 9, 15, and 16, who are currently living with a relative through a court order. Thinking about her children helps Rosemary to keep from using drugs. She is currently in a Christian based treatment program, but is unhappy with the group therapy setting. She prefers working one on one. She states that concern for her children and her desire to have them with her help her focus on recovery. She also reports having had no friends since high school, and reports feeling isolated and lonely.

She reports no medical problems or past withdrawal symptoms.

Anna

Anna is a 20-year-old Vietnamese female who has never been married. She is unemployed and now lives with her parents. She is presenting for treatment because she was mandated by her social worker. She lost her newborn baby for having a positive drug test. She is a daily user with a 5-1/2-year history of methamphetamine abuse. Her last use was today. She has never been diagnosed with a mental health diagnosis. She has current suicidal ideation but has no plan. She has a past history - slit her wrists at age 15 and was not under the influence at the time. She has never been in treatment before and has never been to NA/AA meetings. She doesn't want to quit using.

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