

## **How to Deal with Relapse, Continued Use and Continued Problems: Working Together to Promote Recovery**

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### **A. Definitions of Terms**

<b>Addiction Treatment</b>	<b>Mental Health Treatment</b>
<u>Slip or Lapse</u> – 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)	<u>Lapse</u> – Recurrence of a symptom of a disorder (Evans and Sullivan, 1990). Infrequent symptoms without significant interference in functioning
<u>Slides</u> – 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.	<u>Lapsing</u> – 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
<u>Continued Use</u> – 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.	<u>Continued Problems</u> – A person who has not committed to treatment may continue to have emotional, behavior or cognitive problems as they work through their ambivalence
<u>Relapse</u> – 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)	<u>Relapse</u> – (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). <ul style="list-style-type: none"><li>• Responding to lapses with old solutions likely to result in a return to pretreatment status (Evans and Sullivan, 1990)</li></ul>

### **B. 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.

### C. **Individualized Treatment for Effective Outcomes**

1. The common language of six ASAM Criteria dimensions determine needs/strengths:  
(*The ASAM Criteria* 2013, pp 43-53)

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

#### 2. 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; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
- \* Meetings - AA, NA, AI-Anon; SMART Recovery, Dual Recovery Anonymous, etc.
- \* Monitor - continuity of care; relapse prevention; family and significant others

#### 3. 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

#### 4. Stages of Change and How People 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 to raise awareness of a possible “problem” and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a “problem” or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

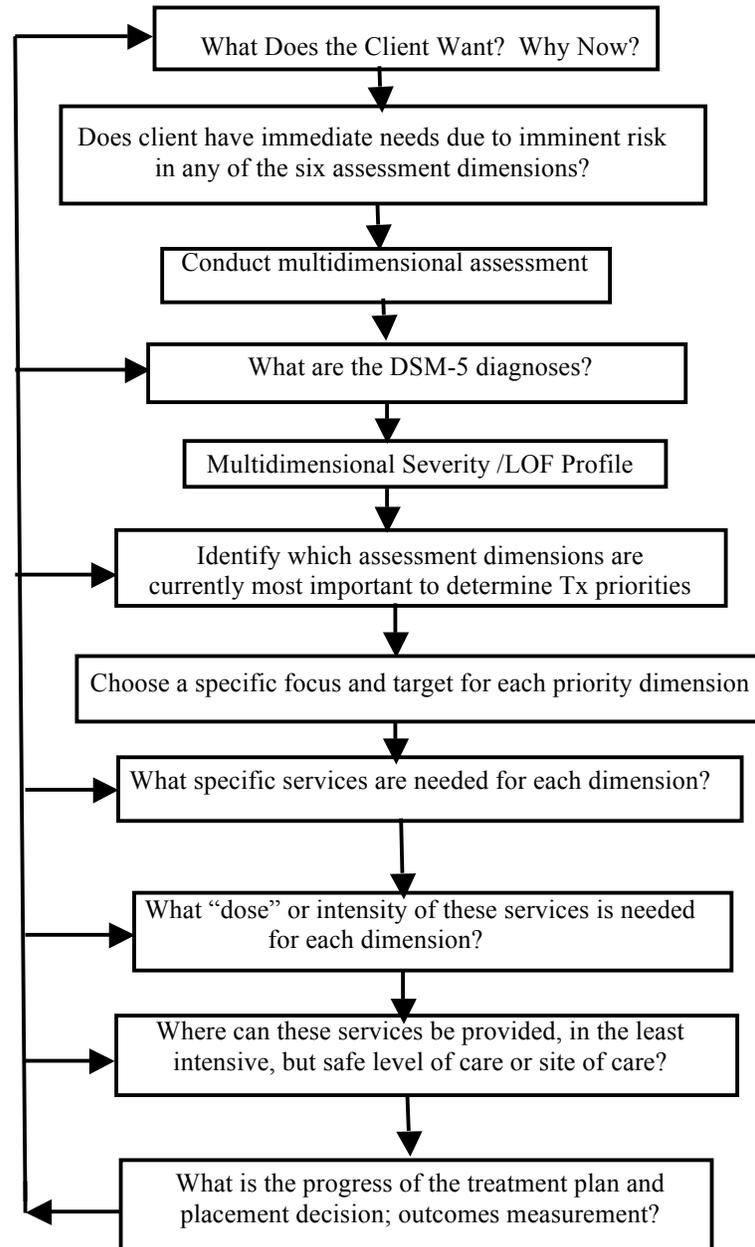
- \* Readiness to Change - not ready, unsure, ready, trying: Motivational interviewing (Miller and Rollnick)

#### 5. Proximal and Distal Goals

- Traditionally: Abstinence is a “distal” goal for participants with addiction (dependence – they need treatment); but a “proximal” goal for those with Substance Abuse (assumes substance use is voluntary)
- Traditionally: Those with complex needs, “regimen compliance” is “proximal” goal. Better still “treatment adherence”
- Traditionally: Increase treatment for substance use early in treatment for participants with addiction; but punish with sanctions once engaged in treatment and some sustained sobriety
- Traditionally: For non-addicted participants, use escalating sanctions in initial phases to end voluntary use and not “reward” use

**Recommendations:**

- This all based on a behavior modification approach when addiction is biopsychosocial-spiritual
- If participant has addiction, treatment is needed. If not, education, risk advice and escalating legal consequences (like speeding fines and DUI)
- Abstinence is a “proximal” or “distal” goal for participants with addiction depending on their stage of change regarding abstinence assessed in treatment
- Use escalating sanctions in initial and/or later phases of treatment for lack of good faith effort in treatment. Don’t sanction for signs and symptoms of addiction flare-ups and poor outcomes.



(The ASAM Criteria 2013, p 124)

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