Challenging Cases and Situations: Consultation, Communication and Conflict Resolution

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A. The Power of Language and Terminology

1. 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. Changing the Concept of Resistance

- In the Glossary (Miller & Rollnick, 2013. page 412): "Resistance – A term previously used in Motivational Interviewing, now deconstructed into its components: sustain talk and discord."
- Notice "previously used" means: "Resistance" as a term and concept will no longer be used as in previous editions- "Rolling with Resistance"; "Responding to Resistance".

So if you start deleting "resistance" from your clinical vocabulary and focus on "sustain talk" and "discord," you are now in a better position to attract a person into recovery than responding to them as a resistant, non-compliant person in denial.

What is "sustain talk"?

- It is "the client's own motivations and verbalizations favoring the status quo." (p. 197). The person is not interested in changing anything; I am OK with keeping things the way they are – status quo, sustain what I have already got or where I already am.
- "There is nothing inherently pathological or oppositional about sustain talk. It is simply one side of the ambivalence. Listen to an ambivalent person and you are likely to hear both change talk and sustain talk intermingled." (p. 197). "Well maybe I have a drug problem and should do something about it if I don't want to be arrested again." (Change talk). "But it really isn't as bad as they say, they're just overacting." (Sustain talk).

What is "discord"?

- "If we subtract sustain talk from what we previously called resistance, what is left? The remainder …more resembles disagreement, not being "on the same wavelength," talking at cross-purposes, or a disturbance in the relationship. This phenomenon we decided to call discord." (p. 197).
- "You can experience discord, for example, when a client is arguing with you, interrupting you, ignoring, or discounting you." (p. 197).

"Sustain talk is about the target behavior or change" – drinking or drugging, over-eating, gambling etc. "Discord is about you or more precisely about your relationship with the client – signals of discord in your working alliance." – Are you on the same page as your client? Are you more interested in abstinence and recovery than they are? Are you doing more work than them about going to AA or taking medication?

3. Compliance versus Adherence

Treatment or medication *compliance* is a term that has had long use in the health care field in general and the addiction and mental health sectors in particular. Webster's Dictionary defines "to comply" as "to act in accordance with another's wishes, or with rules and regulations." By contrast, it defines "adhere" as "to cling, cleave (to be steadfast, hold fast), to stick fast."

4. Criminal Justice's Mission versus Treatment's Mission

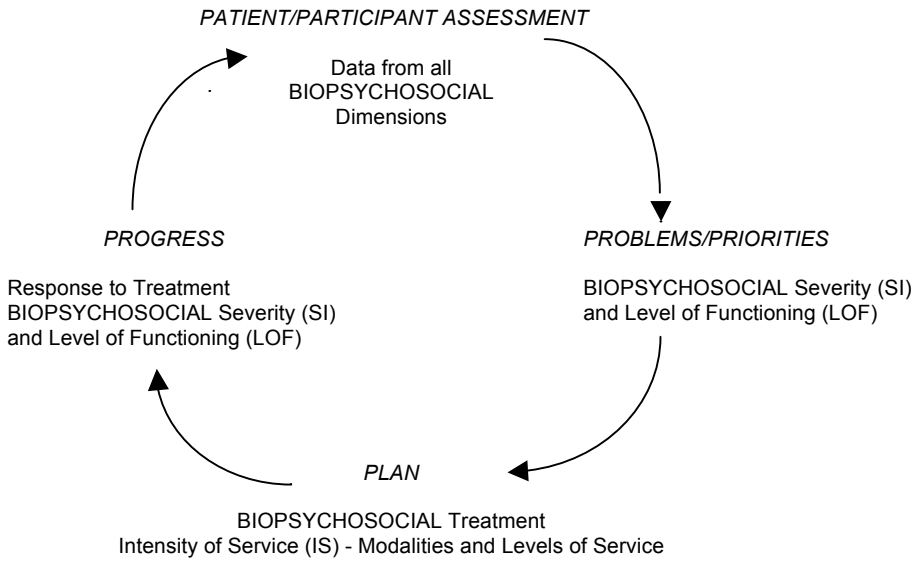
The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms 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/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. **Underlying Principles of The ASAM Criteria**

1. Individualized, Clinically and Outrcomes-driven Treatment



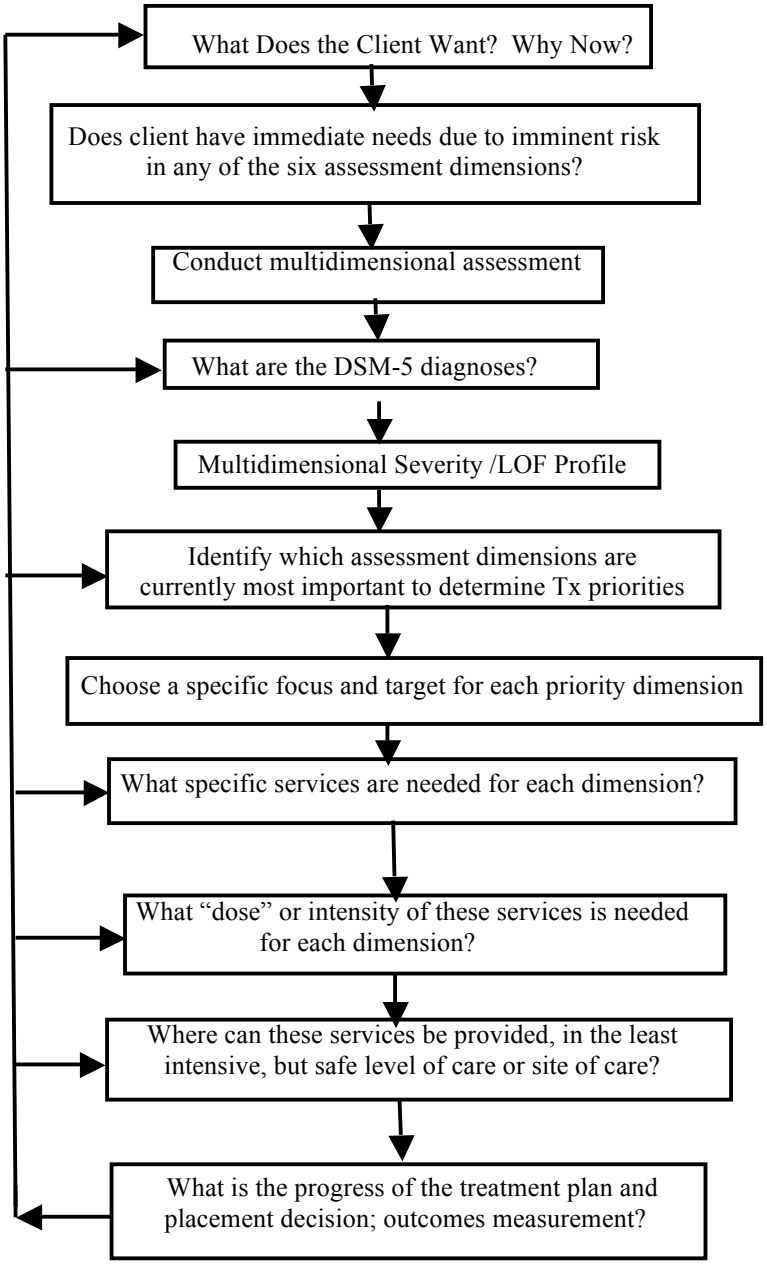
2. Assessment of Biopsychosocial Severity and Function *(The ASAM Criteria* 2013, pp 43-53)

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

3. Biopsychosocial Treatment - Overview: 5 M's
   * Motivate - Dimension 4 issues; engagement and alliance building
   * Manage - the family, significant others, work/school, legal
   * Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; 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 Interventions Services
   1 Outpatient Services
   2 Intensive Outpatient/Partial Hospitalization Services
   3 Residential/Inpatient Services
   4 Medically-Managed Intensive Inpatient Services

C. **How to Target and Focus Treatment Priorities** *(The ASAM Criteria* 2013, p 124)



D. **Improving the System of Care to Implement The ASAM Criteria**

1. Case Presentation Format *(The ASAM Criteria* 2013, pp 119 -126)

Before presenting the case, please state why you chose the case and what you want to get from the discussion

I. Identifying Client Background Data

Name
Age
Ethnicity and Gender
Marital Status
Employment Status
Referral Source
Date Entered Treatment
Level of Service Client Entered Treatment (if this case presentation is a treatment plan review)
Current Level of Service (if this case presentation is a treatment plan review)
DSM Diagnoses
Stated or Identified Motivation for Treatment (What is the most important thing the clients wants you to help them with?)

First state how severe you think each assessment dimension is and why (focus on brief relevant history information and relevant here and now information):

II. Current Placement Dimension Rating (See Dimensions below 1 - 6)

1.
2.
3.
4.
5.
6.

(Give brief explanation for each rating, note whether it has changed since client entered treatment and why or why not)

This last section we will talk about together:

III. What problem(s) with High and Medium severity rating are of greatest concern at this time?

Specificity of the problem
Specificity of the strategies/interventions
Efficiency of the intervention (Least intensive, but safe, level of service)

2. Moving from Punishment to Accountability for Lasting Change – Implications for sanctions and Incentives

(Tips and Topics, Volume 12, No. 6, September 2014. www.changecompanies.net; click on Blogs; click on Tips and Topics and go to the Archives on left hand side.)

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 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 and 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 Alcoholics Anonymous meetings in 90 days; or ordering sanctions that may be ineffective in producing improved treatment engagement and real client functional change.

3. Dealing with All Stakeholders Who Are at Different Stages of Change

(a) Individualized Staff Development Plans based on what the staff person wants
(b) Individualized Agency Development Plans – expectations for progress and change
(c) Individualized Court Personnel Development Plan – reaching consensus on what is expected from treatment and what is expected from court personnel
(d) Incentives and leverage to facilitate continuing change and development

Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorders, 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 was not using anything. 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 said he is holding for a friend.

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