Building Effective Therapeutic Partnerships: The Most Important Evidence-Based Practice

Introduction

During the past few years the field of Medication Assisted Treatment (MAT) has increased its focus on Evidenced Based Practices (EBP). These include Motivational Interviewing (MI), Integrated Dual Disorders Treatment, Dialectical Behavior Therapy, Matrix Model, Motivational Incentives Approach, as well as MAT (SAMHSA, Evidenced Based Practices 2008). Most professionals agree that the effective dissemination of these practices is essential for efforts to improve outcomes. With the exception of MI however, little attention is paid to the fundamentals of doing counseling or to those factors known to enhance positive change, such as forming and maintaining the therapeutic relationship or the instillation of hope. MI (MI; Miller & Rollnick, 2002) has been widely recognized as an effective counseling technique within addiction treatment settings and has received significant empirical support in over sixty clinical trials.

Regardless of the quality of the training and supervision or the fidelity to the model, the quality and effectiveness of the treatment model will be seriously eroded unless the counselor has quality skills in "the basics" of doing counseling. Research indicates that the therapeutic relationship accounts for 30% of patient outcomes. Further, 15% is attributed to the expectancy, also known as placebo effects. Only 15% is attributed to the specific counseling techniques used (The Heart & Soul of Change; Hubble, Duncan & Miller 1999). This research is consistent with Carl Rogers' Person-Centered Approach and Abraham Maslow's humanistic focus. Rogers noted that the important therapeutic factors for a growth-promoting therapeutic relationship include unconditional positive regard, genuineness, and accurate empathy (Rogers 1951). Both the contributions of Rogers and Maslow's focus on the actualization of potential reflect the basic assumptions of a "recovery-oriented approach". Unfortunately, many in the field either have not received quality training in the fundamental counseling skill of forming and maintaining the therapeutic relationship or have forgotten the basics during the course of their career. Given the importance of the therapeutic relationship in outcomes relative to specific counseling techniques, this core therapeutic skill should be of primary concern within the scope of any clinical development initiative or anyone interested in improving patient outcomes and increasing retention. It could be argued based on the empirical evidence, that this specific skill should itself be studied and developed as an EBP. It is clear from the plethora of available research on MAT that longer treatment duration and increased retention correlates with long term recovery. Counselors with a strong ability to form a positive therapeutic relationship with the patient would have a positive effect on patient retention.

Proposal

The proposed workshop will focus on the opportunities and unique challenges involved in enhancing the therapeutic alliance with medication-assisted patients within the clinic setting. The presenter will first address the rational for making this EBP a priority in training and supervision. The presenter will review the fundamentals of forming and maintaining a therapeutic relationship and the factors that affect the quality of the therapeutic relationship utilizing a power point presentation and interactive exercises. The constructive use of patient feedback during the course of counseling to strengthen the therapeutic alliance will be discussed. Boundary issues specific to the counselor in recovery will also be explored. The presenter will provide the clinician with a roadmap for the successful integration of the skills with their current clinical approach and existing clinical culture where they work. The presenter will also address counselor and patient "expectancy" as a therapeutic factor. The development of positive expectancy is a unique challenge in medication-assisted treatment. Despite wide professional recognition as the "Gold Standard" in treatment for opioid dependence, studies continue to demonstrate extremely high rates of negative or inaccurate beliefs regarding this form of treatment by both patients and counselors . The presenter will discuss recent experiences with enhancing the communication of positive expectancies for medication-assisted treatment. This workshop is designed for the "basic track" and was well-received when presented at previous AATOD Conferences as part of the basic track. The presentation will be 60 minutes in duration. A 30 minute discussion and question and answer period will follow.

Developing and Integrating Peer Mentoring Within Methadone Maintenance Treatment

Introduction

The Bridge to Recovery (BTR) is an innovative peer mentoring based treatment initiative designed to increase retention and produce positive treatment outcomes for patients receiving Methadone Maintenance Treatment. The initiative was developed and implemented by a Methadone Treatment Program administrator and a patient advocate in long term methadone maintenance. It is a peer mentoring focused approach which is designed to address the common reasons patients drop out of treatment prematurely; low motivation, lack of a healthy support system and the absence of a therapeutic alliance with the treatment program. The initiative recruits and trains patients who are in long term recovery with medication assisted treatment who desire to help others achieve their own recovery. The mentors meet with patients who are having difficulty maintaining sobriety, missing counseling sessions, and are at risk of dropping out of treatment. In most cases these patients lack a therapeutic connection or alliance with the program and lack motivation to make healthy behavior change. The goal of the initiative is to create a therapeutic alliance between the patient and the treatment program with the peer mentor being the catalyst or "bridge" for the alliance. Hence, the program is called "Bridge to Recovery". The program works because the mentors have the ability to quickly form a bond with the patient who lacks one with the program staff. They then extend this alliance to the program counselors. The mentors are literally a "bridge" to connect the non-engaged patient with recovery. The research indicates that the therapeutic relationship between the patient and the treatment provider is the best predictor of treatment success (The Heart & Soul of Change; Hubble, Duncan & Miller 1999). This initiative helps establish this connection for those who are struggling with their recovery. The Peer Mentors attend the same type of training accessed by counselors preparing for certification as an addictions counselor in Connecticut which provides the peer mentors with a ladder to a career as an addictions counselor. Following the training, the Peer Mentors are eligible to take the certification exam with the CT Certification Board, Inc. For many, becoming a peer mentor is the first step to becoming a certified addictions counselor and a career in the addictions treatment field. This is not only important for the patient in recovery who desires a career but to the field as a whole. According to SAMHSA, the field of addiction treatment is projected to experience a significant future workforce shortage (SAMHSA, 2006). Outcome studies conducted at Connecticut Counseling Centers, Inc. (CCC) following implementation of this innovative approach have been extremely positive including higher retention rates, increased patient and staff satisfaction, and decreases in illicit drug use. An important component of the initiative is collaboration and coordination between the clinical staff and the peer mentors.

In 2012 CCC became a host site for the SAMHSA funded "Beyond MARS" project which is designed to replicate the peer support initiative "Medication Assisted Recovery Services" (MARS) at five methadone treatment program around the country. At CCC, the MARS program has joined with the BTR program to provide enhanced seamless peer support services. BTR provides peer counseling/mentoring by extensively trained peer mentors. The MARS program provides peer support, drop-in services, and a recovery oriented social network. The authors found that the two programs complement each other and enhance access to peer services with the availability of an array of peer support services.

The program has been recognized by the Connecticut Department of Mental Health and Addiction Services as a model program to be replicated at other sites. " In April, 2012, the initiative received the SAMHSA "Science and Service" Award for demonstrated excellence and innovation in opioid treatment programs at the 2012 AATOD Conference in Las Vegas, NV. The program has been replicated in full or in part by other organizations as a result of past presentations at previous AATOD conferences.

Proposal

The proposed workshop will include a description of the development of the peer mentoring program, the process of implementation, and integration with traditional MAT services with a specific focus on strengthening the therapeutic alliance between the patient and the program. Outcome data will also be presented. Potential benefits relating to staff utilization management, financial savings, improved outcomes, and an improved therapeutic alliance between the clinical staff and the patient following exposure to the peer mentors will be discussed. The presenters will focus on providing information the workshop participants will need to replicate all or part of the initiatives at their own programs. The current presentation will include a description of the program and video clips of sessions followed by an interactive case discussion between both a Peer Mentor and the workshop participants as before, but will also include a description of the MARS peer support program and how the two initiatives can complement each other by expanding access to peer supports and expanding the number of patients accessing peer support training. It will also include updated outcome data including patient testimonials. The presenters will describe the program from initial concept to implementation utilizing a power point presentation and handouts (60 minutes, 30 minutes each presenter). The remaining 30 minutes will be a question and answer discussion period.