

**A COMPREHENSIVE INTEGRATED
SYSTEM OF CARE
for
CO-OCURRING FAMILY VIOLENCE,
MENTAL HEALTH & ADDICTIONS
ISSUES??**



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Ideal Best Practice Programming Recommendations

- 1. A comprehensive continuous integrated system of care be developed encompassing the addiction, mental health, and family violence.**
- 2. Self-report screening process and instruments that address the levels of addiction, mental health and family violence, for use with physicians, hospital emergency centers, and police.**
- 3. Assessment process and instruments that assess the severity of the addiction, mental health and family violence.**
- 4. A socio-environmental risk assessment tool.**

BEST PRACTICES (Contd.)

5. Awareness education, cross training programs for staff from addiction, mental health, family violence, police, justice and medical agencies and organizations
6. A collaborative case management approach

Ideal Best Practice Programming Recommendations

- 7. Specific program components in each system reflect the current Best Practices initiatives.**
 - a) A Biopsychosocial approach**
 - b) Motivational Interviewing and Counseling Techniques**
 - c) The Transtheoretical Model of Change**
 - d) Harm Reduction and Prevention Strategies and Programming**
 - e) Emphasis on social and interpersonal skills, a community reinforcement approach, marital and behavioural and non-behavioural therapy**
 - f) Culture specific and gender sensitive programming**

The CCISC Model

**Comprehensive,
Continuous,
Integrated System of
Care**

COMPREHENSIVE INTEGRATED SYSTEM OF CARE

- **Brief intervention**
- **Self-assessment programs**
- **Outpatient**
- **Day programs**
- **Short-term residential programs**
- **Long-term residential programs**
- **Detoxification**
 - **Non-medical**
 - **medical**
- **Mutual aid (self-help) groups**

CCISC PRINCIPLES

- 1. Co-occurring disorders are an expectation
Not the exception.**
- 2. The core success in any setting is the
availability of empathic hopeful clinical
relationships.**
- 3. The population of individuals with co-
occurring disorders/issues can be organized
into four sub-groups**
- 4. Case management needs to be balanced with
empathetic detachment**

CCISC PRINCIPLES (Con't)

5. When substance use, mental health and family violence disorders/issues exist a CCISC which supports the provision of concurrent responses to all as primary disorders is recommended,
6. Substance abuse, mental health and family violence disorders tend to be persistent.
7. There is no one correct program or intervention
8. Outcomes for patients/clients need to be individualized.

Principle #1

- Co-occurring mental health, addiction and family violence issues- are an **expectation**, *not an* exception

Prevalence Studies Indicate

- **60% of persons with a substance use disorder have an identifiable psychiatric diagnosis (Kessler et al, 1996)**
- **55% of persons in treatment for Schizophrenia report lifetime substance use disorder (Reigier et al, 1990)**

Prevalence Studies con't ...

- **About 50% of persons with severe mental illness in community mental health programs develop substance abuse use disorder at some time in their lives. (Drake & Mueser, 2000)**
- **Morrow (2002) linked early childhood trauma to depression, borderline personality disorder, multiple personality disorder and substance abuse**

Prevalence Studies (cont)

Canadian Community Health Survey (2002)

- Canadians suffer from a major depression as from other leading chronic conditions.
- 1-10 Canadians 15yrs + over (2.6 million) reported symptoms consistent with alcohol/illicit drug dependence or mental disorder.
- Teenagers and young adults 15-24 were most likely to report suffering from mental disorder/substance abuse.

Mental Health and Addictions AFM Clients

	Residential	
	F	M
Ever Prescribed Antidepressants	75%	44%
Seen for Emotional Problems	58%	37%
Hospitalized as a result of Emotional Problems	30%	19%

Alcohol/Drug & Violence - Shelters

Meridith, (1996) estimated of the women seeking assistance from either an addiction agency or an anti-violence agency who were experiencing both family violence and addictions:

- **65% had partners who were currently abusing substances**
- **62% were currently or previously violent**
- **The majority of women in both agencies reported a history of addiction in their families of origin.**

AFM Adult Residential Clients Experiencing Violence/Abuse (2003)

	Family Program	
	FEMALE	MALE
Physical Abuse	41%	44%
Sexual Abuse	33%	18%
Emotional Abuse	83%	44%
Verbal Abuse	85%	87%
Do memories affect your life	54%	33%
Currently involved in or recently left an abusive relationship	37%	14%
Concerned about safety	6%	7%

Gambling – Family Violence Prevalence

- National Gambling impact study (2002) showed a 300% increase in domestic violence requests for intervention after the arrival of casinos.
- Qualitative study (Hallebone 1999) found that all female problem gamblers experienced physical and/or sexual abuse as children.
- Director of Women's Shelter in Rankin Inlet found that the majority of abuse was related to gambling.
- Member of the Board of Directors of YWCA shelter in Thompson noted a dramatic increase in gambling related to family violence in the past 3 years.

AFM GAMBLING CLIENTS (Female) 2003

- **34%** said that they used alcohol or other drugs while they gamble.
- **65.3%** had children living with them
- **66%** were currently involved in or recently left an abusive relationship
- **53.1%** had thought of committing suicide

Suicidal Ideation and Attempts - AFM Residential Clients (2003)

	Residential	
	F	M
Have you ever thought of committing suicide?	58%	57%
Have you ever attempted suicide?	57%	36%
Were you ever hospitalized as a result	61%	38%
Were you under the Influence	74%	74%
If no, was something consumed a few days before?	27%	50%

Women Experiencing Addiction, Mental Health and Family Violence Who Are Aggressors

- Chase, Farrell, Murphy and Stewart (2003) noted in the year prior to treatment 50-60% of women enacted violence against their male partner. 25%-35% enacted severe violence against male partner.
- Shelters have asked for education/training in “Managing the Aggressive/Intoxicated Client.”

Family Violence Team Female Aggression

The Family Violence Intervention teams estimated that:

- One-third of clients engaged in mutual aggression.
- Another third of the women were identified as the aggressor.
- 80% of clients suffer from an addiction or mental health disorder.

AFM Residential Clients Aggressive Behaviour (2003)

	Residential	
	Female	Male
Behave violently when sober	30%	26%
Behave violently when using alcohol or other drugs	57%	52%

Principle #2

- The core success in any setting is the availability of empathic, hopeful clinical relationships

Principle #3

- The population of individuals with co-occurring mental health, addiction and family violence can be organized into four sub-groups

The Four Subgroups

QUADRANT IV

- PSYCH HIGH
- SUBSTANCE HIGH

QUADRANT III

- PSYCH LOW
- SUBSTANCE HIGH

QUADRANT II

- PSYCH HIGH
- SUBSTANCE LOW

QUADRANT I

- PSYCH LOW
- SUBSTANCE LOW

Best Practices

2. SCREENING PROCESS

- ★ **A Screening process that includes Self-report screening instruments that address the levels of addiction, mental health and family violence, for use with physicians, hospital emergency centers, and police.**

(Failure to screen or assess co-existing addiction, mental health and family violence issues is considered professionally negligent)

What Are We Screening?

To have fuller understanding of the range of an individual's needs and environmental risk conditions you will want to know whether your client:

- Uses alcohol and/or other drugs frequently or in high volumes
- Has been a victim of emotionally, psychologically or physically abusive behaviour
- Behaves abusively toward others
- Suffers from depression, bi-polar, anxiety and/or PTSD.

Red Flags

- Witnessed/experienced childhood abuse
- Family history of addiction problems
- Harmfully or dependently involved
- History of depression
- History of Interpersonal conflict

Benefits of Screening

- Prevent the onset of drug use to cope with the client's experience with violence
- Prevent drug use from becoming more of a problem
- Help clients develop plans and access resources that may enhance their safety and security
- More effectively eliminate violence
- Match appropriate treatment and services with multifaceted problems of the client

Levels of Involvement



A framework to describe the range of individual gambling, alcohol or other drug involvement. This framework covers non-problematic to highly problematic behaviours, & describes the various levels of involvement in terms of observable data or reported experiences.



Levels of Involvement



- Non-Involvement
- Irregular Involvement
- Regular Involvement
- Harmful Involvement
- Dependent Involvement
- Transitional Abstinence
- Stabilized Abstinence

Problems vs. Risk

Problem Description

- Current Behaviour Pattern
- Current & Past Consequences

Risk Assessment

- Possible FUTURE Consequences

Levels of Involvement Framework is NOT used to assess Risk.

Best Practices

#3 Assessment Process and Instruments

Assessment process and instruments that assess the severity of the addiction, mental health and family violence.

Assessment

Purpose of Assessment Process:

1. To describe the presenting situation for mutual understanding of issues.
2. Identify the interrelationship of addiction, mental health and family violence issues.
3. Identify those problems and issues associated with the behaviours occurrence and maintenance.

Assessment

Purpose of Assessment Process:

4. Develop an appropriate integrated rehabilitation plan that incorporates all relevant issues.
5. Identifies environmental risk conditions that could affect the outcome of rehabilitation process.

Asking Questions

- It is important not only to obtain information on areas of concern, but to gain an understanding of the historical and current context in which the behaviour occurs. This will assist to also identify the interrelationship between their behaviour and impact on their relationships.

Interrelationship between AOD use Family Violence and Mental Health Issues

- Important to explore the context in which the abuse occurs and identify the chain of events and emotions that preceded or accompanied the AOD/abuse.

Questions on Interrelationship between AOD use and Family Violence

- How do they/their partner deal with angry feelings
- What happens when they/their partner loses their temper?
- How much of the abuse occurs:
 - While they/their partner is using/gambling?
 - Prior to using/gambling?
 - Within 72 hours after using/gambling?
 - What feelings precede and accompany the use of AOD/Gambling?
 - What drugs were used to “recover” from the incident?

BEST PRACTICES

- 4. A SOCIO-ENVIRONMENTAL RISK ASSESSMENT TOOL – based on the determinants**

Population Health Model

Risk Factors

Elements—often behaviour patterns—that tend to predispose people to poor health

- Smoking, high fat diets

Risk Conditions

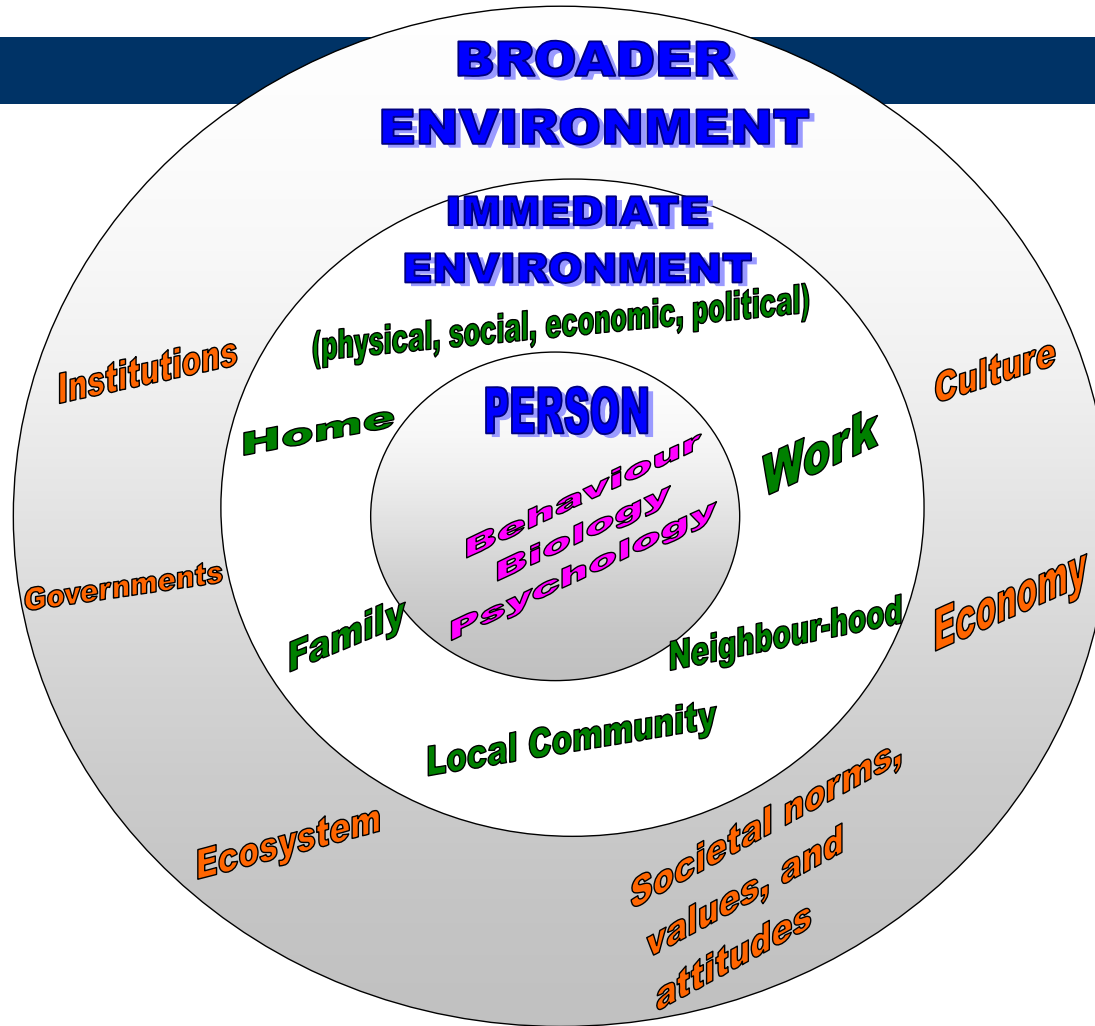
General circumstances, over which people have little or no control, that are known to affect health status

- Air pollution, street crime

Hamilton, N. & Bhatti, T. (1996). Population Health Promotion: An Integrated Model of Population Health and Health Promotion. Ottawa: Health Promotion Development Division.

DETERMINANTS OF HEALTH

A Systems Model



Health Determinants

- **Income & Social Status**
- **Social Support Networks**
- **Education**
- **Employment & working conditions**
- **Physical Environments**
- **Personal Health Practices & Coping Skills**
- **Healthy Child Environment**
- **Health Services**
- **Culture**
- **Gender**

BEST PRACTICES

5. Awareness, education, cross-training programs for staff from addiction, mental health, family violence, police, justice and medical agencies and organizations

AWARENESS EDUCATION AND TRAINING

Key Stakeholders: Organizations and program providers in Addictions, Mental Health and Family Violence have been trained in CODI principles and implementation as well as Best Practices.

There is **cross-training** as well as a **Trainer of Trainers** approach to training staff of these organizations and program providers to standardize screening and assessment tools, motivational interviewing techniques, intervention strategies, and program development and implementation.

BEST PRACTICES

6. A COLLABORATIVE CASE MANAGEMENT APPROACH WITH ALL AGENCIES AND ORGANIZATIONS INVOLVED

COLLABORATIVE CASE MANAGEMENT APPROACH

Key Stakeholders of the CODI initiative have signed a contractual agreement to implement standardized screening and assessment tools, referral processes, share resources and decision making as well as participate in cross-training programs forming a cadre of trainers throughout Manitoba who will conduct trainer-of-trainer programs in their respective organizations, agencies and health regions.

BEST PRACTICES

7. **SPECIFIC PROGRAM COMPONENTS IN EACH SYSTEM REFLECT THE CURRENT BEST PRACTICES INITIATIVES.**

7A. BIOPSYCHOSOCIAL APPROACH

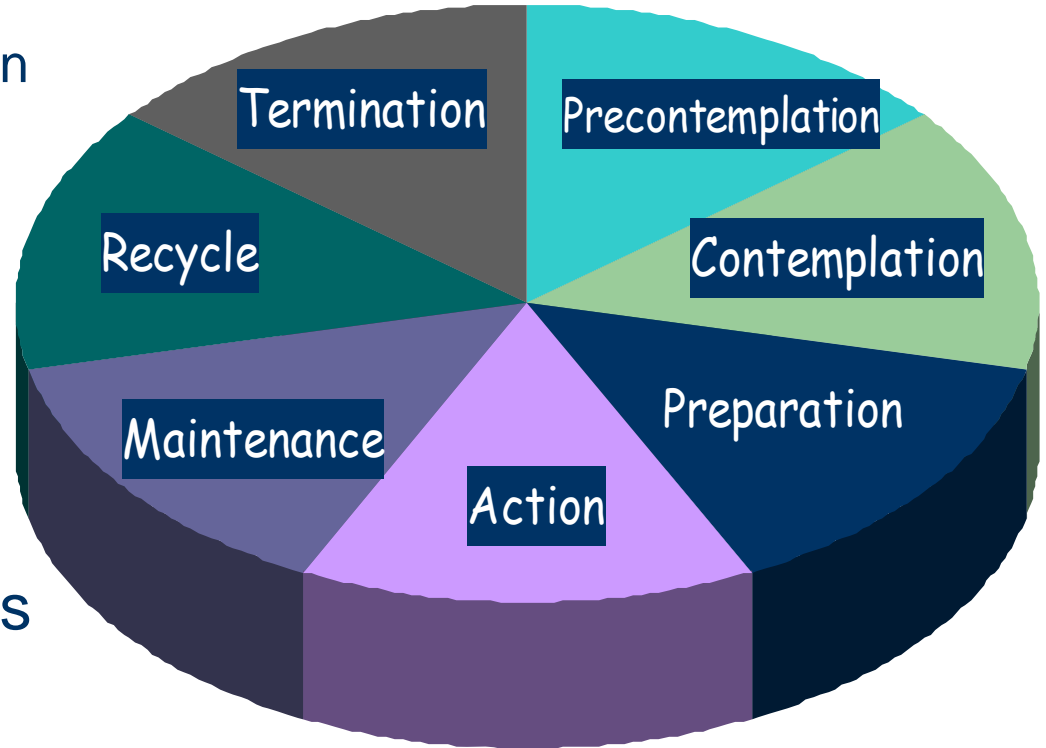
The Bio-psycosocial Model reflects the belief that addictive behaviours, mental health and family violence issues, problems and experiences arise from complex and ongoing interactions between various biological, psychological and socio-cultural forces.

The model focuses attention on the diversity of the individual needs by recognizing that the combinations, interactions and the weighting of specific contributing factors will be different for different individuals.

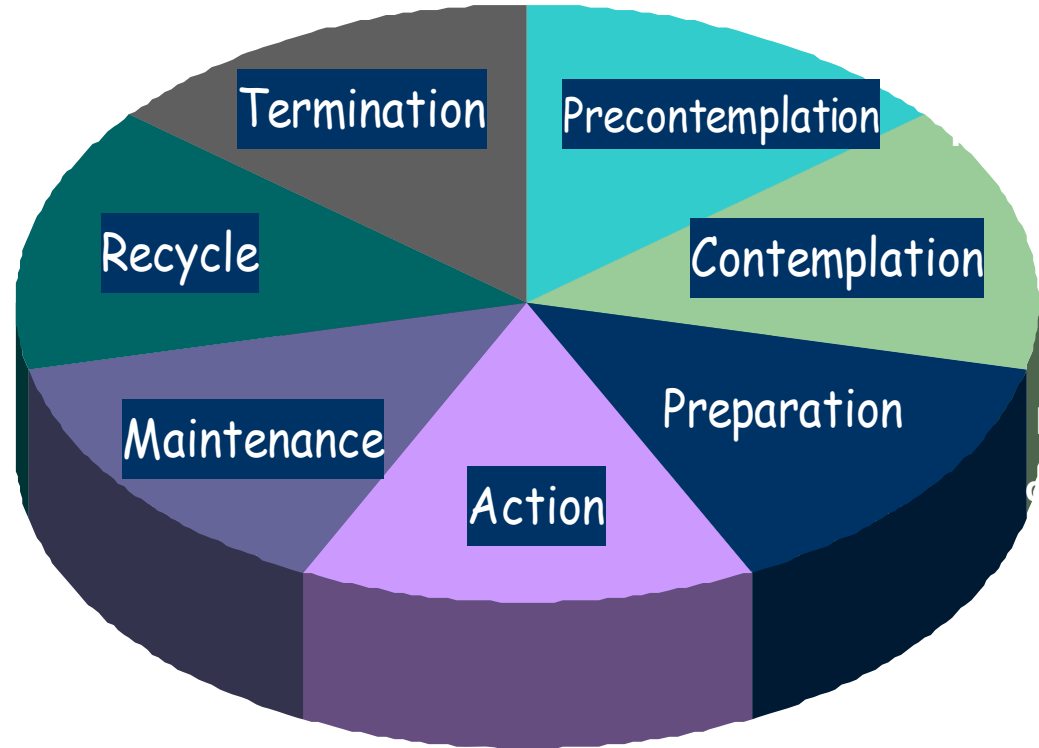
7B TRANSTHEORETICAL MODEL OF CHANGE

Developed by Prochaska, DiClemente & Norcross, in 1982

- Adapted from the book “Changing for Good”
- Emphasis is on change as a process



Stages of Change



7c MOTIVATIONAL INTERVIEWING & COUNSELING TECHNIQUES

Definition of Motivational Interviewing:

“A directive client centered counseling style for eliciting behavioural change by helping clients explore and resolve ambivalence”

Principles of Motivational Interviewing

- **Develop Discrepancy**
- **Avoid Express Empathy**
- **Argumentation**
- **Roll with Resistance**
- **Support Self Efficacy**

Techniques of Motivational Interviewing

- **Establish Rapport**
- **Open ended questions**
- **Listen Reflectively**
- **Affirm**
- **Summarize**
- **Elicit self motivational statements**

Establishing Rapport

1. Emphasize the questions are routinely asked of everyone.
2. Explain terms used by giving specific examples and have handouts with terminology available as part of the process.
3. Demonstrate comfort asking the questions and discussing the answers.
4. Demonstrate respect and interest in the person's responses.

CCISC PRINCIPLES

5. When substance use, mental health and family violence disorders/issues exist a CCISC which supports the provision of concurrent responses to all as primary disorders is recommended,
6. Substance abuse, mental health and family violence disorders tend to be persistent.
7. There is no one correct program or intervention
8. Outcomes for patients/clients need to be individualized.

Goals Of Rehabilitation Are To:

- Reduce involvement or harm associated with the addiction.
- Improve physical and/or psychological emotional functioning.
- Improve family and/or social functioning
- Improve employment and/.or vocational/educational functioning
- Reduce involvement with the criminal justice system.

7d Harm Reduction & Prevention/Rehabilitation Strategies and Programming

ADDICTION – AOD and Gambling

- **Gain client's agreement not to use AOD/s while in program**
- **Reduce frequency and amount of use**
- **Drink only on weekends**
- **Arrange for designated driver**
- **Leave Interac and credit cards at home**
- **Have daily withdrawal limit reduced.**

HARM REDUCTION STRATEGIES

Mental Health (*In Collaboration With physician*)

- Reduce dosage of Medication (*If feasible*)
- Avoid AOD's while on medication
- Consider taking medication to relieve anxiety, confusion, depression during withdrawal and early recovery
- Participate in family violence program or mental health program.
- Participate in a PTSD programming

HARM REDUCTION STRATEGIES

Family Violence - Abuser

Reduce level of abuse

1. Lower voice, restrict threatening gestures
2. Learn to recognize triggers
3. Strike inanimate objects, leave – time out

HARM REDUCTION Strategies

Family Violence – Abuser

Strategies to reduce stress:

- Participate in Anger and Stress Management programs
- Participate in Parenting programs
- Participate in AOD/Family Violence Programs
- Participate in PTSD Programs

Harm Reduction Strategies

Family Violence - Abused

- Develop Safety Plan
- Avoid using provocative labels/words/statements
- Seek legal protection
- Access – Shelter/safe place if verbal abuse escalates
- Participation in an AOD/Family Violence programming
- Participate in a PTSD Program

Harm Reduction Strategies - Both

Avoid emotional provocative discussions when:

1. Their partner has been using AOD's
2. Deliberately trying to engage partner in an argument
3. Has a hangover/in withdrawal

Avoid using provocative labels, words or statements at any time.

7D REHABILITATION PROGRAMMING

- **Social and Interpersonal Skills**
- **Communication skills & techniques**
- **Community Reinforcement Approach**
- **Marital and Family Counseling (where one or both partners behave abusively and where there are no legal issues)**
- **PTSD Programming (Seeking Safety)**
- **Relapse Prevention Strategies**

Rehabilitation & Continuing Care Issues

- *If a client believes they are in immediate danger or are concerned about returning to an abusive environment, the helping professional should respond to this situation before addressing any other issue.*
- **Timing**
- **Mental Health Issues**

Mental Health Issues - Gender

- Symptoms of PTSD and Depression may worsen as women achieve abstinence and is a major contribution factor in relapse.
- Addicted women showed relapse rates that were 3 to 4 times higher for clients with PTSD (Brown, Stout & Miller, 1999)
- Co-occurring problems indicates a much more complex and problematic treatment population (e.g. suicide attempts, criminal behaviour, relationship instability and violence).

Low Self-esteem and Guilt

- Females experiencing AOD problems are more likely to have experienced shame and guilt associated with their AOD use.
- Extremely interrelated with involvement in a number of unhealthy relationships
- Lesbian and bi-sexual women face internalized and external homophobia, social oppression and family conflict (Drabble & Underhill, 2002)

Relationship Issues

- Clients currently involved with an addicted and/or abusive partner may find it difficult to access and participate in a program of recovery.
- Partners may physically threaten the women if they continue with treatment and/or refuse to drink or use.
- When both partners are AOD users and mutually abusive, their AOD use is the relationship glue, giving a distorted sense of attachment to one another (Lauder et al., 1999).

FAMILY ISSUES

Although family relationships are unhealthy when one or more parents are using, experiencing mental health problems, and are abusive and/or violent, family members have been accustomed to certain roles and responsibilities within this system.

Family members therefore may resist or sabotage their partners recovery. *(There are more divorces/separations after person recovers than when actively using.)*

SEPARATE REHABILITATION SERVICES FOR WOMEN

- **Historically, rehabilitation programs have been written for men**
- **Women have been under-represented in alcohol treatment studies**
- **Women may more freely discuss issues of physical and sexual abuse, incest, sexuality and orientation, body image, and guilt and shame over child related issues and parenting concerns**
- **Women need a physically and emotionally safe environment**

WOMEN-ORIENTED REHAB

- **Reduce barriers to recovery from drug dependence that are more likely to occur for women**
- **Are delivered in a context that is compatible with women's styles and orientation, and is safe from exploitation**
- **Take into account women's roles, socialization and relative status within the culture.**

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- **Take into account women's roles, socialization and relative status within the culture.**

Integrated Rehabilitation

- All issues must be addressed at the start of rehabilitation. Relegating any condition to secondary status fosters denial and impedes the recovery process.
- Rehabilitation counselors should be screening all clients to determine whether they batter or are battered, or experiencing mental health problems. ***Failure to screen and intervene is professionally negligent.***

Benefits of an Integrated System

- **Enhances the confidence and competence of service providers.**
- **Creates inclusive empowering environments.**
- **Increases overall system efficiency.**
- **Enhances the quality of service, and research design.**

THANK YOU,

QUESTIONS???

- *CONTACT US.....*

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LEVELS OF INVOLVEMENT

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INTRODUCTION

In order to offer assistance to individuals with addiction problems, it is first necessary to be able to accurately describe those problems in a meaningful way. The meaning must be shared by the individual and the helper. There has been an evolution of terminology, definitions and directions within the addictions field in recent years, making communication about addiction issues less clear. What is the difference between an alcoholic and a problem drinker? Is there a difference? How do addicts differ from alcoholics? Is someone who spends too much time at the VLT's a pathological gambler?

Historically, prevention and rehabilitation services offered by addiction agencies focussed on disorders or conditions which were identified as illness or disease. The mandate of agencies such as the AFM was the prevention and 'treatment' of the illness of chemical dependency. However, the rapidly expanding knowledge base in the field of addictions, combined with the changing nature of service demands and customer needs over the past two decades, created an impetus for change in both the mandates of addictions agencies, as well as the services they offered. The addition of gambling services contributed to a re-examination of philosophies in an effort to achieve a coherent outlook. A new way of thinking about addiction necessitated a new 'language' to talk about it.

This module presents the new language developed by AFM, and a framework, incorporating that language, for understanding the range of alcohol and other drug use and gambling behaviours.

HISTORY AND RATIONALE OF DEVELOPMENT OF LEVELS OF INVOLVEMENT FRAMEWORK

In 1997, the AFM developed a framework to describe the range of individual gambling, alcohol or other drug involvement. This framework covers non-problematic to highly problematic involvement, and describes the various levels of involvement in terms of observable data or reported experiences. The focus is on consequences of involvement at different levels, rather than descriptions of frequency of use or perceived reasons for use. A focus on consequences is congruent with the Harm Reduction approach. The Levels of Involvement Framework (LOI) was officially adopted by AFM for use in all of its service initiatives in January 1998.

The term ‘involvement’ was chosen to reflect the concept of active participation--drinking, using drugs or gambling are activities which individuals engage in, rather than being passive recipients of. Involvement also denotes the present tense, indicating that the level of involvement may change over time, and does not remain static. Change in level of involvement reflects the actions of the individual.

Much of the commonly used terminology describing addictions has focussed on the *individual*, ie: ‘alcoholic’, ‘addict’ or ‘pathological gambler’. The LOI focuses on *behaviour* and avoids labelling people.

The LOI framework addresses an observation made by many front-line addictions counsellors. Most addictions services were designed to assist individuals who were dependently involved, ie: ‘alcoholics’, ‘drug addicts’, ‘pathological gamblers’. However, many people who present for services do not meet the description for dependent involvement, (to be outlined later), but still are experiencing problems in their lives related to their drug use or gambling. This constituted a gap in service.

This gap in service was further complicated by stigma. Many people believe the AFM, and other addictions agencies, only work with ‘alcoholics’, ‘addicts’ or ‘pathological gamblers’, and they do not want to self-identify with those labels. For example, a person may believe they must decide between either having no concern about alcohol at all, or that they are alcoholic. Many individuals who experienced problems related to their use of alcohol, such as family arguments or impaired driving charges, were not seeking or receiving assistance because they did not see themselves as ‘alcoholics’.

The LOI framework assists people to identify degrees of concern based on descriptive criteria, without limiting them to either 'being addicted' or 'having no problem.' The problem is defined collaboratively by the individual and the counsellor, using data derived from counsellor observation and the individual's self-reported subjective experiences. The framework is intended primarily to assist in the problem naming process which occurs in the context of helping conversations. The 'Problem Naming' process refers to the work counsellors do to assist people to describe, identify, and name (or label) their experiences. The distinction here is that in the case of 'diagnosis', meaning tends to be assigned by an 'expert', whereas with problem naming, meaning is negotiated or co-created by clients and counsellors working together.

INTENDED APPLICATIONS AND LIMITATIONS

The LOI framework is intended as a rudimentary guide to estimating approximate levels of involvement. Categories represent ranges of behaviour along a continuum and are characterized by a few descriptive statements intended to provide a general sense of range parameters. Category descriptions are neither completely inclusive, nor completely exclusive.

The LOI is not an assessment tool, but rather a tool to assist clients to identify where they see themselves, based on linking their behaviours to their levels of use.

In addition to information collected from the individual, information from collateral sources and objective data collection instruments may also be used to determine LOI.

LEVELS OF INVOLVEMENT FOR ALCOHOL, OTHER DRUGS & GAMBLING

LEVEL	DEFINITION
Non- Involvement	<p>Where a person has:</p> <ul style="list-style-type: none"> - never gambled, used alcohol or other mood/mind altering substances; or - chosen a non-involved lifestyle following some involvement
Irregular Involvement	<p>Where a person has:</p> <ul style="list-style-type: none"> - random or infrequent involvement, usually confined to specific occasions or situations - little or no evidence of any harmful or adverse consequences (includes experimental involvement, defined as trying a substance or gambling activity once or several times)
Regular Involvement	<p>Where a person has:</p> <ul style="list-style-type: none"> - regularly recurring involvement (patterns evident) - some evidence of adverse, related consequences may be apparent (typically minor or isolated) <p>(Often characterized by individuals who actively seek involvement, or where involvement has become a regular feature of their lifestyle)</p>
Harmful Involvement	<p>Where a person has:</p> <ul style="list-style-type: none"> - evidence of recurring adverse consequences, for example: <ul style="list-style-type: none"> -failure to fulfil major role obligations at home, school or work - financial or legal problems <p>(continued involvement despite repeated or persistent problems, in one or more life areas, which are caused by or made worse as a result of the involvement)</p>

<p>Dependent Involvement</p>	<p>In addition to the characteristics of Harmful Involvement, at this level, involvement tends to be patterned and is characterized by particular features:</p> <ul style="list-style-type: none"> - the individual experiences a physiological and/or psychological need for continued involvement; and - the individual experiences some loss of control over his/her involvement <p>Evidence of dependent involvement may include:</p> <ul style="list-style-type: none"> - impaired control <ul style="list-style-type: none"> - levels of involvement frequently exceed original intentions - several unsuccessful efforts have been made to cut down or otherwise control involvement - the individual experiences a compelling need to continue involvement - preoccupation <ul style="list-style-type: none"> - increasing amounts of time, money and energy are devoted to activities related to maintaining involvement or recovering from it - individual has given up or has significantly reduced involvement in other previously valued activities - adverse consequences <ul style="list-style-type: none"> - involvement is continued despite the individual's knowledge that the persistent physical, mental, social or financial problems they experience likely have been caused or made worse as a result of the involvement - the individual attempts to cope with losses through continued involvement - withdrawal distress <ul style="list-style-type: none"> - the individual experiences physical or mental distress as a result of abstaining from involvement and may continue involvement in order to avoid experiencing that distress - progression <ul style="list-style-type: none"> - increased levels of involvement (frequency, quantity or duration) are required over time to achieve or maintain the desired effect
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<p>Transitional Abstinence</p>	<p>Where an individual with past involvement at harmful or dependent levels:</p> <ul style="list-style-type: none"> - has chosen to abstain from alcohol, other drugs or gambling, but has yet to achieve a sense of comfort with, or confidence in, that decision - although usually regarded as a positive step toward personal growth and development, it is at the same time often characterized by some apprehension, anxiety, ambivalence or uncertainty - will typically occur in relation to the Action stage of change, but could occur at other stages of change <p>(it should be noted that although transitional abstinence may occur as an initial period of abstinence prior to the achievement of a more stabilized abstinence, periods or episodes will also occur in conjunction with harmful or dependent levels of involvement. In fact, one of the characteristic features of dependent involvement is the occurrence of repeated, unsuccessful attempts to abstain)</p>
<p>Stabilized Abstinence</p>	<p>Where an individual with past experience at harmful or dependent levels:</p> <ul style="list-style-type: none"> - has chosen to abstain from alcohol, other drugs or gambling <i>and</i> has achieved a sense of comfort with decision, or a measure of confidence in the ability to maintain an abstinent lifestyle - will occur in relation to the Maintenance stage of change

Note: Although linear in appearance, the continuum is not intended to imply that client changes will always involve movement in only one direction or movement to the next sequential level. People can and do move back and forth along the continuum. Similarly, it is not intended to imply that Abstinence (last 2 levels) is the only option for successful risk reduction or risk management.

Abstinence is the recommended course of action for individuals who have reached a dependent level of involvement.

PROBLEM DESCRIPTION VS. RISK ASSESSMENT

The LOI framework was designed as a descriptive tool. It describes the current pattern of behaviour as well as identifies the consequences of that behaviour that have already been, or are currently being, experienced by the individual—problem description.

Risk assessment is more complex. Risk is defined here as the possibility of future adverse consequences. Degree of risk may vary considerably across individuals determined to be at the same level of involvement. Risk, therefore, should be assessed independent of the level of involvement. Assessment of risk involves consideration of the Determinants of Health (See Section I, Module 2) and the impact each Determinant *may* have on the individual in the future.

The Levels of Involvement Framework is NOT used to assess risk.

ADVANTAGES OF LOI

The LOI is equally applicable to alcohol, other drug, and gambling involvement. It is not based on any single theory of causation, and thus can be adopted for use by service providers who work from a number of theories and ideologies. The LOI, however, is not only for professionals. Clients, after having the LOI explained to them may self-identify their level of involvement at a given point in time.

When used to support the assessment process, the continuum will allow for changes in assessment over time, reflecting an individual's progress or regress. It can help clients see what they are doing that is helpful or not helpful in achieving their target behaviour changes.

The LOI framework is compatible with a range of desired outcomes, including non-abstinence goals. It can be used in harm reduction programming.

From an administrative point of view, the LOI framework provides a common language and reference base for inter-program communication and is practical for data collection and reporting.

The LOI framework does not rely on quantitative measurements, such as number of drinks a person consumes or how much money someone loses at gambling, to assess severity of problems. Rather, it focuses on the negative impact behaviour has on an individual's life. It relates personal consequences to personal behaviours. Determination of level of involvement therefore becomes an individualized process, rather than a comparison to some predetermined standard that a person either passes or fails. Use of the LOI facilitates client centred service.

HARMFUL USE OR ACTIVITY VS. HARMFUL INVOLVEMENT

The occurrence of any adverse consequence is evidence of harmful use/activity. Harmful use may be an isolated incident which occurs at a regular or irregular level of involvement. Many people experience harmful use at one time, but once they experience the negative consequences, (ie: hangover, loss of too much money, impaired driving charge) they re-evaluate their actions and change their behaviours to avoid future risk. Isolated incidents of harmful use may result in serious consequences and may precipitate some form of intervention, even though the individual may only have irregular or regular involvement, (ie: court mandated referral to the Impaired Driver's Program).

When the behaviour continues, despite recurring adverse consequences, this is indicative of harmful involvement. Harmful involvement is repeated harmful use/activities over time.

INDICATORS OF HARMFUL INVOLVEMENT

Indicators of harmful use are the adverse consequences individuals have already experienced or are currently experiencing due to their addictive behaviour. They are not potential consequences that may occur if the behaviour continues, (as used to determine level of risk). And they are not pre-existing conditions which place individuals at increased risk for developing addiction problems, (pre-disposing factors). It is important to distinguish between these terms. Indicators are used to determine current level of involvement.

Adverse consequences of drug use or gambling activity may be noticeable across many areas of an individual's life. For ease of discussion and to facilitate awareness within clients, life areas have been compartmentalized into six major categories: family relationships, social relationships and activities, physical and emotional health, occupational or educational performance, involvement with the legal system, and addiction specific behaviours. The 'Life Areas' chart lists some examples of indicators of problems which may be related to addiction issues. Part of the assessment process for a counsellor and client is to determine which of the problem indicators are related to the addictive behaviour, and how they are related.

Recent research has begun to look at consequences of drinking behaviour and rank them along a progressive scale, (Vik et. al., 2000). Based on a literature review and a study of college students who reported heavy drinking episodes, (5+ drinks per occasion) the authors suggest that certain consequences are associated with 'more' harmful involvement than others.

The consequences were grouped into three categories: common events related to drinking, less frequent consequences, and uncommon problems. The common consequences involved ‘careless behaviours’ such as: missing class, arguing with friends, forgetting where you were or what you did. Less frequent consequences involved ‘risky or reckless behaviour’—unprotected sex or unplanned sex, impaired driving. Those consequences that were uncommon involved conflicts with authorities such as trouble with campus police or arrests related to alcohol or drug use. The authors suggest that there may be meaningful distinctions between heavy drinkers, based on the consequences experienced, and that these distinctions could have implications for intervention. More research is needed.

DEPENDENT INVOLVEMENT

The operational description of a dependent level of involvement within the framework is based on diagnostic criteria for Substance Dependence Disorder and Pathological Gambling Disorder, established by the American Psychiatric Association in their publication DSM-IV, (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, 1994). The AFM recognizes that the definitional and diagnostic standards set forth in the DSM-IV are intended for use by licensed medical/psychiatric practitioners only. Non-medical clinicians at AFM use the descriptions contained in the framework, and do not diagnose.

Dependent involvement is characterized by ongoing harmful use, despite negative consequences, plus some combination of the following experiences: progression, withdrawal, loss of control, and preoccupation, as described in the framework. ‘Withdrawal’, ‘loss of control’ and ‘preoccupation’ are all familiar terms within the addictions field. ‘Progression’ is less often used.

‘Progression’ is an inclusive term. With chemical addictions, the clinical term ‘tolerance’ is used to describe a need for increased amounts of a substance to achieve a desired effect or intoxication. The term cannot be applied, however, to describe a similar gambling experience--the need to gamble with increasing amounts of money in order to achieve the desired excitement. In LOI, therefore, the term ‘progression’ is used to reflect both experiences. Progression is a key element in dependent involvement.

INDICATORS OF DEPENDENT INVOLVEMENT

As per the chart, indicators of dependent involvement include evidence of harmful involvement (ie: continued involvement despite repeated or persistent consequences in one or more life areas) plus evidence of some of the following: impaired control, preoccupation, withdrawal distress, and/or progression.

Dependent Involvement is not determined simply by the number of negative consequences and individual is experiencing, or by the severity of those consequences. There must also be evidence of one or more of the other four indicators.

TRANSITIONAL & STABILIZED ABSTINENCE

The LOI framework includes categories of involvement that extend beyond the range of other, traditional classification systems. Transitional and stabilized abstinence reflect qualities of behavioural non-involvement, but have been added to the opposite end of the continuum to depict abstinence as qualitatively different from Non-Involvement.

In the addictions field, abstinence is most often recommended as the ultimate behaviour change goal for individuals whose involvement has reached a dependent level. The achievement of abstinence is viewed as a process of trial, error, learning and evolving confidence and self-efficacy. Transitional abstinence is described in a way that reflects less stability, greater personal discomfort and lack of confidence in exercising self-control. Stabilized abstinence is described as involving individual perceptions of greater, more realistic self-confidence. It occurs later in the learning curve and is associated with long-term efforts to achieve abstinence.

The AFM does not view abstinence as the only option for problem resolution open to those who may consider themselves as being involved at harmful or dependent levels. In most cases where continuing harmful or dependent involvement is evident however, it is likely that abstinence would be encouraged as the favoured option or goal for individuals. At the very least, this would likely be recommended as a short-term, therapeutic objective.

LIFE AREAS CHART

Family	Social	Physical/ Emotional	Occupational/ Educational	Behaviour	Legal
<input type="checkbox"/> Quarrels over use/ gambling <input type="checkbox"/> Physical/ Emotional abuse <input type="checkbox"/> Decreased socializing with friends <input type="checkbox"/> Divorce <input type="checkbox"/> Withdrawal by children <input type="checkbox"/> Reluctance to bring friends home <input type="checkbox"/> School behavioural problems in children <input type="checkbox"/> History of addiction/rigid abstinence <input type="checkbox"/> Broken home <input type="checkbox"/> Children leaving home <input type="checkbox"/> Signs of Fetal Alcohol Syndrome/ Effects <input type="checkbox"/> Financial worries	<input type="checkbox"/> Loss of interest in activities not associated with use/gambling <input type="checkbox"/> Not seeing usual friends <input type="checkbox"/> Seeking out new friends with similar patterns <input type="checkbox"/> Marked behaviour/ personality change after use/gambling <input type="checkbox"/> Irritability <input type="checkbox"/> Sensitive to comments about behaviours <input type="checkbox"/> Inappropriate phone calls <input type="checkbox"/> Poor judgment <input type="checkbox"/> Inability to concentrate; memory impairment	<input type="checkbox"/> Hangover (malaise, red eyes, hand tremor) <input type="checkbox"/> Alcohol or mouth wash on breath <input type="checkbox"/> 'Accident prone' i.e. fractures, cuts, burns <input type="checkbox"/> Vague minor complaints <input type="checkbox"/> Blackouts <input type="checkbox"/> Injuries, especially where treatment is delayed 24 hours <input type="checkbox"/> Hospitalization for peptic ulcer, gastritis, pancreatitis <input type="checkbox"/> Bladder problems due to lengthy urine retention <input type="checkbox"/> Back pain <input type="checkbox"/> Injection site abscesses <input type="checkbox"/> Weight loss <input type="checkbox"/> STD's <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Less concerned about appearance	<input type="checkbox"/> Work pace more spasmodic <input type="checkbox"/> Avoiding boss/ associates <input type="checkbox"/> Neglecting details formerly attended to <input type="checkbox"/> Job changes (frequently) <input type="checkbox"/> Frequent absences from work <input type="checkbox"/> Disappears in afternoon <input type="checkbox"/> Neglected household tasks <input type="checkbox"/> Failing grades <input type="checkbox"/> Frequent absences from school <input type="checkbox"/> Garnished wages <input type="checkbox"/> Loss of interest in hobbies/ volunteer work /extra curricular activities	<input type="checkbox"/> Shifting from one alcoholic beverage to another <input type="checkbox"/> Urgency to begin the activity <input type="checkbox"/> Admits behaviour is more than peer group <input type="checkbox"/> Uses/gambles to relieve anger, depression etc. <input type="checkbox"/> Repeated conscious efforts at abstinence <input type="checkbox"/> Blatant, indiscriminate use of alcohol/drugs <input type="checkbox"/> Using/Gambling alone <input type="checkbox"/> Hiding bottles/lying to cover up debts <input type="checkbox"/> Using before going to a social function <input type="checkbox"/> Not knowing how many drinks one has had <input type="checkbox"/> Not knowing how much has been spent <input type="checkbox"/> Sharing needles <input type="checkbox"/> Suicide thoughts or feelings <input type="checkbox"/> Looking forward to or planning next use	<input type="checkbox"/> Driving under the influence <input type="checkbox"/> Frequent auto accidents <input type="checkbox"/> Other offences i.e. assault disorderly conduct, property crimes, public drunkenness, reckless driving <input type="checkbox"/> Referral to an Alcohol Safety Program <input type="checkbox"/> Under-age purchase of alcohol <input type="checkbox"/> Embezzling funds <input type="checkbox"/> Writing bad cheques <input type="checkbox"/> Drug possession charges

(Adapted from: NIAA (1978). The Community Health Nurse and Alcohol-Related Problems. Rockville, MD: Author)

SUMMARY

In this module, the framework used by AFM to categorize individual involvement with alcohol, other drugs, and gambling was presented. This framework implies a continuum of involvement that may change over time. Such changes may occur in either direction—towards more involvement with increased harmful consequences, or towards less involvement with fewer harmful consequences.

The LOI describes, rather than measures, involvement. This means that the categories of the framework describe the pattern of use of an individual, as well as the behaviours and the consequences associated with that pattern. The categories do not count drinks, doses or amount spent.

A special feature of the LOI framework is that it is intended to be applied separately to each drug of choice or gambling activity. Therefore, an individual is not a ‘drug addict’, but may be dependently involved with cocaine, regularly involved with marijuana, irregularly involved with LSD, and non-involved with all other drugs, including alcohol.

A strength of using the LOI framework is having the descriptions of behaviour. These descriptions give concrete examples of what can be changed. It is difficult to change thoughts and feelings associated with alcohol and other drug use and gambling, but it is easier to change concrete behaviours.

The next module outlines a model of behaviour change that fits well with the LOI framework.

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THE STAGES OF CHANGE

Adapted from the AFM STAGES OF CHANGE Participant Resource Course Manual
2004

WHAT ARE THE STAGES OF CHANGE?

People with problems usually tackle them in the same way. Initially, they ignore the problem; then they think about it and consider doing something about it; later they make definite plans to change. Eventually, they gather resources--internal and external--and take action, making changes. If successful, they then work at maintaining the change. If unsuccessful, they may give up for a period of time before trying again, with a new plan. This process is characterized by six distinct stages:

- ◇ Precontemplation
- ◇ Contemplation
- ◇ Preparation
- ◇ Action
- ◇ Maintenance
- ◇ Termination

It is best if people complete one stage before moving on to another, in order to minimize the occurrence of problems. Sometimes people get stuck in one stage and do not progress. At other times they regress, or stop trying to change and move back to a previous stage. Regression is call 'recycling' in this framework.



PRECONTEMPLATION STAGE

The individual is not considering making any change as there is no perceived need for change.

The most important thing to keep in mind when speaking to people in the precontemplation stage is that *others* think they have a problem, but *they do not*. If there is a problem, it is not self-identified. Most people in this stage want to change the others in their lives, not themselves. Generally, they have come for service as a result of pressure from others--family, courts, or employers. Once the pressure is relieved, they will return to old ways of thinking and behaving if they do not move on to the next stage of change. It is in the precontemplation stage where the risk is highest for dropping out of rehabilitation programs and plans.

The person in the precontemplation stage may present in two ways--the individual may have no awareness of a problem and thus feel no need to change; or they may have some awareness, but as yet have not felt a need to change. In some cases, the person in the precontemplation stage may have some vague goal to change in order to 'prove' to others that their alcohol or other drug use, or gambling is not problematic.

People will remain in the precontemplation stage without some external force moving them. This force may be an age related change ie: maturation; a sudden event; or pressure from others. The encouragement of family and others for individuals to seek assistance, and the subsequent efforts of counsellors can be integral to ultimate successful change efforts. For this reason we do not wait until a person has 'hit bottom' before offering assistance. If counsellors wait until there is a change in attitude, ie: "come back when you're ready to do something," that occasion may never happen. The person's situation may result in the development of increasingly painful and ineffective beliefs and behaviours. They may become so demoralized and debilitated, they will not care about change, will not know where to begin, or may not even have the ability to begin.

As people in the precontemplation stage become more aware of the problem they become more receptive to the idea of change. For all other stages of change the question the person asks is, *what kind of help do I need?*; in this stage, the individual's question is *whether any help is needed at all*. The longer people wait, the harder it is to change as thoughts and behaviours become entrenched. Society does not wait for people to 'hit bottom' or for their attitude to change with problems such as heart disease, diabetes, or

cancer. When the symptoms appear, others exert pressure for the person to see a doctor. The doctor then works with the individual on the problem regardless of what stage of change the person is in, provided they show up for the appointments. This concept of stage appropriate intervention is equally applicable in the addictions field.

People in the precontemplation stage of change need to be reassured that they will not be pressured into changing. It would be most helpful to engage them to identify the harms associated with their behaviour.

What Kind of Precontemplation?

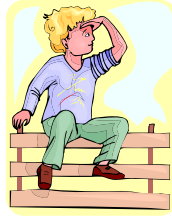
People in **precontemplation** are either unaware of problem behaviour or are unwilling or discouraged when it comes to changing it. As clinicians our challenge is to learn why our client may be resistant to change and to use strategies that diffuse that resistance in a positive way.

Reluctant Precontemplation: Through lack of knowledge or perhaps inertia, these people do not want to consider change. It may be that they are fearful of change, or perhaps they are comfortable where they are and don't want to risk the potential discomfort of change. For these clients, careful listening and providing feedback in a sensitive, empathic manner can be very helpful.

Rebellious Precontemplation: Often have a great deal of knowledge about the problem behaviour. They are invested in the behaviour, and in making their own decisions. They do not like being told what to do! It is easy to recognize the person in rebellious precontemplation—they will let you know that they don't want to be there. Providing a menu of options seems to be the best strategy for working with these people. The real challenge is to shift some of the energy invested in the behaviour into contemplating change.

Resigned Precontemplation: These clients have given up on the possibility of change and seem overwhelmed by the problem. Instilling hope and exploring barriers to change are the most productive strategies for those people in resigned precontemplation. Build confidence a bit at a time by assisting them in making the decision to begin with a small change and affirming each success they have, however small.

Rationalizing Precontemplation: These clients are not considering change because they often think they have figured out the odds of personal risk or believe that their behaviour is the result of another's problem, not theirs. They will engage in point-counterpoint debate. While it may feel like resistance, rationalizing is more about thoughts, while resistance is more about emotion. Empathy and reflective listening is the best way to help these people. Starting with a decisional balance is excellent. Have the client start listing the good things.



CONTEMPLATION STAGE

The person is thinking about making some changes.

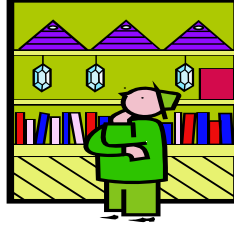
In order to move to this stage, the person has to have received adequate information about their behaviour, and identified a personal connection to the information. This allows them to consider change. The individual is now thinking about making some changes, but may be a long way from making a commitment to change. Being in the contemplation stage is more stressful than being in the precontemplation stage because the person is beginning to admit there is something significantly wrong, and they are feeling ambivalent about changing.

The nature of being in the contemplation stage is to know what the goal is, maybe even have a general idea of how to attain it, but not be ready yet to commit to the process involved in achieving the goal. The person in the contemplation stage may have indefinite plans to take some kind of action within the next six months. It is common for people in this stage to think for years about making a change. The length of time spent in the contemplation stage varies with the complexity of the person's problems, as well as the amount of introspection and understanding that has previously been achieved. This stage may best be visualized as 'fence sitting'.

This stage is characterized by a feeling of being stuck. Individuals have an awareness of their problem, and are struggling to understand it more fully--its causes and possible solutions. Many people with addiction issues remain stuck because they believe there is a great deal to give up if they change. The desire to change exists simultaneously with the desire to remain where they are. Fear of failure and fear of the unknown are key factors in the ambivalence. People seem to "want to have their cake and eat it too." That is, they would like to continue to live as they have, but to experience no consequences. In the contemplation stage, people are eager to talk in order to explore and fully understand their problem. They are weighing the pros and cons of change in order to make a decision.

Movement in this stage is marked by two changes: 1.) focussing on the solution rather than the problem; and 2.) thinking more about the future than the past.

People in the contemplation stage of change need to have their desire to quit the behaviour and their desire to continue the behaviour acknowledged. Then they can be encouraged to realistically assess the risks associated with continuing the behaviour.



PREPARATION STAGE

The person is preparing and becoming determined to make changes.

People in this stage are actively getting ready for change. The preparation stage takes people from the decision to change, made in the contemplation stage, to the specific steps required to make their change in the action stage. The individual is committed to taking action within the next month. The success of long-term change depends on what is done during the preparation stage.

Although the individual commits to change in this stage, they may not have resolved their ambivalence yet. People in this stage will continue to re-evaluate themselves and their problem, but will become increasingly confident about their decision to change. Their focus has shifted to solutions rather than the problem and they will be making the final necessary adjustments before they begin their behaviour change. These activities ready people to handle unexpected challenges and may involve certain tasks that make up the first steps to action.

There are three major tasks individuals complete while in the preparation stage. One is to fully answer the question “Why am I doing this?” Answering this resolves the ambivalence. The second is to develop a detailed plan of how they will do it. The third is to help prepare significant others in their lives for the change they are about to make. Preparing others is one way to elicit helping relationships. Making public their intent to change is an important step in the process of commitment.

A common danger for changers is moving to the action stage prematurely, before being fully ready. Such a move ultimately lowers the chance of success. Time should be taken to develop careful, detailed plans for action. The individual is not ready to move into the action stage until change becomes their highest priority. Near the end of this stage, many feel anxious because change is threatening. No matter how serious the problem is, there is comfort in the known routine. It is important that people be allowed to experience this distress, for without it, no real commitment will be made. It is a very high-risk period for individuals with anxiety. They may return to problem behaviour, ie: alcohol, other drugs, or gambling, to relieve the anxiety.

People in the preparation stage of change often get stuck on information and believe that thinking is action. Having them complete the 3 major tasks helps them to begin action.



ACTION STAGE

The person is actively making changes through modifying behaviours.

This stage is marked by overt, obvious changes in behaviour. People begin to eliminate some behaviours, modify others, or introduce new ones. Change may involve a combination of all three. Changes of behaviour in the action stage, because they are the most visible, most frequently gain recognition from others. This stage is not the only time of progress, however. Action is only one stage of change. Alterations in thought, awareness, emotions and self-image occur in preceding and following stages and are just as important to overall success. It is vital that those involved in helping relationships with people trying to make change remember this, and encourage, as well as acknowledge, progress in all stages.

The action stage, of all the stages of change, requires the most commitment of time and energy. In the first month or two, it is also a likely time for resumption of old behaviours due to feelings of being overwhelmed by the amount of effort involved. Skill development is crucial during the action stage.

People in the action stage may experience an increase in self-esteem because they are acting on their own belief that they 'can do it'. They are ready for change and get impatient with people who talk to them about the pros and cons of what they are doing.

People in the action stage of change need support and reassurance as they face unknown situations with new, untried skills.



MAINTENANCE STAGE

The person is consistently maintaining changes made over an extended period of time.

In this stage, people maintain changes made in previous stages, and build on them. Continued work is required to consolidate gains. Successful change means change that is sustained over a long period of time, often a lifetime.

The maintenance stage is characterized by achievement of a change goal that then becomes a permanent part of the person's life. It is no less important than the action stage, and is often more difficult. There are negative conditions and circumstances that can lead to erosion of commitment to sustained, long-term effort and revised lifestyle. It is another busy and active period of change that requires learning new coping mechanisms. Many changers succeed in the short term. Changes that last only for short periods of time are usually a result of action taken without a maintenance strategy. Change never ends with action.

People in the maintenance stage have concerns about high-risk situations or environmental temptations. True maintenance, however, includes weathering new situations that require new and adaptive problem solving.

Without strong commitment to maintenance and recognition of how important continued work is, there will be setbacks. Rehabilitation programs that do not have a strong maintenance component contribute to backsliding by the people who attend them. For this reason, many rehabilitation services strongly encourage membership in ongoing support groups. Early in the maintenance stage, fear may wear off and change may no longer be a primary focus--people let their guard down somewhat. All of these factors can lead to complacency.

The maintenance stage involves a series of tasks; time in which to try them; and energy and dedication, just as all previous stages. It must not be forgotten that former behaviours will continue to hold some attraction for long periods of time, or during stressful occasions. This attraction may include a sense of longing and feelings of deprivation. The maintenance stage for complex problems, such as addictions, lasts a minimum of six months and as long as a lifetime.

People in the maintenance stage of change are still vulnerable to situations that can trigger the old behaviour. Self-efficacy can be built by assisting them to use the new skills they have learned to handle on-going temptations.



TERMINATION STAGE

The person no longer needs to attend to the task of maintaining the change.

The termination stage is the ultimate goal for all people making changes. In this stage, the former problem no longer holds any temptation or threat; there is knowledge that behaviours will not return; and there is confidence in one's ability to cope without recycling. Termination means exiting the spiral of change.

Some people say individuals with certain problems can never reach termination, but will remain for a lifetime in maintenance, though a less wary level of maintenance as time progresses. In the case of alcohol, other drug and gambling addictions, for some changers, this point may have validity. However, it is equally true that many, if not all new behaviour, attitude and lifestyle changes can become permanent and comfortable for these people.



THE PHENOMENON OF RECYCLING

The individual moves back to an earlier stage of change.

Recycling is not a stage, but rather a process that can occur while an individual is working at any of the stages of change. Recycling occurs when, having made progress to later stages of change, the individual resumes old thought patterns and behaviours associated with their problem. The term 'recycle' implies an opportunity to learn. During a period of recycling the individual returns to a previous way of thinking about or approaching the behaviour. For example, someone who had stopped attending casinos begins to question whether they really have a gambling problem. They may need to try to resolve the ambivalence. This would be recycling from action to contemplation.

When people are consciously aware that they have recycled, the feelings that are most often experienced are guilt and disappointment. The person may feel so demoralized that they return all the way to the precontemplation stage. They may become defensive and try to avoid addressing the issue of the return to a previous stage of change. The vast majority of people who recycle, however, do not give up on themselves and their ability to change. Most return to the contemplation or preparation stages, relatively close to making commitments to renewed action.

Although recycling is not a goal, it is not the end of the world. In fact, it is more common than not. If viewed as a learning experience, it may be a case of taking one step backward in order to take two steps forward. After a period of recycling, most people benefit from taking the time to engage in some self re-evaluation, to learn from their recent mistakes.

For people who have recycled, it is important to resume the change efforts by attending to the tasks that go with the stage of change the individual has recycled to, and not simply pick up where they left off before.