www.takingtheescalator.com

Chapter 1 – Background: Understanding the Escalator Methodology Basics, First from a Theoretical Perspective:

"If I have seen further than others, it is by standing upon the shoulders of giants" *- Isaac Newton*

Before we get into the tools of engagement, it is helpful to understand the method behind it all. The Escalator method is all about meeting people where they are and building motivation and insight upward from there. The Escalator method is so effective because it is based on four established evidence-based treatment practices. If you are already familiar with one or more of these practices then you are at an advantage when it comes to using the Escalator to help your clients. Nevertheless, you do not have to be an expert in these areas as this manual will walk you through the essential aspects of each evidence-based practice that the Escalator is founded upon. The four evidence-based practices that form the pillars of the Escalator method are:

- **Motivational Interviewing** – (William R. Miller, PhD. And Steven Rollnick, PhD.) – https://en.wikipedia.org/wiki/Motivational_interviewing

Click here to read the Motivational Interviewing Overview
on the Escalator Website – (Once on the website, scroll down and click "MI")

- **The Stages of Change Model** – (aka the Transtheoretical Model – James O. Prochaska and Carlo DiClemente) – https://en.wikipedia.org/wiki/Transtheoretical_model

Click here to read the Stages of Change Overview
on the Escalator Website – (Once on the website, scroll down and click "Stages of Change")

- **Cognitive Behavioral Therapy** – Two of the earliest forms of Cognitive behavioral therapy were Rational Emotive Behavior Therapy (REBT), developed by Albert Ellis in the 1950s, and Cognitive Therapy, developed by Aaron T. Beck in the 1960s. - https://en.wikipedia.org/wiki/Cognitive_behavioral_therapy

Click here to read the Cognitive Behavioral Therapy Overview
on the Escalator Website – (Once on the website, scroll down and click "CBT")

- **Harm Reduction –** "A range of public health policies designed to reduce the harmful consequences associated with various human behaviors, both legal and illegal" - https://en.wikipedia.org/wiki/Harm_reduction

Click here to read the Harm Reduction Overview
on the Escalator Website – (Once on the website, scroll down and click "HR")

An Important "Umbrella" -
An Integrated Approach to
Co-Occurring Disorders and other Coexisting Issues:

These four evidenced based treatment practices, *(Motivational Interviewing, Stages of Change, Cognitive-Behavioral Therapy, and Harm Reduction)* are all to be used under the expanded umbrella of an additional evidence-based perspective: *Integrated Care for Co-Occurring Disorders*. In its simplest terms, Co-Occurring disorders is "the coexistence of both a mental health and substance use disorder" - https://www.samhsa.gov/disorders/co-occurring - (If this or any other SAMHSA link does not work directly, cut and paste into browser)

The prevalence of co-occurring mental health disorders that are often present along with substance use issues is well documented. See below, the following excerpt from the US Substance Abuse and Mental Health Services Association (SAMHSA) website:

> "SAMHSA supports an integrated treatment approach to treating co-occurring mental and substance use disorders. Integrated treatment requires collaboration across disciplines. Integrated treatment planning addresses both mental health and substance abuse, each in the context of the other disorder. Treatment planning should be client-centered, addressing clients' goals and using treatment strategies that are acceptable to them. Integrated treatment or treatment that addresses mental and substance use conditions at the same time is associated with lower costs and better outcomes" - http://www.samhsa.gov/treatment

Therefore, the key aspect of taking an effective approach to co-occurring disorders is to view both substance use issues and mental health issues in an integrated manner.

Integrated: adj. –

- Combining or coordinating separate elements so as to provide a harmonious, interrelated whole
- Organized or structured so that constituent units function cooperatively

The Escalator method emphasizes the importance of full integration of all relevant client issues into the treatment matrix. This means looking at the whole person and always keeping in mind the variety of life issues and problems that may affect one another in an interrelated manner. Taking this as step even farther, the Escalator goes beyond just the traditional meaning of "Co-Occurring Disorders" (COD) which emphasizes the relationship primarily between substance abuse and mental health. The Escalator uses the term *Coexisting Issues* (COI) which is a much broader perspective that takes into account much more than just mental health and substance use. This broader perspective stresses the inclusion of not just mental health and substance abuse but also medical concerns, employment, housing, and any other life issues that may be impacting a person's functioning.

To understand more, please read the following background information on Coexisting Issues, which really defines what COI's are all about: (Excerpt from Taking the Escalator; An Alternative to the 12 Steps)

Click here to read "What are Coexisting Issues?"
(Once on the website, scroll down and click "Intro to Coexisting Issues")

In summary, the umbrella of coexisting issues, should thoroughly permeate all aspects of the treatment process from start to finish and beyond. Substance abuse does not come about nor does it manifest itself in people's lives in a vacuum. Therefore substance abuse treatment needs to fully avoid the outdated "tunnel vision" approach of isolating the addiction as the one cause and effect for all other life problems. In reality, we all are complex, multi-faceted and unique individuals. Who we are at any point in life is a direct function of our own experiences, education, upbringing, beliefs, circumstances, ailments, strengths, weaknesses and many, many other factors; some based on our choices and preferences yet many other areas completely beyond our control (such as genetic predispositions as one example). Therefore, true, person-centered treatment needs to be sensitive to the wide array of coexisting issues that may impact lives.

Why Use this Combined Approach of Evidence Based Practices? (EBP's)

Evidence-Based Practices (EBP) are so effective because they are appropriately named in that these treatment approaches have been clinically proven (based on evidence) to have positive treatment outcomes when used properly. When it comes to many EBP's, some treatment providers find one that really works for them and they may use that approach exclusively. Take Motivational Interviewing (MI), for example, there are some substance abuse treatment providers who use MI exclusively making them a Motivational Interviewing "purist". The same holds true for other EBP's such as Cognitive Behavioral Therapy (CBT) as there are many clinicians who use one approach exclusively. Although EBP "purists" who stay loyal to one approach can be effective clinicians, "purists" are not the norm overall in the treatment world. Particularly when using a person-centered treatment approach, which starts with the person (or client)'s needs and goals first, it often may be more desirable to utilize an "eclectic" or mixed approach which includes a variety of EBP's used together. The Escalator method which is the foundation for this manual is an eclectic or mixed approach which strategically combines multiple EBP's for use in conjunction with one another. Because the Escalator

approach views a client's insight and motivation as the driving factors behind positive change, then this approach calls for emphasis on using different EBP's during varying situations and circumstances across the overall change process. What might work early in treatment, often needs to be adjusted later as a client's needs change, for example. As a client gains motivation and insight, the clinician needs to adapt his or her approach accordingly. Therefore, varying the use of multiple EBP's based on client's needs, circumstances and motivation and insight levels thus empowers clinicians to remain client centered across an entire spectrum of care.

Going forward, we will outline and contrast the four Evidence Based Practices that make up the Escalator counseling method – *(Motivational Interviewing, Stages of Change Model, Cognitive-Behavioral Therapy and Harm Reduction*). Some of the common challenges that many clinicians may come across with using one of these EBP's alone are highlighted. Therefore, the goal in this section is not to disparage or discredit the effectiveness of any of these EBP's. To the contrary, these EBP's that make up the Escalator were chosen because of their proven effectiveness. The challenges to using these EBP's alone in isolation are highlighted to emphasize the importance of a blended viewpoint of these multiple approaches. The Escalator is based on this effective combination of these EBP's in a way that each one of the four chosen EBP's fills any gaps left by using one alone. Again, considering client motivation and insight as key factors that drive change in the Escalator approach, we will review how these some EBP's are more effective than others based on our client's ever changing insight and motivation levels. It comes down to knowing when to stress the proper EBP at the proper time during this process. This concept will become much clearer as you read on. If you are not already somewhat familiar with Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT), Harm Reduction (HR) and the Stages of Change models, then go back to the previous sections and review the brief links to the theoretical overviews of these approaches. Otherwise, to get started next consider the following breakdown of the four EBP's that make up the foundation of the Escalator. The following chart breaks down the strengths and challenges of the four main EBP's that make up the Escalator Method:

The Evidence-Based Foundation for the Escalator Approach

Evidence Based Practice:	Strengths:	Areas of Challenge When Used Alone:
Motivational Interviewing	✓ Motivationally-Based ✓ Non-Confrontational – (Arguments avoided) ✓ Non Judgmental ✓ Based on Empathy and Active Listening Skills ✓ Versatile, adaptable – Useful for wide array of substance use, mental health issues ✓ "The Spirit of MI" and the skills involved (Rolling with Resistance, Expressive Empathy, Summaries, etc.) prepare a clinician well to deal effectively with challenging clients	The "flow" of MI for many clinicians and clients not "conversational" enough Does not take into account enough of: • Counselor personality, "natural engagement skills" • Counselor's experience and expertise • Counselor's ability to inspire, motivate, encourage, bring enthusiasm, anecdotes, illustrations "Beating around the Bush" - Sometimes it is more effective to confront. A counselor "earns" the right to confront with time Sometimes it is appropriate to give advice MI "reflective listening" can be difficult with adolescents, particularly defiant or quiet types – You cannot reflect when someone won't give you anything to reflect on MI alone can be challenging with groups

CBT	✓ Practical and effective use of skill building with a variety of client issues ✓ Great for COD's, particularly mental health concerns	Does not take into account motivation! - What good are the tools if someone does not want to use them?
Harm Reduction	✓ Truly Person Centered – Start where client is ✓ Accepts incremental change ✓ Nonjudgmental – open minded philosophy ✓ Accepts and embraces a wide variety of clients	"HR Gone Wild" – There has to be a line somewhere, no? The abstinence issue can be inescapable for many individuals who want to use HR The line between HR and Enabling can be very thin. There can be a lot of gray areas Checks and balances needed Harm Reduction does not stand alone as a treatment approach as additional tools, skills, supports, are often needed for positive change. Motivation and insight building can be a missing piece. HR alone may not challenge a client to try to change for the better
Stages of Change	✓ Matches counselor interventions with motivation level – excellent!	Not enough specific interventions at some of the earlier stages: There is plenty of available counseling material for Action oriented stage but not enough for the more common, less insightful, Precontemplation and Contemplation stages – (More Insight and Motivation building materials needed)

To clarify the above chart further, let's review each area in a little more detail, first looking at strengths, then followed by reasons for looking beyond simply using that approach alone.

Motivational Interviewing: MI

Strengths: As you read on you will see a lot of similarities between the Escalator method and Motivational Interviewing. That is because Motivational Interviewing has had such a huge positive influence on substance abuse treatment over the past several decades. MI paved the way for modern substance abuse treatment using a person-centered, motivationally- based viewpoint that is critical for positive client outcomes. MI opposed the less effective old-fashioned way of confrontational and "expert-based" treatment in which counselors often used to express a "my way or the highway" viewpoint. Prior to MI, clients who resisted change for too long were simply thrown out of treatment. Thankfully due in a large part to MI, the counseling field finally figured out that difficult, challenging and ambivalent people need help too, therefore treatment should not be limited to just compliant and cooperative patients who cooperatively follow counselor orders and suggestions.

The "Spirit" of MI has guided many counselors to adapt to a much needed person-centered viewpoint to treatment. The spirit of MI includes key concepts such as partnership, acceptance, compassion, and evocation as core elements which can be further broken down to include and emphasize: empathy, affirmation, collaboration and autonomy, (William R. Miller, PhD. And Steven Rollnick, PhD.) The MI oriented concept of "nonjudgmental empathy" has been a backbone of modern substance abuse treatment stemming directly from the MI approach. MI strategies such as "rolling with resistance" and

reflective listening and others better equips substance abuse counselors for work with less motivated clients from a wide variety of backgrounds with an extensive array of issues. This is particularly due to the flexible and versatile nature of the MI style. Last but not least, MI brought the concept of motivation as a key factor for positive change to the forefront of the addiction counseling universe right where it belongs. MI clearly has many strengths, however when MI is used exclusively there can be some challenges which are reviewed in the next section:

Why Look Beyond just MI?

There are many MI trained therapists who are highly effective because of the proven success associated with Motivational Interviewing as an evidence-based practice closely associated with positive treatment outcomes. Clinicians who can master MI can expect to see their results and success rates with clients improve with this highly efficacious approach that has the research to back it up. Therefore, there is a lot to be gained for anyone who is pursuing a career as an MI based therapist, provided that one can consistently master MI skills in practice. However, many MI trained experts will admit that the skills are not easy.

Having myself been to dozens of Motivational Interviewing trainings over the past two decades, I have made a few observations. Keep in mind, these are just personal observations, but perhaps you have felt the same way yourself if you have ever had Motivational Interviewing training. In my experience, it is the spirit of MI, (the emphasis on being client-centered, collaboration, using empathy, being non-judgmental, etc.) that draws the most interest toward learning Motivational Interviewing as a clinical approach to substance use and co-occurring disorders treatment. However, beyond, the spirit itself, when it comes down to putting the actual strategies into practice in session on a consistent basis, many clinicians face some challenges for a variety of reasons. Let's consider some of these challenges one by one:

1 - In practice, some individuals find MI alone not to be "conversational' enough

By definition, "conversational" means:

- **Conversational** – of, relating to, or characteristic of ***conversation***
- **Conversation -** informal interchange of thoughts, information, etc., by spoken words, the ability to talk socially with others

Once again, most people learning about MI find it easy to adapt to the overall spirit and viewpoint of MI as most see the value in the more basic strategies of MI such as open ended questions, affirmations, reflections, and summaries. These clearly are valuable and effective tools and you will clearly see that the "spirit of MI" is a critical part of the foundation of the Escalator method. However, performing the MI strategies and skills as directed by the MI method itself can be very difficult for some clinicians due to the fact that when utilized as recommended, often the interchange between clinician and client may not have the same "feel" of typical conversation. Some have even described the MI counseling verbal clinician-client interchange as "robotic." If you have practiced MI, it is likely you may understand what is being stated here. If not and you want to see for yourself, try looking on the web or Youtube for some MI examples as an illustration. This point is not meant to be a criticism of MI rather the goal is to point out that many clinicians find that lack of conversational flow when utilizing MI to be a huge obstacle to mastering this approach. One of my colleagues summarized this well when she said "at times when I am trying to use MI, I find myself concentrating too much on the process and protocols of MI rather than really listening to the content of what my client is trying to say

and instead focusing on engagement" Kudos to those clinicians who can effectively develop their MI skills consistently, however if you are one of those counselors who simply cannot get comfortable using MI in its "pure" form, then you are not alone. MI to many counselors, when used exclusively, just does not feel "natural" especially when compared with the more familiar and instinctive conversational interchanges that we may find to be more effective when eliciting our clients personal thoughts, insights, feelings and motivations.

2 – MI may not take into account enough of the abilities, experiences, expertise, and motivating drive of the clinician. Let's consider a few of these areas:

<u>Counselor Personality and "Natural" Engagement Skills</u>

In my 20 plus years as working in the substance abuse/mental health field, most in a supervisory and training role, I have trained hundreds of new counselors and interns. For the past 15 years in particular I have had on average of 10 to 12 Master's level interns working under me for training as counselors working with adult and adolescent individuals, groups and families with substance use concerns and coexisting mental health and other issues. One experience that I have had time and time again is working with interns and counselors in training who possess "natural" engagement skills. Some individuals come into the counseling field with the natural ability to effectively engage others with little or no formal training beforehand. Where exactly these special individuals get these natural engagement skills may vary however in the end it does not matter. "Natural" engagement skills seem to be instinctive for some, or gained through previous life experience for others.

Consider for example, an inexperienced counseling intern from an intact, supportive family, who has never even touched a drug or been arrested, and has never really been on the receiving end of any trauma, abuse, oppression, poverty, or other serious misfortune or suffering worth mentioning. Personally I have witnessed many interns who fit this description who were able to work effectively in counseling situations with clients with "hard core" drug abuse and severe life circumstances (such going as in and out of jail, being raised in multiple foster care settings, abuse history, chronically mental illness, multiple hospitalizations, etc.) One might construe that a lack of experience would be a barrier to engagement in such situations, however certain individuals with "natural" abilities can transcend their lack of experience and training when working with challenging clients. Counseling skills such as displaying empathy, actively listening, being genuine and sincere, and taking a non-judgmental, open-minded stance with others clearly comes more "naturally" to some counselors than others. These natural abilities cannot be ignored and to the contrary should be cultivated and encouraged

MI does not discourage the use of these "natural" engagement skills that many people bring to the table as counselors. In fact in MI there is an acknowledgement of the fact that training itself is not the most important factor for effective use of the MI approach. Nevertheless, MI requires the utilization of a specific set of skills and strategies that does not fully take into account or necessarily encourage "natural" engagement skills outside of the MI based set of tools. As you will soon see when you read on, the Escalator approach not only incorporates but encourages using the clinician's personality strengths as part of the engagement process. For example, if you have a good sense of humor, by all means, use that sense of humor to your advantage. If you are naturally charming, compassionate, sincere, flexible, or have any other aspects of an engaging personality then the Escalator encourages you to further develop and use these unique traits to your advantage in your own unique and personalized fashion. The same would hold true for a counselor who is musical, artistic, athletic or

otherwise talented as these strengths should be infused into one's overall counseling approach. In most cases, each of us develops our own style of counseling based on our own areas of strength and proficiency when it comes to relating well to our clients. The Escalator encourages the development one's own individualized style of counseling and engagement based on these personal strengths, attributes and natural "gifts"

Counselor experience and expertise

One of the reasons why 12 Step programs are so effective is because of the "addicts helping addicts" phenomenon. Of course, in the counseling field, one does not have to be an addict to help an addict. To the contrary, if a counselor's approach is to serve primarily as an addict helping other addicts based only on personal experiences, then that counselor will soon find that the scope of their abilities is limited. For the "addicts helping addicts" approach to work, the client needs to respect the counselor's personal addiction experience and he or she must be open to learning from it. Quite often that is not the case, particularly with adolescents and with other treatment resistant individuals who may have no qualms telling their counselor that they do not care about his or her personal experience as an addict. To provide counseling based primarily on personal experience can open the door to a counselor being pigeon holed into being a "one trick pony" who is limited to helping only those who respond to this personal experience based approach. Otherwise, a counselor relying solely on personal experience can be rendered useless when faced with clients who do not respond to his or her experiences.

With that said however, when I train counselors who possess a wealth of relevant personal experience, the focus of their training is for them to learn to use personal experience, *only when appropriate* as a means to *supplement* their foundation of evidence-based counseling skills. This can be looked at similarly to the way one may add spices to enhance the flavor of a meal. Personal experience, when used as an adjunct (spice) to the primary use of evidence-based treatment approaches (meal), can be a highly effective addition to the counseling process, *when used appropriately in a client-centered manner*. When it comes to Motivational Interviewing however, consider the following:

"Although empathy is the foundation of a motivational counseling style, it "should not be confused with the meaning of empathy as *identification* with the client or the sharing of common past experiences. In fact, a recent personal history of the same problem area...may compromise a counselor's ability to provide the critical conditions of change" (Miller and Rollnick, 1991, p. 5).

The Escalator approach agrees that sharing common experiences can be a barrier to a clinician's ability to provide critical conditions of change" - *when used inappropriately.* However, with training, the Escalator approach encourages use of common experiences if used with the right timing and consideration for the client's reaction to these experiences. Personal experience, can be an extremely effective aspect of counseling and should remain a part of the process of engagement and treatment. Again, personal experience should not be the primary source of counseling education for our clients, but neither should it be ignored entirely. The Escalator approach encourages strategic use of personal experience when relevant and accepted by the client. In instances where we, as counselors, view an opportunity in which a client can identify with one of our experiences it can be helpful to supplement our counseling approach with some appropriate and carefully managed self-disclosure.

This is not simply limited only to addiction experiences, similar to a 12 Step format. In fact, any personal experience, when used appropriately can be a useful aspect of the engagement process.

For example, things such as childhood experiences, similar experiences working with other clients (while protecting confidentiality), hobbies, interests, likes/dislikes, when shared in an open interchange with a client in an appropriate manner can actually serve as a catalyst in the clinician-client engagement process. This will be discussed in much greater detail later in this book. The point is that personal experience and self-disclosure should not be the backbone of any counselors approach, however it should not be ignored or neglected. *When implemented properly,* personal experience can build bridges in many challenging clinical situations.

Counselor's ability to inspire, motivate, encourage, and bring enthusiasm, anecdotes, and illustrations

Motivational interviewing is focused on eliciting and evoking self-motivational statements referred to as "change talk". This is based on the principle that motivation comes from within and must be drawn out. This principle is entirely true and remains a critical aspect of the Escalator motivational methodology similar to MI. The Escalator method compares motivation at times to be like an ember in someone's heart that needs nurturing in order to grow into a flame of motivational action toward positive change. Ultimately it is true that real and lasting motivation comes from within.

However, to discount a counselor's ability to inject enthusiasm, encouragement and inspiration to process of change is a huge oversight. Think for a few minutes about the people in your life who have inspired and motivated you. Perhaps it is a family member, mentor, teacher, etc. who had that special something that got you excited about looking at your situation and making it better. If you were to hire a personal trainer at the gym or a coach to instruct you in a certain competitive sport, it would only make sense to search out someone who helps inspire and encourage you, particularly when you may lack those feelings on your own from within. Therefore, the Escalator approach not only recommends that counselors work toward being inspirational and motivational, it requires all of us to constantly develop and refine these inspirational, energetic and hope-building skills. For sure, true lasting motivation is like an internal flame that comes from within but effective counselors know how to fan those flames from the outside by being a source of enthusiasm and encouragement. So often inspirational and motivational exchanges between a clinician and client expand well beyond the simple reflections and open ended questions utilized in the traditional MI framework

Therefore, inspirational stories, quotations, illustrations, etc., can be used over and over when there is an attention to the timing and appropriateness of these hidden "gems" of engagement. A timely inspirational quote or saying or a suitable motivational story or anecdote can truly accelerate the engagement process. The Escalator again and again encourages counselors not only to be good listeners but also to practice using these types of practical tools to actively be a source of inspiration for our clients.

If appropriate time spent on engagement establishes a solid therapeutic relationship, then a clinician can "earn" the right to be directive and stop "beating around the bush"

This section may make more sense to those who have practiced MI which tends to stick with the established set of strategies for eliciting change statements from clients. Over time, however, the Escalator approach deviates from MI in that it encourages the clinician to explore being more directive over time as the clinician-client bond increases. The basic principle is that with time, a clinician "earns" the right to provide more direct advice in a straightforward manner. Obviously, early in the process, advice-giving is usually ineffective and can fall on deaf ears, at times even having the reverse effect with a newer client going directly against your advice right after you make a suggestion. However, similar to the way any other interpersonal relationship develops, at times the need to "beat

around the bush" and use an indirect approach lessens especially as rapport and trust is developed. The Escalator approach takes into account, timing and appropriateness, with these types of issues but when suitable, it can be appropriate for a clinician to spell things out directly particularly in situations that may seem obvious. At times direct advice giving is effective, especially after a stronger therapeutic relationship has been established

For example, consider a client-clinician relationship with time-proven rapport and trust established. The client in this example had gone through multiple abusive relationships and recently got out of one but is already again starting a new one. Suppose you could see right away as this client's counselor, that the client was again going down the same path with someone who clearly appears to potentially be another abuser. Would it make sense to engage in reflective listening using a series of leading open ended questions to try to lead to the obvious? Sometimes in such cases, the direct approach is the most effective. Sometimes the clinician should be forthcoming, while still remaining considerate to the client's needs. Although "telling it like it is" should never be a "front line" strategy, when there is trust and rapport present, there is a time and place to just put things out there at face value, provided it is conveyed in a respectful manner. Often when we have a rapport and trust with a client, he or she may actually appreciate your direct and decisive response to a key situation in therapy.

Special Situations: Adolescents and Group:

Finally, two situations in which purely sticking with MI strategies alone can be an extreme challenge includes when working with highly resistant adolescents and in some group situations:

- Adolescents – Children and teens often require special engagement skills beyond just a listening ear. MI uses reflections in session which makes sense, however when a highly resistant client, such as an adolescent refuses to converse, then there is nothing to reflect back when the client isn't speaking. The Escalator, includes strategies for "fishing" for a client's areas of interest using more proactive skills for engagement with these difficult populations. Adolescents in particular can have an extreme difficulty tolerating uncomfortable prolonged silences so often the clinician needs to be prepared to bring more tools of engagement than provided by typical MI strategies alone. MI based reflective listening with some teens is not enough.

- Groups – MI strategies are effective with groups when used selectively, however groups of less motivated and less insightful clients often requires a more proactive skill-set by the clinician. Because of the variation of personalities, behaviors, attitudes, motivation/insight levels and personal goals among group members, the counselor needs to be prepared to be flexible and

adaptable. Quite often, specialized counseling tools are required to “draw out” participation with resistant group members. The Escalator approach is built around specialized tools designed to be highly effective with many kinds of challenging group therapy situations even when insight and motivation may be lacking within the group.

http://www.takingtheescalator.com/therapy-tools

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy is focused on skill building which is extremely useful, provided one thing is present: *The client wants and is ready to use the skills*. Therein lies the primary limitation of this technique. CBT is excellent for helping individuals and groups with a variety of issues including substance use and many coexisting mental health issues. However, skills can be useless when there is no desire present to use them.

When explaining this I like to use my children as an example. Suppose I was having a problem with my son not cleaning his bedroom. To solve this problem, let’s say I go out and buy a vacuum, some cleaning materials: brooms, mops, brushes and other cleaning products. Then to make sure everything is going to work out well, I take the time to show my son how to use these cleaning tools in practice to get his room nice and spotlessly clean. If, in this example, I woke up the next morning, and the morning after that, and found his room still to be a mess then what likely is the problem? The answer is that he simply does not want to clean his room! Obviously, the tools are only as good as the person’s desire or motivation to use them. The same principle applies with CBT. A clinician can provide all the right tools and training needed for a given therapy issue, however it is all useless if the client has little desire or motivation to change. This is also true when a client lacks insight and doesn’t even think there is a problem at all in the first place.

Many new clinicians experience this phenomenon when they give their clients homework, journaling assignments, relaxation techniques, and make other practical CBT based suggestions to help a mental health or substance use issue, only to find that the next week the client didn’t even try any of it. The reason was that the client was not motivated enough for these action-based strategies. In addition, if a client doesn’t even believe they have a problem CBT skills can be even more irrelevant. For example, imagine teaching CBT based skills to a person who does not even believe there is a real reason that they need to stop drinking in the first place. That client in that scenario is nowhere

near ready for that kind of work. Clearly *issues with insight and motivation need to be addressed first* before really getting into CBT based skills building. CBT, although effective when clients are ready, it does not take into account the critical role of motivation and insight in the change process.

Stages of Change Model:

The Stages of Change model is based on an excellent concept: *It makes great sense to match our interventions with our client's readiness to change*. What a clinician does with someone in the *precontemplation* stage (the person isn't even thinking about change) should be very different than what we would do with someone in the *action* stage (the person is ready and willing to take action to change). It truly is a brilliant concept as many clinicians have learned that if we do not match our interventions with client's readiness to change, then compliance is low. For example, consider a group of actively using, marijuana smoking teenagers who spend the group espousing the amazing wonders of weed smoking with little, if any desire to stop. Would it make sense to teach this group relapse prevention techniques? Of course not, because their readiness to change simply is not there yet. Therefore they would not even care about preventing relapse when they are already still actively using and loving it. This would be a group that the clinician would focus on insight and awareness-building and consciousness-raising which is appropriate to their stage of change. Taking into account out clients' current insight and motivation levels is synonymous with philosophy of the Stages of Change approach.

So the concept of matching interventions with readiness to change makes sense. The main problem with the Stages of Change model as it stands now is illustrated in what I call, the "Barnes and Noble Challenge." Having an interest in substance abuse and having written a book myself, I always make sure to look at the substance abuse section whenever I go to the book store and my findings are always the same: The vast majority of written material out there for helping people is focused on helping people in the "Action" stage of change. In other words, most substance abuse books are made for people who are ready to change and who are actively ready to do something about it. Sadly however, in reality, just about all substance abuse counselors will attest to the fact that the vast majority of people who enter substance abuse treatment are ***not ready to change***. Therefore, the majority of materials and tools available is not congruent to the types of clients we really see in our programs. People simply do not tend to write books to help unmotivated people for one main reason: Unmotivated people don't buy books about changing. People in the action stage are much more likely to purchase a self-help book therefore that is why most written material on substance use issues is for people in the action stage. There is a significant lack in available material focused on clients with lower insight and motivation levels. This particularly applies to the precontemplation and contemplation stages of change which are the most commonplace yet also the most challenging. So the main point being made here with the Stages of Change model is that this model used alone is limited by the lack of tools available for the majority of our less motivated and less insightful clients.

So, in summary, the Stages of Change model as a foundation makes sense because matching interventions with motivation levels is logical, practical and effective. However the Escalator adds an essential missing piece by providing more tools for use with people who are not ready to change, which is the much larger share of those people we treat.

Harm Reduction

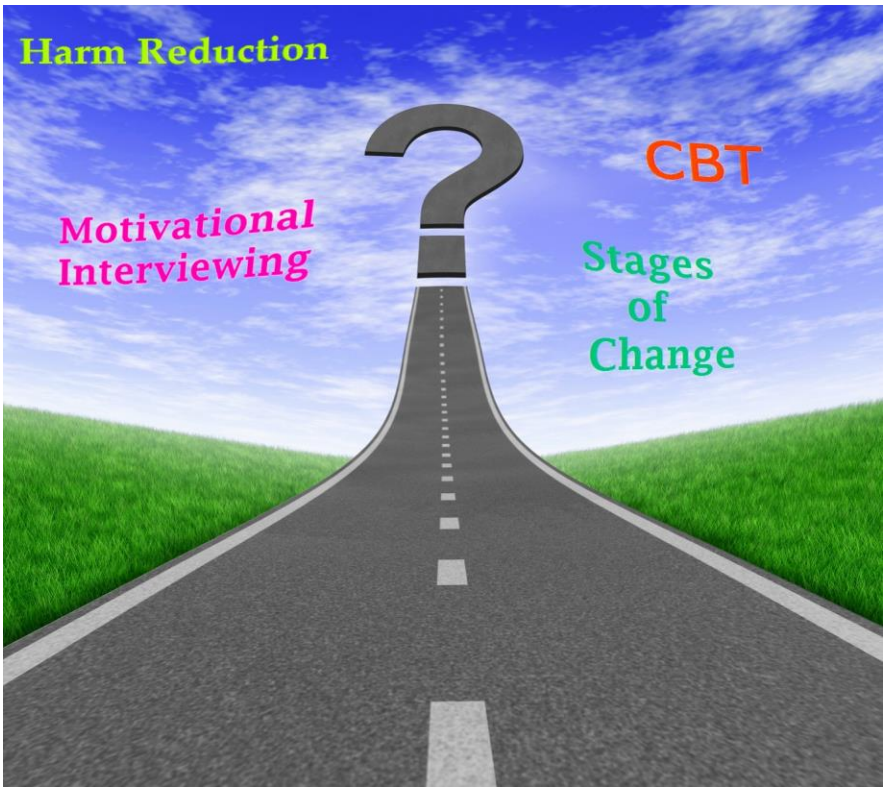
Harm Reduction is less of an approach, skill or a technique and more of a guideline, paradigm, or viewpoint. Harm Reduction, in its simplest terms is about accepting all types of people across the

entire motivational spectrum by starting where each unique individual is and then accepting progress on their terms and at their pace. Harm Reduction accepts incremental change which is truly an essential factor in accurately understanding the overall change process. When using the Escalator approach you will learn more about understanding the difference between ideal goals such as complete abstinence and the more realistic smaller goals that counselors need to accept along the way, such as reducing use, switching to less harmful substances, and other subtle lifestyle modifications that may not be ideal, but are still relevant toward being a reasonable measure of progress. Harm Reduction allows for an inclusion of a wider variety of people in treatment which is so valuable. This is because Harm Reduction discourages clinicians from simply discharging someone who would not fully abstain from their substance use but rather it encourages clinicians to instead focus on being motivating and supportive at all stages. HR accepts the use of Medication Assisted Treatment (MAT) as a valuable tool in the change process for those individuals who choose it. HR teaches counselors to be more patient and requires greater resourcefulness for helping more change-resistant clients who need more help than “ideal” more motivated and compliant clients. HR prevents the “It’s our way or the highway” viewpoint in any counseling center.

However Harm Reduction alone is not enough. Despite its value as a guiding philosophy in substance abuse treatment much more is needed from a clinical perspective. Harm Reduction alone does not in itself provide tools for therapy and other treatment strategies that counselors need to help facilitate motivation and insight building. Therefore Harm Reduction is a great navigational principle for treatment decisions but the other areas we discussed: MI, CBT, and Stages of Change used in conjunction with HR help fill the gap with regard to these clinical skills and tools for working face to face with our clients.

Also, there is a phenomenon which we will refer to “Harm Reduction Gone Wild”. Using a HR approach to substance abuse treatment requires an ongoing daily pattern of evaluation and re-evaluation of various clinical situations as there can be a lot of “gray area” involved. At times there can be a thin line between Harm Reduction and *enabling* when a treatment provider is not careful to maintain a system of checks and balances. This is because there are times when a client needs to be discharged from one level of care and referred to another. There is a time to “cut the cord” in a proverbial sense, when a client simply is not responding in spite of a variety of strategies used by clinical staff.

“Harm Reduction Gone Wild” in this case, refers to those situations where Harm Reduction is being used but the point where it clinically needs to be cut off. There are few if any absolutes in client-centered treatment, however there is a time and place when HR can go too far. For example, in a HR based outpatient facility, a person would not be discharged simply because they are still using substances. HR allows even someone who is actively using to have a reasonable amount of time to build the insight and motivation needed to start making positive changes even if that person is struggling for a while. However, if a person consistently and persistently fails to make any viable sustained progress there is a point where discharge needs to be considered. Simply allowing someone to hang around and get high with no progress forever makes little sense and could be a case where a client may be exploiting the HR process. Therefore, Harm Reduction alone, with absolutely no limits or scrutiny at all can in itself be harmful. In fact, the Escalator approach recommends that with time and practice it is acceptable to steadily increase expectations in treatment as progress is made. This can be done while still remaining client-centered. A counselor can still allow a client to work at his or her own pace while providing an appropriate but gentle “push” for progress from the outside, which we will discuss later.



In Summary: What do we need?

The Escalator can be considered a "best of" combination of tools and strategies from Harm Reduction, CBT, Motivational Interviewing and Stages of Change with ever-present consideration of integrating Coexisting Issues at all phases of care.

In short, we need:

1) An expanded perspective for a changing world
2) Practical tools that work, particularly for challenging clients who may lack motivation and insight

Expand our Perspective: The field of substance abuse/addictions treatment has changed so much over the past several years. It makes no sense to try to keep using the same old strategies now when circumstances are so different today. *(For more detail about some of these changes consider "Why Take a Different View?" From the 2016 book "Taking the Escalator: Express" – Click to view)"*

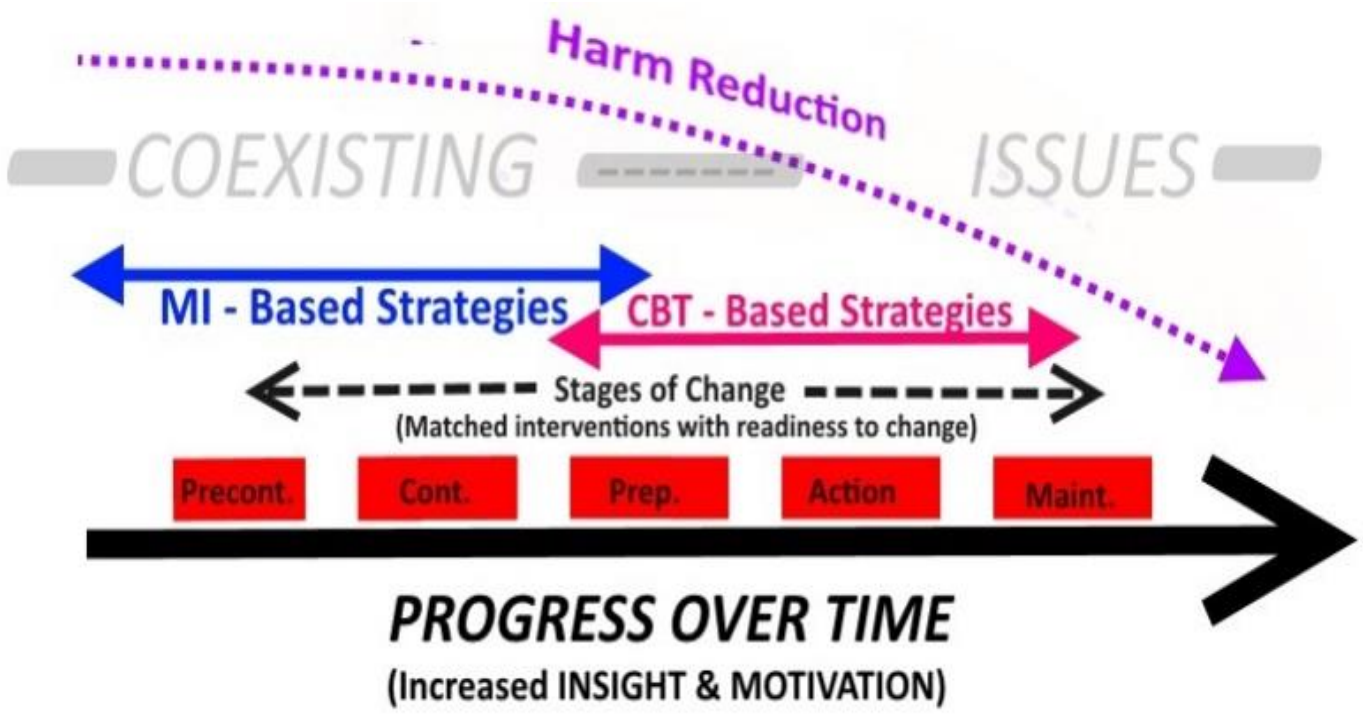
We need to adapt. To handle these changes we need to be flexible, open minded, and be willing to modify and change our ways while adjusting our perspective. We ask our clients to overcome their resistance, yet some counselors continue to be stuck viewing things from the dangerous "this is how it has always been done" fixed viewpoint.

Let's start with what we know already works. Starting with evidence-based treatment practices that we know already work is an excellent foundation. Then as life situations and circumstances change we can adapt, adjust, and grow from there in a flexible, proactive manner. The Escalator method is designed to expand our perspective and integrate the progressive tools we need for our changing clientele.

In summary the Escalator combines the following aspects of these evidence based practices:

- Motivation-building of MI
- Skill Building of CBT
- Matching interventions strategies with client readiness to change from the Stages of Change model
- Accepting, encouraging and embracing incremental change from Harm Reduction
- Fully integrating the full spectrum of coexisting issues in an effort to treat the “whole person” throughout the entire change process, not just the “addiction”

The following diagram illustrates the use of these evidence based perspectives:



(Keep in mind the above diagram is a general guideline for illustrating the interaction of MI, CBT, HR, Stages of Change and COI’s)

- Stages of Change – As progress is made, insight and motivation increase and vice-versa. As outlined in the Stages of Change model, strategies and interventions used by the clinician should match client readiness to change. In the diagram above, for the sake of simplicity change and progress is demonstrated in a linear manner. However in reality, change ebbs and flows and can move backwards and forwards. Therefore, the clinician should be ready to be flexible with adjusting his or her approach to where the client’s insight and motivation levels are at any given time in the change process. The important aspect of including the Stages of Change model is to continuously maintain the process of matching appropriate treatment strategies with clients changing levels of motivation, insight and overall readiness to change.

- Motivational Interviewing – MI strategies are effective throughout the course treatment and therefore should not be overlooked. However, use of MI based strategies tend to be more necessary when the client is exhibiting lower levels of insight and motivation which usually is the case early in treatment. Helping clients to increase their motivation and self-awareness is quite often the primary focus of early-stage treatment when less readiness to change is present. Therefore integrating MI into the mix early on is often essential for initial engagement particularly where there may be resistance (or heightened ambivalence) However there are times when it may be beneficial to abandon MI strategies, for example:

    - ***When empathetic reflection is not enough***: If a client is not giving the counselor enough information to reflect on, more proactive engagement strategies are needed outside of the scope of MI

    - ***Opening others up***: When faced with some more challenging individuals or groups, at times the clinician must again use more directive and proactive strategies and tools to get people talking and listening. Quite often when faced with more challenging situations, particularly with difficult groups, the counselor needs to be prepared to bring more to the table than just asking open ended questions and expressing empathetic reflections.

    - ***The direct approach and advice giving***: Particularly during later stages when rapport is strong, it can be helpful to abandon MI and address some issues directly and even give advice if done so carefully and with forethought

- Cognitive Behavioral Therapy – CBT strategies are often ineffective in early treatment for reasons stated earlier: When there is little insight and motivation present, clients rarely will use tools provided by therapist, despite the therapist's best intentions. However, as motivation and insight increases and readiness to change becomes more evident, then a shift toward introducing more and more CBT strategies is recommended. As clients are ready to take action and make changes, that is when it becomes critical that the clinician is ready to provide the tools for various client treatment issues. CBT equips our clients with needed skills provided that clinicians first incorporate more motivational and insight building strategies to help clients prepare to be ready to implement these CBT based skills. Motivation and insight are routine prerequisites for expertise and action.

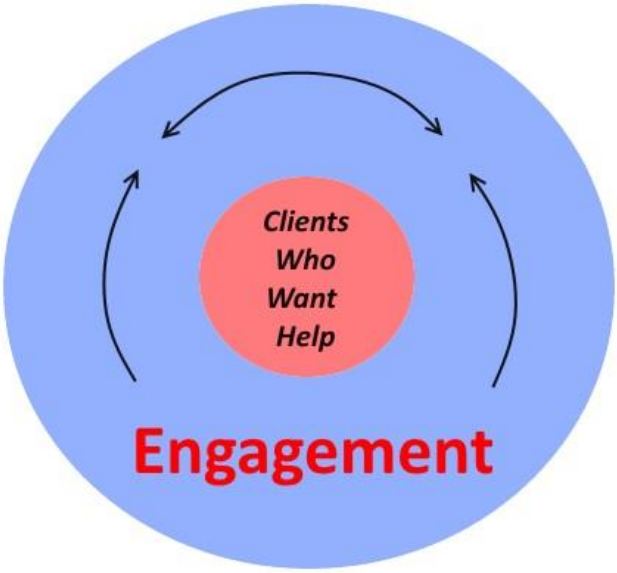
- Harm Reduction: Considering the use of HR as an overall viewpoint and guideline is fundamental throughout the entire course of one's treatment, from early stages all the way through maintenance. As clients' increase their motivation and insight with progress, along with the increased levels of trust and rapport in the therapeutic relationship, then the clinician may elect to carefully guide the client toward more abstinence-based goals. Of course, treatment should always remain client-centered. However, earlier in treatment, a clinician may be less inclined to challenge a client in comparison with later stages when a clinician may find it is appropriate to "push" a little with regard to client expectations. For example, using an HR viewpoint with a client in treatment for heroin addiction, the clinician may elect to "leave alone" the fact that this client is still using marijuana on a daily basis. This is because there is progress being made based on an HR viewpoint. Nevertheless, with time, progress, and increases in client insight and motivation, the clinician may elect to suggest something such as "Since you have done such a great job staying off the heroin for so long now, how would you feel about starting to cut back on your weed smoking?" Obviously if the client was still dead set against this suggestion, that is not the end of

treatment. Still with progress, motivation and insight clients are often willing to take on new behavioral challenges for self-improvement at later stages in the overall process. This is based on the same principle as discussed earlier when reviewing motivational interviewing: as rapport and trust is built in the therapeutic relationship then the clinician can carefully introduce more directive approaches and suggestions. When looking at HR, as progress is made it can be practical to steadily challenge HR based goals.

- Coexisting Issues (COI) – Consideration of the integration of COI's into the treatment process should be ever-present throughout the entire treatment process from admission to discharge. Full integration of mental health, physical health, social and family issues, etc.; anything impacting the client's present functioning can and should be integrated into the overall treatment milieu as clinically indicated. Coexisting issues is a critical paradigm at all stages of motivation, insight and progress from start to finish and beyond in any treatment setting. We always want to consider the whole person, not just a tunnel vision view toward substance abuse alone.

Tools…Tools….and More Tools: ***For Insight and Motivation Building*****:**

Helping Individuals with Lower Levels of Insight and Motivation – With the move toward harm reduction, the substance abuse treatment world has had to adapt to the once-ignored reality that most people are not ready to change when it comes to addiction and substance abuse issues. In the "old days" of substance abuse treatment decades ago, when someone didn't think they needed to stop (lack of insight) or they openly stated that they didn't want to stop (lack of motivation) quite often the outcome for those individuals was to be discharged from treatment. In the past, the rationalization for discharging unmotivated/less-insightful clients was to say that these people simply "are not ready" or "in denial". Today, things are no longer so black and white, as individuals who may be lacking in insight and motivation are still engaged in the treatment process without simply casting them aside as resistant or "difficult" clients. As a result, however, substance abuse counselors need a much expanded skill set. Motivation and insight building interventions have become an increasingly critical aspect of client care. Engagement strategies, as outline in this book, are the tools for survival for counselors working with less motivated, less insightful clients. The following diagram below illustrates the extensive role that ***engagement*** has in the treatment process in when treating less motivated and less insightful clients. The red section in the middle of the diagram represents the smaller amount of clients who openly want help and are ready to make changes (insightful and motivated clients). The primary skill set for counselors with this more motivated and insightful inner group is often much different than with the outer blue circle which represents those clients in treatment who are lacking in insight and/or motivation. The skill set utilized by counselors falling in this outer group is primarily focused on engagement skills. Motivation and insight building is completely contingent on a counselors engagement abilities. With the less motivated and less insightful clientele, often an unavoidable truth is: ***No engagement, then no treatment***. Although some degree of engagement is required with all clients at all stages, as we have already discussed, *engagement is the key with those clients who are not ready.*



Prior to embracing Harm Reduction, the field of substance abuse treatment focused primarily on those clients in the middle circle above, which includes those clients who have some motivation and insight into their substance abuse and therefore want help. With the expansion of harm reduction, more and more clients in the blue outer circle are being treated in substance abuse programs. These clients need help but may lack the insight and motivation needed to embrace and then sustain progress. Clinicians today are required to enhance their engagement skills to help these clients build the needed insight and motivation to increase in their level of inspiration and progress

Last but not least, the Escalator method requires active effort on the clinician's behalf to engage clients, particularly when insight and/or motivation for change is lacking. The Escalator method provides an array of specific tools and techniques for this challenging engagement process. The main point of this book is to outline some of those tools and strategies in a constructive and practical manner to help the reader better help others. It is likely that you are already using some of these skills yourself on a daily basis however any level of expansion and improvement that any of us can make with regard to our skills as clinicians, empowers us to better help those we serve, which is the primary reason most of us entered this field. In addition, the www.takingtheescalator.com website can be viewed as an ever expanding "garage" of stored tools for repeated use in a wide variety of therapy situations. As a clinician, you are encouraged to continue to devise and share your own tools as you gain experience and grow as a treatment provider. Keep checking the Taking the Escalator website regularly as counseling tools are continuously being added and updated.

Click this tool link to view therapy tool database

This is an excerpt from the publication: "The Tools of Engagement: Taking the Escalator Counselor Handbook – (2017) – Available on Amazon – (Link)