

# **STRATEGIES FOR ENGAGING DIFFICULT-TO-REACH, MULTI-PROBLEM CLIENTS WITH SUBSTANCE USE DISORDERS**

**by**

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## **ABSTRACT**

*The shift toward evidence-based practices in addictions and behavioral health care is long overdue. For too long practitioners in the behavioral health field have been led by what they think works rather than by evidence-based practices. Fifty percent of chemically dependent clients drop out of treatment prematurely. It is difficult to utilize an evidence-based practice unless clients are engaged in treatment first. This article outlines fifteen strategies for engaging difficult-to-reach, multi-problem clients with substance use disorders.*

## **KEYWORDS**

**Engagement, treatment, recovery**

After reviewing forty years of research on what works in therapy, Duncan, Miller, & Sparks completed their megastudy by concluding that client engagement is the number one evidence-based practice (2004). Research on addictions treatment reveals that the longer clients are engaged in treatment, the better the outcomes (Hubbard, Craddock, & Anderson, 2003). Research also reveals that a working alliance between the counselor and client is one of the most important factors in retaining chemically dependent clients in treatment (De Weert-Van Oene et al., 2001). Miller found that client engagement is the strongest predictor of short-term and long-term retention in addictions treatment (2009). White, Kurtz, & Sanders found that the use of peers as recovery coaches is effective as a pre-treatment

engagement strategy. This approach can help prime the pump by preparing clients for treatment in order to increase the probability that they will not be administratively discharged. Recovery coaches can also be effective as an in-treatment engagement strategy by helping to keep clients engaged in treatment, thus decreasing the chance that they will leave treatment prematurely and as a post-treatment engagement strategy to help clients deal with the fragility of early recovery (2005).

Other findings on the importance and benefits of client engagement in addictions treatment include: engaging clients by phone prior to the first counseling session decreases client no-shows (Miller, 2009); counselors who possess qualities of empathy, nurturance, warmth, and genuineness do the best job of engaging chemically dependent clients in treatment (Kasarabada et al., 2002); and an egalitarian relationship during the treatment planning process helps clients stay engaged with the counseling process (Corey, 2009).

Respecting cultural differences during the engagement phase of counseling helps clients stay actively involved in therapy (Sue & Sue, 2007). The use of motivational incentives (rewards) increases programmatic retention, clean drops, and recovery rates (Higgins et al., 2008). Engaging spouses in treatment increases programmatic compliance and retention, decreases relapses, and helps facilitate recovery (Miller, 2009). Engagement strategies based upon the client's level of readiness to change helps reduce resistance and keep clients engaged in treatment longer (SAMHSA, 2008). Demonstrating a respective alliance and honoring the client's right to self-determination by referring him or

her to the level care he or she is motivated for increases programmatic outcomes (Rosengren, 2009). Providing telephonic recovery support following discharge from treatment increases recovery rates (White, 2008).

The aforementioned research is necessary, because historically, many chemically dependent clients are difficult to engage in counseling for myriad reasons, ranging from mandated status, a lack of motivation to discontinue drug use, discomfort opening up to strangers, co-occurring conditions, multiple diagnoses, difficult symptomatology, initial therapeutic approaches that increase resistance, and confrontation techniques that leave clients feeling defensive (O'Connell & Beyer, 2002). Thus, 50% of chemically dependent clients fail to make their second counseling session (Miller & Rollnick, 2002; White, 2005). Below is a list of strategies to engage difficult-to-reach, chemically dependent clients in counseling.

- Provide a welcoming atmosphere. When clients are met with a friendly greeting from a receptionist, are invited into a waiting room that contains plants, pictures on the wall, and pleasant music, etc., this can go a long way to facilitating rapport. Noted psychiatrist Kenneth Minkoff travels the country giving workshops to receptionists on how to welcome clients into their agencies. Minkoff & Cline (2004) have described the creation of a welcoming environment for clients as a necessary and promising practice.
- Offer a snack while the client waits. This hospitality can be instrumental in reducing client resistance within the first few minutes of contact. Research by Petry and Bohn (2003) reveals that the use of low-cost incentives, such

as candy bars, has been effective in increasing engagement and programmatic retention in addictions treatment.

- Exude warmth. This counselor quality is effective in facilitating client engagement (Corey, 2009). Research indicates that the warmth of a counselor's voice tone communicated over the telephone prior to the first counseling session can decrease client dropout rates (Miller & Rollnick, 2002).
- Focus on a strength and something the client does well as soon as possible during the rapport-building phase. Many chemically dependent clients are defensive and resistant to counseling because they feel they have failed. A strength-based approach can decrease that defensiveness (Sharry, 2004). Counseling approaches that focus too much on what clients have done wrong, rather than on what they are capable of doing right, leave clients feeling defensive and resistant to counseling (Duncan, 2005). Clients are often asked questions in the initial intake session that increase their feelings of stigma and defensiveness, such as:
  - How much do you drink?
  - How many times have you relapsed?
  - Have you ever been treated for mental illness?
  - How many times were you hospitalized?
  - Have you ever attempted suicide? How many times?
  - Have you ever had a venereal disease?
  - Have you ever shared a dirty needle?

- Have you ever been arrested? How many times? How many felonies?

Strength-based questions can be instrumental in decreasing clients' resistance and facilitating engagement (Sharry, 2004). Examples include:

- What do you do well?
- How have you been able to endure so much?
- What do you like to do in your leisure time?
- What are the best three moments you can recall in your life?
- What is the best thing you have ever made happen?
- What is your previous life suffering preparing you to do with the rest of your life?
- Which of your life challenges have taught you the most about your own resilience?
- What sources of strength did you draw from as you faced these challenges?
- What have you learned from what you've gone through?
- Explore the client's experience with counseling in the past. If the experience was negative, let him or her know how the experience will be different with you. Duncan, Miller, & Sparks have pioneered an approach to counseling entitled, *Client-based Evidence*. With this approach, clients complete a brief survey at the end of each session. They are asked to rate the session, specifically focusing on whether the session met their needs

and what they would like to see continued or changed in future sessions (Duncan, Miller, & Sparks, 2004).

- Utilize stage-based interventions. Many chemically dependent clients are in various stages in terms of their readiness to change (DiClemente, 2007). These stages, according to DiClemente, include:
  - Precontemplation stage. At this stage the client is not considering the possibility of change. The client is unaware of having a problem or needing to make a change.
  - Contemplation stage. Awareness of the problem has arisen, and the client is ambivalent about making a change.
  - Determination stage. The client is motivated to do something about the problem and has not yet taken the initiative.
  - Action stage. The client engages in action for the purpose of bringing about change.
  - Maintenance stage. The client engages in behavior to sustain the change. When chemically dependent clients are in the maintenance stage, they have been abstinent for six months or longer.

Research reveals that stage-based interventions are effective in facilitating rapport with clients (SAMHSA, 2008; Rosengren, 2009). Stage-based interventions can be particularly effective with clients with multiple problems, because it allows the counselor to base intervention strategies on the client's level of readiness to change each problem (DiClemente, 2007). Consider the client who has schizophrenia and alcoholism, who is in the action stage as it

pertains to addressing alcoholism, evident by the fact that the client attends AA meetings daily, has weekly contact with a 12-step sponsor, and participates in sober activities at the local Alano club, while refusing to take medication, see a psychiatrist, or have contact with a case manager concerning mental illness. This client is clearly in the precontemplation stage as it pertains to mental illness. At a major psychotherapy conference, I heard a noted keynote speaker state, “There is no such thing as a resistant client, but there are many helpers who struggle to accept clients where they are at, and if we accepted them where they were at, we would have no resistance.”

- Minimize confrontation. Confrontation leads to resistance and premature termination. There are studies that report a strong link between counselor confrontation and clients returning to drug use. Other studies reveal that confrontation can be traumatizing to chemically dependent women, as the great majority of them have histories of trauma prior to treatment (Miller & Rollnick, 2002).
- Engage in mutual treatment planning. This respectful approach allows the client to be a partner in his or her own counseling. Establishing a partnership can be an effective way of reducing resistance with difficult-to-reach clients (Corey, 2000). This process can begin by asking the client, “What would you like to accomplish in treatment?” or “What would you like to see different in your life?”
- Have a sense of humor. The shortest distance between two people is a good laugh. Humor in therapy has been found to reduce resistance

(Buckmin, 1994). On a recent *Oprah Winfrey Show*, famed writer Maya Angelou told Oprah Winfrey that only equals laugh with each other. Many multi-problem clients carry a great deal of stigma that leaves them feeling less than. Laughter can be the great equalizer (Buckmin, 1994). A goal of counseling is to feel better and act differently. Many models of counseling attempt to reach this goal by interventions that focus on one of four areas: feelings; behavior; thinking; and biochemistry. Humor can affect change in all four of these areas. It increases feelings of equality in the counseling relationship; it brings the idealized counselor back to life; it can reduce resistance; it decreases cross-cultural tension; and it facilitates bonding between counselors and chemically dependent clients. An important goal for using humor in counseling is to improve the relationship between the counselor and client, lessen client tension, increase client comfort, and help client gain insight (Sanders, 2005).

- Avoid power struggles. Power struggles decrease engagement and can lead to premature termination (Rosengren, 2009). One way to avoid power struggles is to roll with the client's resistance. This can be accomplished by simply acknowledging the client's discomfort when certain subjects are brought up and allowing the discussion to shift to other areas (Miller & Rollnick, 2002).
- Avoid early labels. Early labels can lead to clients feeling defensive and being more difficult to engage (Rosengren, 2009). When counselors diagnose clients with alcoholism, schizophrenia, etc. prior to engagement

and clients respond to the diagnosis by saying, “I don’t have a problem” or “I disagree with the diagnosis,” some clients may spend many years defending their statement by staying out of treatment, attempting to drink socially, refusing to take medication, etc. (Miller & Rollnick, 2002).

- Be willing to have a sensitive discussion about race, gender, and other differences if they are barriers to communication. This can facilitate the building of rapport. A good time to have such a discussion is when the counselor senses that the differences he or she has with his or her client are barriers to trust (Sue & Sue, 2007).
- Ask for permission to give feedback. This respectful approach can go a long way toward facilitating rapport. For many years addictions counselors have given clients unsolicited feedback filled with opinions combined with confrontation, which often created therapeutic walls rather than therapeutic bridges (SAMHSA, 2008).
- Be aware of countertransference reactions. The negative reactions we have toward clients can increase their resistance to counseling. Many difficult-to-reach clients with substance use disorders have myriad behaviors that are easy to judge, as others are victimized by their behaviors. Each person with a substance use disorder affects seven people directly (Kinney, 2002). These behaviors range from DUI offenses, theft, antisocial behavior, physical abuse, sexual abuse, domestic violence, etc. In years past Sigmund Freud indicated that countertransference was something to avoid completely (Corey, 2000).

Modern psychoanalysts view countertransference as a gift. Counselors who have negative reactions to their clients can use these reactions to seek supervision, therapy, peer support, or academic pursuits in order to work with these clients effectively.

- Honor a variety of approaches to recovery. The addictions field has a history of assuming that there is only one way that people recover—namely, treatment followed by 12-step attendance. While this one-dimensional approach has helped many, it has produced a great deal of resistance in others. As the field of addictions treatment emerges, along with research, we are learning that clients have a variety of approaches to recovery, including solo recovery, virtual recovery, religious styles of recovery, medication-assisted recovery, harm reduction, 12-step recovery, and cultural pathways to recovery. Honoring the client's pathway to recovery can be instrumental in reducing resistance (White, Kurtz, & Sanders, 2005). The range of anonymous groups have multiplied throughout the years. Counselors can now engage clients in recovery planning by offering a menu of options. Examples include Women for Sobriety, JACS (Jews Who Are Alcoholic and Chemically Dependent and Significant Others), Dual Disorders Anonymous, Nicotine Anonymous, Marijuana Anonymous, Buddhist Recovery Network, Celebrate Recovery, MAPS (Musicians Assistance Program), and One Church One Addict (White, 2009).

Below is a tool that counselors can use to help clients with recovery planning prior to discharge from treatment. Resistance can be decreased by offering a menu of options to clients that specifically meet their needs (White, 2009).

### **A Tool for Counselors**

Which of the following are important to you in selecting recovery support? (Check all that apply)

People who:

- Have experience with my primary drug
- Are the same gender
- Are close to my age
- Share my ethnic, cultural background
- Share my view on religion, spirituality, secularity
- Share my sexual orientation
- Smoke tobacco
- Do not smoke tobacco
- Have tolerant attitudes toward medication prescribed for addiction or mental illness
- Have prior experience in the criminal justice system
- So not have prior experience in the criminal justice system
- Have approximately the same income level
- Have had severe alcohol/drug problems
- Have had mild to moderate alcohol/drug problems
- Share my goal of complete abstinence
- Share of my goal of moderate use

Alfred Adler was quoted as having said, "If your only tool is a hammer, then every problem seems like a nail." This article has outlined strategies for

engaging difficult-to-reach clients with substance use disorders. It is hoped that you will find some of these strategies useful in your journey to help clients recover.

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