Outline for Sinnissippi's Investigations Group

The Investigations Group was developed approximately five years ago. The approach is based on Prochaska's stages of change model and the evolving client and goal directed work of Scott Miller and others. The target population is "mandated" and "unmotivated" substance abusers.

The goal is to provide a therapeutic service to this population that provides an opportunity for rapid access to service, gives room for "story telling" from the client's perspective, encourages consideration of differing perspectives from others' points of view, formalizes the client's theory of change through written assignments, and provides direct feedback of the client's perspective(s) and goals of change to referring agencies.

We recognize the therapeutic process consists of the consideration of the possibilities and desired outcomes of all interested parties related to the client, in addition to the client. It is in this space of possibility that all ideas of change can be fully expressed, shared, reviewed, tested and perhaps implemented. It is a space of "hosting" to all interested parties. It is also a place to tease out all ideas related to the ambivalence of positive change, characteristic of "contemplators."

Over the last 11-12 years, we have developed a short form/shorthand version of the Prochaska model of change that is used in our range of services, including the Investigations Group:

1. Pre-contemplation – The client perceives the "problem" as a "solution" to some other experienced "problem." All behavior is based on this theory.

2. Contemplation – The client's "solution" is increasingly experienced as problematic and adding to life's difficulties. The "solution" is starting to be recognized as a "problem" in their internal dialogue. To all others, it continues to be presented as a solution. This typically leads to increasingly desperate engagement of the "solution" based behavior. Cognitive dissonance and ambivalence are hallmarks of this stage.

3. Preparation – The problem has become fully apparent to self and others. This is acknowledged to others. Ambivalence changes from "Could it be a problem?" to "How do I modify this to make it work again?" The start of behavioral change, "experimenting with the problem," is central to the client's theory of change. The experimenting results in either perceived successful modifications (a return to the contemplation stage) or acknowledged failure of all experimenting, and a shift to the action stage. This is usually a very brief stage – days or weeks.

4. Action – The period of both perceptual and behavioral positive change, usually based on a combination of fear (past) and hope (future), that frequently lasts approximately 1-2 years. It is a time of testing, experimenting, learning and

integrating what works, setbacks, and a movement toward a new theory of change about life. Setbacks can lead to full relapses. Support that reinforces the client's emerging positive goals of change are critical, as well as the "hard work" required to sustain and grow it.

5. Goal Maintenance – The time of continued growth and integration of what works. The goals of change are experienced as positive and working. This stage is seen largely as "post-treatment," unless a setback is experienced in a way where treatment is seen as valuable to the process of "getting back on track." Usually brief treatment is indicated.

The key aspects of the client/goal driven model of therapy are:

1. Hosting – Primarily making clients genuinely feel welcome and that we are interested in their "situation." We then invite all interested parties to tell their "story" of the situation and the desired outcome. This is very critical to the entire therapeutic process.

2. "LAVing" – Listening, acknowledging and validating the "stories" as they are being told. Frequently, therapy is the first time any/all parties have had the chance to tell their story, have it heard by others and, most importantly, hear themselves really tell it themselves.

3. Therapeutic indicators of change – The three most critical indicators of whether therapy may be helpful are: 1) Positive pre-treatment change (by client); 2) The client's described sense of hope for the future (if any), and; 3) The client's sense of expectancy for the future. This describes what they believe is possible and underlies their theory of change. These three factors account for approximately 2/3 of the predictors for whether therapy will/might be beneficial. To the degree present, accessing these factors is critical to therapeutic and behavioral change. To the degree absent, reflecting on the absence of these factors, the implications of therapy are associated with highlighting the differences in points of view of all interested parties. The possibility exists at this point to amplify the client's theory in relation to others, highlight potential ambivalence and trigger positive movement. In the absence of movement, therapy then consists of reflecting back to all parties their respective positions. Therapy in the future may be indicated, if a client's perspective changes.

4. A client's theory of change – Embedded throughout a client's story, they are telling us what their ideas are about their situation, their ideas about change, if any, and their picture of the future. What are they telling us, what are we listening to and acknowledging, and what can we reflect back without taking their position or having our own position or ideas get in the way?

5. The what and when of treatment – for the precontemplator or early contemplator,

therapy may consist only of the process of drawing out the client's idea of no change, letting the client reflect that back to the other parties, acknowledging the difficulty of the situation at this time, and welcoming them back at some future time, if and as their situation warrants. If the client has experienced their story being heard, acknowledged and validated, they will likely return to this therapist because they will know that the therapist "gets it." In this way, we think of therapy potentially as a continuum of service interspersed over time, with individual episodes tailored to the client's theory of change (and potentially challenged by others) at various points along the way.

6. Client directed treatment goals – All treatment plan goals use client language containing their theory of change, and towards specific goals (i.e., "getting my job back, getting court off my back, staying out of jail, getting my kids back, etc…") and how others will know if this is happening. This keeps future conversations specific and behavioral.

Group Form/Process

Participation in group lasts 4-5 weekly sessions for 2-2-1/2 hours per session. There are three tasks:

1. Clients tell the story of their situation and the ramifications of benefits and costs – their theory of change.

2. Clients talk to 2-3 people in their lives who are important to them and their situation (spouses, parents, children, bosses, probation/parole officers and child welfare workers), questioning how the other sees them and their situation and what is desired or expected. The client then presents the findings to group, with a focus on meanings and implications to client.

3. Clients identify what, if anything, they want to do specifically and what will happen if they do/do not make the changes desired by others.

Copies are made of all tasks completed and are shared with all interested parties and mandating agencies.

If positive behavioral or cognitive change occurs at the completion of group, referral is made back to case managers with recommendations for further treatment as appropriate, in order to continue the positive change.

If no change occurs during group/tasks, referral is then made for further consultation between client and mandating agencies, and to determine if any further treatment is indicated at this time.