Financial Safety Avoid situations that are unsafe or create doubt or mistrust. If you are in the community or at the home of a client, don't carry loose cash in your pockets that could fall out in the home or tempt anyone to help themselves, affecting your trust relationship with your client. Don't lend money or hold money for clients. Keep payment agreements professional and clear. Transparency, including for debt-collection procedures, keeps everyone informed of responsibilities and consequences.

DID YOU KNOW?

Walk and Talk Sessions

The question has come up about whether there are insurance issues for counsellors who offer their clients "walk and talk" sessions as a regular or occasional therapy option. Brad Ackles, Vice President of Mitchell Abbott Group Insurance, the official insurers for BCACC members, says there are no "walk and talk" restrictions to their coverage.

"Our scope of coverage is very broad in that it covers those services 'usual and customary' to clinical counselling or psychotherapy," says Ackles. "There's also no restriction to providing services within a designated premises or office location, so these types of activities don't provide us with any problems or coverage obstacles."

However, Ackles does recommend that anyone in private practice have both Errors and Omissions Liability and Commercial General Liability to enhance their coverage to include most types of injuries, including "slip and fall" type claims. Get more information at mitchellandabbott.com.

PROJECT OVERVIEW

THE REWARDING CHANGE GROUP

Prize-based contingency management intervention is helping clients achieve goals in reducing or quitting illicit stimulant use.

BY HARKAMAL SANGHA, RCC

"Out of the shame spiral. This group breaks the monotony of being in the shame spiral all the time. When you're with people and see the progress they're making, you know it's attainable for you as well."

PROGRAM PARTICIPANT

The Pender Community Health Centre (PCHC) in Vancouver's Downtown Eastside (DTES) provides trauma-informed primary care, home health, mental health, and addictions services to inner-city clients. Clients, particularly those from marginalized backgrounds, are affected by poverty, street entrenchment, housing insecurity, unemployment, social isolation, and discrimination.

Although PCHC offers myriad psychosocial interventions, a challenge amongst clinicians has been finding ways to respond to the prevalent use of illicit stimulants (i.e. crack, cocaine, crystal meth) in the community. With the steady rise of crystal meth usage in the DTES over the past decade (a seven-fold increase reported in 2016 by the *Globe and Mail*[1])along with a gap in treatment services targeting stimulant addiction in the DTES (DTES 2nd Generation Strategy Report, 2015), this has created hardships for clients looking for help and clinicians wanting to offer treatment. In addition, approximately 40 per cent of clients receiving opiate-substitution therapy (i.e. methadose or suboxone) at PCHC have had a recent urine drug screen (UDS) for stimulants, which amongst methadone patients are associated with high attrition rates, poor treatment outcomes, and increased risk of HIV infection.[2]

Moreover, British Columbia is experiencing a public health emergency related to opioid overdoses; it is estimated that approximately 876 people died from a suspected drug overdose between January 2017 and July 2017, most often from fentanyl combined with cocaine, heroin, and crystal meth.[3]

In response, PCHC has been providing prize-based contingency management (PBCM) intervention in a group format for clients struggling with problematic stimulant use, many of whom present with polysubstance use and want to either cut down their stimulant use or quit altogether.

CONTINGENCY MANAGEMENT

Contingency management (CM) is a treatment intervention that involves reinforcing behaviours using incentives and is founded on principles of learning theory. A robust body of literature examining CM provides empirical support for the efficacy of this treatment in addressing problematic stimulant use.[4,5,6] Additional studies have shown CM's efficacy when targeting problematic stimulant use amongst methadone patients, leading to improved treatment outcomes primarily indicated by reduced stimulant use.[7] Research also supports the use of PBCM across a variety of clinical populations. In a study examining concurrent use of cocaine and opiates amongst clients enrolled in a methadone maintenance program, compared to participants receiving treatment as usual, participants receiving PBCM were four times more likely to demonstrate continuous abstinence for 12 weeks. One explanation for these outcomes is related to PBCM's unpredictable reinforcement.[8]

PCHC'S REWARDING CHANGE GROUP

We aptly named our PBCM group at PCHC the "Rewarding Change Group." Based on CM research designs using variable-based reinforcement therapies, we developed a fishbowl lottery in accordance with our budget by using 100 tokens and a fixed ratio of tokens to prizes: 20 per cent draw on no-value prizes (congratulatory certificates), 68 per cent draw on low-value prizes ($5 vouchers), seven per cent on medium-value prizes ($10 vouchers), and five per cent on high-value prizes ($25 vouchers). Clients draw once from the lottery every time a stimulant-free UDS is submitted and a maximum of two draws for consecutive weeks of stimulant-free UDSs. Increasing the frequency of incentive distribution often increases the power of the reinforcement in accordance with the principles of using PBCM interventions.[9] The budget we normally draw on for each group is approximately $250, which, in comparison to the amount researchers spend for 10-12 weeks, is quite low and, thus, feasible in community settings.

The Rewarding Change Group is a closed group held weekly for 10 to 12 weeks and typically consists of five to 10 participants. We try to limit barriers to access the group, so inclusion criteria usually involves clients who reside in the DTES and present with complex medical and psychosocial needs, including polysubstance use with a goal to either cut down or arrest illicit stimulant use, and may or may not be on opiate substitution therapy.

Group structure follows a format: the first half of the session time is often used to check-in and go over weekly goals and facilitators review a topic involving psycho-education or a CBT exercise related to relapse prevention or coping skills; the second half focuses on the fishbowl lottery and UDSs. Clients who submit a stimulant-free UDS are eligible to draw from the fishbowl lottery and win a prize.

WINNING RESULTS

We have done several rounds of treatment with the Rewarding Change Group over the last three years, and in each, we often are amazed by the results, not only in terms of reduced illicit stimulant use (i.e. in one group we compared the average percentage of stimulant-free UDSs for clients 12 weeks prior to the group compared to after completing the 12-week group and results consistently indicated an increase in the percentage of stimulant-free UDSs following treatment), but also other factors that contribute to successful outcomes. For example, as facilitators, we have often witnessed clients breaking out of social isolation and forming supportive relationships, receiving validation and non-judgemental support from peers regardless of submitting stimulant-free UDS and witnessing clients employ new coping skills to deal with daily stressors.

Client feedback is rewarding. "This group is the highlight of my week, because I receive so much support, and I never know what prize I'm going to win, which makes it so fun!," said one client. Another commented, "My goal was to get at least a couple of days clean from using crystal meth, and this group made that possible!"

Providers in our community have also started to use a similar group model in other clinical settings. As well, as there is a paucity of studies focusing on the use of this psychosocial intervention amongst vulnerable populations, we applied for a research grant through the VCH Research Challenge offered in partnership with the VCH Research Institute to investigate the effects of PBCM group intervention on stimulant use as well as psychosocial well-being amongst DTES clients on opiate substitution therapy. Our proposal was awarded a research grant, and we were approved by the UBC Research Ethics Board to go ahead with our study. The project is ongoing.

WANT TO LEARN MORE?
A story of our group was posted in June 2016, on the Vancouver Coastal Health news website at www.vchnews.ca. You can also contact me at harkamal.sangha@vch.ca.

RESOURCES

1 Woo, A. (2016, March 4th). The quiet rise of crystal meth. *The Globe and Mail.* Retrieved March 24th, 2016.

2 Higgins, S.T., Silverman, K., & Heil, S.H. (2008). *Contingency Management in Substance Abuse Treatment.* New York: The Guilford Press.

3 Dhillon, S. (2017, Sept 7th). BC's fentanyl overdose crisis has worsened in 2017, data shows. *The Globe and Mail.* Retrieved September 12th, 2017.

4 Petitjean, S.A., Dursteler-MacFarland, K.M., Krokar, M.C., Strasser, J., Mueller, S.E., Degen, B., ...Farronato, N.S. (2014). A randomized, controlled trial of combined cognitive-behavioral therapy plus prize-based contingency management for cocaine dependence. *Drug and Alcohol Dependence*, 145, 94-100.

5 Benishek, L.A., Dugosh, K.L., Kirby, K.C., Matejkowski, J., Clements, N.T., Seymour, B.L., & Festinger, D.S. (2014). Prize-based contingency management for the treatment of substance abuse: a meta-analysis. *Addiction*, 109(9), 1426-36.

6 Petry, N.M., & Roll, J.M. (2011). Amount of earnings during prize contingency management treatment is associated with post treatment abstinence outcomes. *Experimental and Clinical Psychopharmacology*, 19(6), 445-450.

7 Pierce, J.M., Petry, N.M., Stitzer, M.L., Blaine, J., Kellogg, S., Satterfield, F et al. (2006). Effects of lower-cost incentives on stimulant abstinence in methadone maintenance treatment: A national drug abuse treatment for clinical trials network study. *Archives of General Psychiatry*, 63, 201-208.

8 Higgins et al, 2008

9 Kellog, S.H., Stitzer, M., Petry, N., & Kreek, M.J. (2006). Condensed from the article "Motivational Incentives: Foundations & Principles" (Unpublished Chapter).

ADDITIONAL RESOURCES

Roll, J.M., Madden, G.J., Rawson, R., & Petry, N.M. (2009). Facilitating the adoption of contingency management for the treatment of substance use disorders. *Behavioral Analysis in Practice*, 2(1), 4-13.

Seades-Villa, R., Garcia-Fernandez, G., Pena-Suarez, E., Garcia-Rodriguez, O., Sanchez-Hervas, E., & Fernandez-Hermida, J. (2013). Contingency management is effective across cocaine-dependent outpatients with different socioeconomic status. *Journal of Substance Use Treatment*, 44, 349-354.

BEING CLEAR, STAYING WELL

"THE SELF-CARE PIECE IS ESSENTIAL FOR THERAPISTS," SAYS MARIE-JOSÉ DHAESE. AND YOU OWE IT TO YOURSELF TO FIND AN APPROACH TO SELF-CARE THAT WORKS FOR YOU.

BY CAROLYN CAMILLERI

"The essence of our work comes from our capacity to attune to ourselves first and then to others, and then how we hold the space for them — it's bound to call upon our boundaries," says Dhaese, founder of the Centre for Expressive Therapy in Parksville and a pioneer in expressive play therapy and animal-assisted therapy. She has been teaching for more than 30 of her 43 years in practice and offers "Therapy for Therapists" by phone, in person, and at healing retreats.

No matter what emotions and issues your clients bring with them to session, you need to maintain a level of clarity and stamina to hold that space, and then know how to "clean it up" afterwards. "It's very difficult to keep finding ways of cleaning yourself up each day — and after each session — and reconnecting to yourself, re-grounding yourself, and getting ready for the next client," says Dhaese. "It takes a lot of practice."

Another problem is information overload. "People are becoming disconnected from what they really know, from their natural instinct, and it's very hard to attune to yourself when your head is full of things you're supposed to do."

Self-care helps you maintain your stamina, clear toxicity, process new information, and restore your own energy to prevent health problems and to allow yourself to grow as a counsellor. Finding a self-care approach that works well for you means thinking about what you like to do.

"I always look for what gives this person pleasure and what's easy for them — things they need in their lives at different times for different parts of themselves," says Dhaese.

She believes there has to be an aspect of self-care that is physical. "I'm 70 years old, and I walk an hour and a half each day at the end of my day. That's what's kept me going."

Rhythmic, physical release allows you to "flow and flush," she says. "It's like natural EMDR, where there is bilateral movement, and you let it reconnect you to your body, especially when you spend a whole day sitting in a chair — or on the floor, as we do as play therapists."

If Dhaese finds walking isn't enough, she listens to inspiring podcasts until her mind gets quieter. She also suggests colouring, which provides that EMDR-like, back-and-forth effect. "With some people, a cup of tea while knitting and listening to music might be what they do."

You may want to explore music, art, or sand therapy and make it part of your self-care regime. And sometimes you need to take self-care to the next level. For example, if you are dealing with an issue of transference or counter-transference or if you've been activated in own your issues.

"I can't imagine having been a therapist for 43 years and not having had somebody I could go to regularly if something stirred me up, because no amount of walking is going to take care of that."

Supervision or consultation is also important so you have someone to debrief cases with and to discuss new information with.

"I would say to any therapist, it's really important that you come back to how you view human beings, what it is that you know, and digest it really well before you start using it in therapy with your clients. It's like a compassionate understanding that allows you to have boundaries — that neutrality and clarity are really what makes a therapist."

The hardest lesson, she says, is to value and cherish yourself. "And really remember that if you don't have your health — your physical and emotional health — you cannot keep swimming in toxicity and not be affected," she says. "It has a side effect to be a therapist. I have seen so many people come and go in this field over the years. You have to make self-care a priority."

One of Dhaese's favourite ways to "flow and flush" is making snow angels. "There's nothing like it, to let yourself fall into the snow and look up at the sky."

SELF-DATING

Do something special for someone you love — yourself. There is nothing selfish about treating yourself to some extra attention to boost your spirits and help you better appreciate your own company.

- Make a reservation for dinner somewhere nice, then dress up and go. If you are nervous about dining alone, bring a book.
- Go to a concert and sing, dance, and get lost in the music.
- Pack a gourmet picnic lunch, go to a park, and enjoy nature.
- Light candles, play some soothing music, turn off your cell phone ringer, and relax in a warm, fragrant bath.
- Sign up for a class in painting, pottery, poetry, cooking, gardening — whatever creative endeavour takes your fancy.
- Tour a vineyard or a farm and stay for lunch to enjoy the setting.
- Imagine someone is visiting you from out of town. Plan a tour to show them the sights and then take yourself.