

Right Intervention, Right Time: Evidenced Based Interventions Across the Stages of Change

Michael Oldenburg MA LCPC CADC CODP





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WHY THIS MATTERS

The Case for Stage-Matched Care

20% ↑ 80%

Over a period of 12 months those who have stage matched interventions achieved more recovery days compared to those who do not.

Source: Roseance

85%

Relapse is widely accepted as part of the process of recovery. 85% of individuals receiving stage matched interventions return to contemplation stage as opposed to relapsing over.

Source: Schmitz/Smith/Leider

Retention

A study on community-based treatment found that MI significantly improved participant retention through the critical 28-day mark, overcoming the high drop-off rates typically seen during initial intake.

MI.gov

"Different people need different things at different times."

- James O. Prochaska

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THE MODEL

What Is the Transtheoretical Model?

Developed by Prochaska & DiClemente (from 1977, first published 1983) by studying how smokers quit – the model has since been validated across alcohol, opioid, and stimulant use disorders.

Change is a process, not an event. People move through stages cyclically – often revisiting earlier ones before change lasts. Treatment matched to a person's current stage produces meaningfully better outcomes than a one-size-fits all approach.

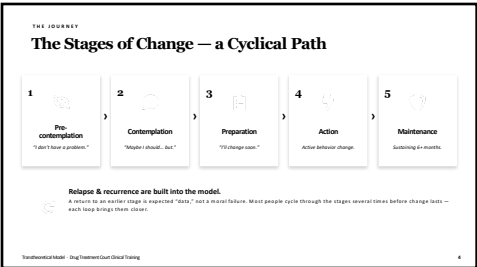
TTM is a framework for selecting interventions. Different evidenced based interventions are most effective at different stages of change.

FIVE CORE CONSTRUCTS

- Stages of change**
A person's readiness to act, from precontemplation to maintenance.
- Processes of change**
The content and event activities that move people between stages.
- Decisional balance**
Weighing the pros and cons of changing the behavior.
- Self-efficacy**
Confidence in the ability to sustain change under temptation.
- Levels of change**
The depth of issues a person is working to change.

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STAGE 1 OF 5

Pre-contemplation

"I don't really have a problem."

STAGE OF TREATMENT
Engagement

WHAT THIS STAGE LOOKS LIKE
No intention to change in the next six months. The person may be unaware the behavior is a problem — they often state feeling like they do not have a choice to be in treatment.

What you'll see & hear
Denial, minimization, defensiveness, and externalized blame. Pious of using outweigh perceived costs.

MATCHED EVIDENCE-BASED INTERVENTIONS

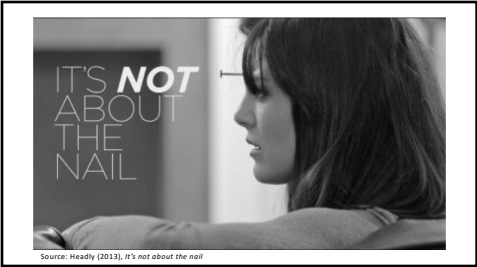
Build rapport & trust	Reflective listening
Raise awareness, non-confrontationally	Psychoeducation
Set — engaging skills	Explore values vs. effects of use

CLINICAL GOAL
Build confidence and plant doubt — move toward contemplation

AVOID
Pushing action-oriented demands — it deepens resistance

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STAGE 2 OF 5



Contemplation

"Maybe I should change... but."

STAGE OF TREATMENT

Precussion

WHAT THIS STAGE LOOKS LIKE

Beginning to recognize the behavior as a problem and intending to act within six months — yet deeply ambivalent, weighing pros and cons with equal emphasis.

What you'll see & hear

"Yes, but..." thinking. Ambivalence interlarded with hesitation and self-doubt about changing.

WATCHED EVIDENCE-BASED INTERVENTIONS

Motivational interviewing

Develop discrepancy

Elicit change talk

Decisional balance exercise

Explore ambivalence openly

Affirm autonomy

Clinical Goal

Develop ambivalence and tip the balance toward change.

Avoid

Arguing for change — it grounds custom talk.

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Source: Dawn Clifford's MI TIPS (2019)

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STAGE 3 OF 5



Preparation

"I'm going to change — soon."

STAGE OF TREATMENT

Precussion

WHAT THIS STAGE LOOKS LIKE

Committed to acting within the next 30 days and already taking small steps — researching options, setting dates, telling others. Belief that change leads to a healthier life.

What you'll see & hear

Goal setting and planning behavior, often shadowed by fear of failure or relapse.

WATCHED EVIDENCE-BASED INTERVENTIONS

Collaborative change plan

Anticipate obstacles

Build self-efficacy

SMART goal setting

Readiness & confidence rulers

Multiple supports

Clinical Goal

Build a concrete plan and the confidence to start.

Avoid

Major plans — they stall momentum into action.

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STAGE 2 OF 5

Action

"I'm doing the work now."

STAGE OF TREATMENT

Active Treatment

WHAT THIS STAGE LOOKS LIKE

Qvert behavior change made within the last six months — the most visible and demanding stage, requiring considerable time and energy and leaving the person vulnerable to relapse.

What you'll see & hear

Concrete changes plus stress, fatigue, and exposure to triggers and temptation.

WATCHED EVIDENCE-BASED INTERVENTIONS

Cognitive behavioral therapy

Relapse prevention planning

Medication for OUD (MAT)

CLINICAL GOAL

Support and reward action — carry it into maintenance.

Skills & coping training

Contingency management

Reinforcement & validation

AVOID

Withdrawing support once early gains appear.

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STAGE 3 OF 5

Maintenance

"I need to keep this going."

STAGE OF TREATMENT

Relapse Prevention

WHAT THIS STAGE LOOKS LIKE

Change sustained for six months or more, with active work to prevent relapse. On the URICA this is measured as "struggling to maintain" — vigilance is still required.

What you'll see & hear

Growing confidence alongside ongoing effort to manage cues, stress, and high-risk situations.

WATCHED EVIDENCE-BASED INTERVENTIONS

Relapse prevention skills

Strengthen social support

Lifestyle & routine change

CLINICAL GOAL

Stabilize change and reinforce a recovery identity.

Consolidate coping strategies

Ongoing CM & MAT

Accountability structures

AVOID

Testing recovery as "finished" — ignore team.

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WHEN CHANGE LOOPS BACK

Relapse & Recurrence

Relapse is not a stage — it is a return from action or maintenance to an earlier stage. The model treats it as expected information, not a moral failure.

Expected, not exceptional

Most people cycle through the stages several times before change becomes lasting.

A learning mechanism

Each recurrence surfaces triggers and gaps — information that strengthens the next attempt.

Re-engage without shame

Re assess the current stage, revise the relapse prevention plan, and regain the cycle.

The Court's Response Matters

A positive drug test is clinical data first. Weigh therapeutic adjustments — a change in treatment intensity or modality — against punitive sanctions in light of the participant's stage of change.

Sanctioning recurrence as mere misconduct — rather than measuring therapeutic risk — punishes participants away from recovery and out of the program.

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QUICK REFERENCE

Matching the Intervention to the Stage

Stage	What you hear	Stage of treatment	Lead interventions
Precontemplation	"I don't have a problem."	Engagement	Support, reflective listening, awareness, MI engaging
Contemplation	"Maybe... but..."	Persuasion	MI, decisional balance, developing discrepancy
Preparation	"I'll change soon."	Persuasion	Change plan, SMART goals, confidence scales
Action	Active change	Active Treatment	CBT skills, relapse prevention, CMR, SMART
Maintenance	"Things are going..."	Relapse Prevention	Coping, socialization, support, ongoing CBT/SMART
Relapse / recurrence	A return, not failure	Re-engage	Non-judgmental re-entry, re-assess, re-set plan

Stage of treatment (Engagement → Persuasion → Active Treatment → Relapse Prevention) pairs each stage of change with the clinical posture that fits it.

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THE TOOLKIT

Four Core Evidence-Based Interventions

Motivational Interviewing Best fit Early-stage Person-centered method to resolve ambivalence. Spirit: partnership, acceptance, compassion, evocation. Builds intrinsic motivation and empowers resistance.	Contingency Management Best fit Action-Maintenance Tangible rewards for negative tests and recovery milestones. Backed by 150+ studies over ~40 years; complements counseling — it doesn't replace it.
Medication for OUD Best fit Action-Maintenance Buprenorphine, methadone, naltrexone reduce overdose and mortality. Courts should facilitate — never penalize — a participant's use of evidence.	CBT & Relapse Prevention Best fit Action-Maintenance Builds coping skills, identifies triggers, and reinforces high-risk situations — turning early setbacks into double recovery.

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ENGAGING THE AMBIVALENT – MOTIVATIONAL INTERVIEWING

MI Skills for the Early Stages of Change

Building intrinsic motivation in precontemplation and contemplation

OARS: The Core Micro-Skills Open-ended Questions – invite the person to do most of the talking and surface their own reasons for change. Affirmations – recognize genuine strengths and effort to build confidence and a trusting alliance. Reflective Listening – mirror back meaning to people feel understood and explore ambivalence about. Summaries – pull change talk together and confirm you've heard it accurately.	Early-Stage Strategies Engage Active Listening – build rapport first; readiness grows out of a strong working relationship. Develop Discrepancy – gently highlight the gap between a person's values and current behavior. Roll with Resistance – avoid arguing or persuading; pushing harder only deepens defensiveness. Shift Change Talk – draw out and reinforce the person's own arguments for change. Skip the Righting Reflex – resist the urge to fix or lecture; ask permission before offering advice.
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DOING IT RIGHT - CONTINGENCY MANAGEMENT

Contingency Management: The Do's

Design principles that make reinforcement actually work

Reinforce Immediately

Deliver the reward right after a verified success — delay weakens the behavioral link.

Make Rewards Tangible

Use vouchers, prizes, or privileges that participants genuinely value and can receive.

Escalate for Consistency

Raise reward value as negative risks bring together to motivate sustained effort.

Reward the Right Targets

Reinforce objectives worth clearing (e.g., screens, intentions, and concrete milestones).

Reset After a Slip

Return to the baseline reward, then let value rebuild — stay corrective, not punitive.

Keep the Rules Clear

Define behaviors, rewards, and schedules up front and apply them transparently every time.

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MEASURING READINESS

Tools to Assess the Stage of Change

URICA

One of Rhode Island Change Assessment

32 items, four subscales (precontemplation, contemplation, action, maintenance).
Combine and C + A + M = PC for a Readiness-to-Change score.

Readiness Rulers

Importance & confidence, 0-10

Two quick rulers used within MI: "Why a 6 and not a 0?" and "What would move you to a 10?" which change talk.

SOCRATES

Stages of Change Readiness & Treatment Engagement

Alcohol (BA) and drug (BD) versions in SAMHSA TIP 35 — a brief validated readiness screen for courts.

Interpret scores in light of readiness. A low-readiness score in someone who has already stopped using doesn't mean denial — it means they are first of the problem. The number never replaces clinical judgment.

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MEASURING READINESS - TOOL 1 OF 3

URICA: Readiness Across Four Stages

University of Rhode Island Change Assessment

What it is
A 32-item self-report questionnaire that locates a person along the stages of change, rated on a four-point agree-disagree scale.

How it works
Four subscales — Precontemplation, Contemplation, Action, and Maintenance — combine and C + A + M = PC for a single Readiness-to-Change score.

Best used for
Setting a baseline at intake and tracking how readiness shifts over the course of treatment.



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MEASURING READINESS - TOOL 2 OF 3

Readiness Rulers: A Conversation in Two Scales

Importance & confidence rulers, scored 0-10

What it is

Two quick 0-10 scales — how important is change, and how confident are you — used conversationally within motivational interviewing.

How it works

Ask for a number, then explore it. “Why a 6 and not a 10?” surfaces reasons to change. “What would move you to a 10?” builds the next step.

Best used for

Fast in-session checks-in that elicit change talk with no forms — ideal for gauging momentum and to exit.



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MEASURING READINESS - TOOL 3 OF 3

SOCRATES: A Brief Readiness Screen

Signs of Change Readiness & Treatment Engagement Scale

What it is

A short, validated self-report screen with alcohol (BA) and drug (BD) versions, featured in SAMHSA TIP 35.

How it works

Alcohol items yield three scores — Recognition, Ambivalence, and Taking Steps — profiling where a person stands entering treatment.

Best used for

A quick readiness snapshot at intake when a full assessment battery isn't practical.



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PUTTING IT TO WORK

Best Practices & Common Pitfalls

DO THIS

Match service intensity to assessed risk and need.

Align treatment with action & maintenance — reward, don't just sanction.

Facilitate medication for OUD; never penalize it.

Use motivational interviewing across the whole court team.

Weigh therapeutic adjustments before jail sanctions.

AVOID THIS

Applying action-stage demands to precontemplative clients.

Treating relapse as moral failure rather than clinical data.

Misreading low-readiness scores as denial.

One-size-fits-all programming for every participant.

Confronting resistance head-on — break the “faking reflex.”

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