Using Community-Based Services to Engage People in Client-Driven, Lasting Change: Think Outside the Residential Treatment Box

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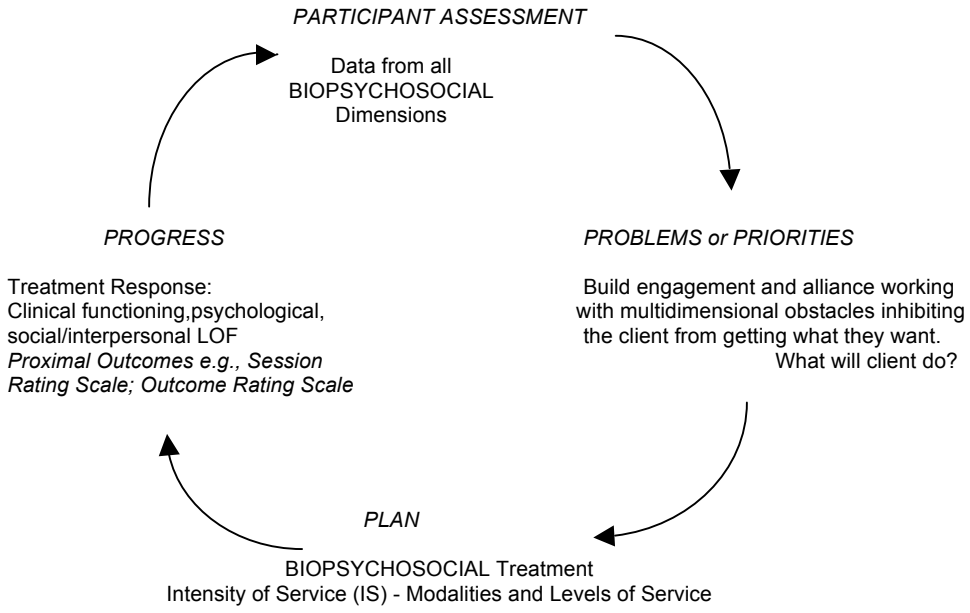
A. Underlying Principles and Concepts of the ASAM Criteria

1. Measurement-based Care -Feedback Informed Treatment



2. Assessment of Biopsychosocial Severity and Function *(The ASAM Criteria* 2013*,* pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

3. Biopsychosocial Treatment - Overview: 5 M's

* Motivate - Dimension 4 issues; engagement and alliance building
* Manage - the family, significant others, work/school, legal
* Medication – withdrawal management; HIV/AIDS; anti-craving anti-addiction meds MAT; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
* Meetings - AA, NA, Al-Anon; SMART Recovery, Dual Recovery Anonymous, etc.
* Monitor - continuity of care; relapse prevention; family and significant others

4. Treatment Levels of Service *(The ASAM Criteria* 2013*,* pp 106-107)

1 Outpatient Services
2 Intensive Outpatient/Partial Hospitalization Services
3 Residential/Inpatient Services
4 Medically-Managed Intensive Inpatient Services

ASAM Criteria Level of Withdrawal Management Services for Adults	Level	Note: There are no separate Withdrawal Management Services for Adolescents
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.
Clinically-Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery
Medically-Monitored Inpatient Withdrawal Management	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring
Medically-Managed Inpatient Withdrawal Management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability
ASAM Criteria Levels of Care	Level	Same Levels of Care for Adolescents except Level 3.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	1	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	2.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	2.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	3.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)	3.3	24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
Clinically-Managed High-Intensity Residential	3.5	24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
Medically-Monitored Intensive Inpatient	3.7	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
Medically-Managed Intensive Inpatient	4	24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment
Opioid Treatment Services	OTS	Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone

B. **Engaging People in Client-Driven Lasting Change**

1. What Works in Treatment - The Empirical Evidence

(a) Extra-therapeutic and/or Client Factors (87%)

(b) Treatment (13%):

- 60% due to "Alliance" (8%/13%)
- 30% due to "Allegiance" Factors (4%/13%)
- 8% due to model and technique (1%/13%)

(Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.
Miller, S.D., Mee-Lee, D., & Plum, B. (2005). Making Treatment Count. In J. Lebow (ed.). *Handbook of Clinical Family Therapy. New York: Wiley).*

2. Developing the Treatment Contract *(The ASAM Criteria* 2013*,* page 58)

	Client	Clinical Assessment	Treatment Plan
What?	What does client want?	What does client need?	What is the Tx contract?
Why?	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
How?	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
Where?	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
When?	When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

3. Definitions of Compliance and Adherence

Webster's Dictionary defines "**comply**" as follows: to act in accordance with another's wishes, or with rules and regulations. It defines "**adhere**": to cling, cleave (to be steadfast, hold fast), stick fast.

4. Stages of Change and How People Change

Transtheoretical Model of Change (Prochaska and DiClemente):

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; active resistance to change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of a possible "problem" and possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a "problem" or needs to change; wants to change, but this desire exists simultaneously with resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong resistance and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out and regression in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorder, with occasional cocaine (crack) use on weekends. He reports no withdrawal symptoms, but then he really doesn't think he has a problem and you are basing your tentative diagnosis on reports from the school, probation officer, and older sister.

Carl has been arrested three times in the past eighteen months for petty theft/shoplifting offenses. Each time he has been acting intoxicated but says he has not been using any drugs. The school reports acting up behavior, declining grades and erratic attendance, but no evidence of alcohol/drug use directly. They know he is part of a crowd that uses drugs frequently.

Yolanda, Carl's 24 y.o. sister, has custody of Carl following his mother's death from a car accident eighteen months ago. She is single, employed by the telephone company as a secretary, and has a three y.o. daughter she cares for. She reports that Carl stays out all night on weekends and refuses to obey her or follow her rules. On two occasions she has observed Carl drunk. On both occasions he has been verbally aggressive and has broken furniture. A search of his room produced evidence of marijuana and crack, which Carl says he is holding for a friend.

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