Moving Beyond Compliance to Lasting Change: How The ASAM Criteria and Evidence-Based Practices Can Help

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A. Understanding How People Change and How to Facilitate Change

1. Natural Change and Self-Change

(DiClemente CC (2006): "Natural Change and the Troublesome Use of Substances – A Life-Course Perspective" in "Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It" Ed. William R Miller and Kathleen M. Carroll. Guildford Press, New York, NY. pp 91; 95.)

The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But "treatment is an adjunct to self-change rather than the other way around." "The perspective that takes natural change seriously…shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change." (DiClemente, 2006)

2. What Works in Treatment - The Empirical Evidence
- Extra-therapeutic and/or Client Factors (87%)
- 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).*

3. Three aspects of the Therapeutic Alliance (Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY. Guilford Press.p. 39):
(a)

(b)

(c)

4. Stages of Change

*   Transtheoretical Model of Change (Prochaska and DiClemente):

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

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

<u>Preparation</u>: 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.

<u>Action</u>: 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.

<u>Maintenance</u>: 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.

<u>Relapse and Recycling</u>: 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.

<u>Termination</u>: 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.

B. **<u>Engaging the Participant in Collaborative Care</u>**

1. <u>Developing the Treatment Contract and Focus of Treatment</u>

	Client	Clinical Assessment	Treatment Plan
<u>What?</u>	What does client want?	What does client need?	What is the Tx contract?
<u>Why?</u>	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
<u>How?</u>	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
<u>Where?</u>	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
<u>When?</u>	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?

2. Mandated Treatment's Mission versus Treatment's Mission

The mandated client can often present as hostile and "resistant" because they are at "action" for staying out of jail; keeping their driver's license; saving their job or marriage; or getting their children back. In working with referral agencies whether that be a judge, probation officer, child protective services, a spouse, employer or employee assistance professional, the goal is to use the leverage of the referral source to hold the client accountable to an assessment and follow through with the treatment plan.

Unfortunately, clinicians/programs often enable criminal justice and mandating agencies' thinking by blurring the boundaries between "doing time" and "doing treatment". For everyone involved with mandated clients, the 3 C's are:

> ⚐ Consequences – It is within mandating agencies and criminal justice's mission to ensure that participants take the consequences of their illegal or unsafe behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the participant and the public is best served by providing treatment rather than punishment, then clinicians provide treatment not custody and incarceration. The obligation of clinicians is to ensure a person adheres to treatment; not to enforce consequences and compliance with court orders.

> ⚐ Compliance – The participant is required to act in accordance with the court's orders; rules and regulations. Mandating agencies and criminal justice personnel should expect compliance. But clinicians are providing treatment where the focus is not on compliance to court orders. The focus is on whether there is a disorder needing treatment; and if there is, the expectation is for adherence to treatment, not compliance with "doing time" in a treatment place.

> ⚐ Control –Mandating agencies and the criminal justice system aim to control, if not eliminate, illegal acts that threaten the public or safety to children and families. While control is appropriate for the courts and child protective services, clinicians and treatment programs are focused on collaborative treatment and attracting people into recovery. The only time clinicians are required to control a client is if they are in imminent danger of harm to self or others. Otherwise, as soon as that imminent danger is stabilized, treatment resumes collaboration and client empowerment, not consequences, compliance and control.

The clinician should be the one to decide on what is clinically indicated rather than feeling disempowered to determine the level of service, type of service and length of service based on the assessment of the client and his/her stage of readiness to change. Clinicians are just that, not right arms of the law or child protective services or the workplace to carry out mandates determined for reasons other than clinical.

Thus, working with referral sources and engaging the identified client into treatment involves all of the principles/concepts to meet both the referral source and the client wherever they are at; to join them in a common purpose relevant to their particular needs and reason for presenting for care. The issues are:

- Common purpose and mission – public safety; safety for children; similar outcome goals
- Common language of assessment of stage of change – models of stages of change
- Consensus philosophy of addressing readiness to change – meeting clients where they are at; solution-focused; motivational enhancement
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create and provide incentives and supports for change
- Communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change ; keep our collective eyes on the prize "No one succeeds unless we all succeed!"

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C. **The Power of Language and Terminology**

1. From Pathology to Participant
  ⚔ Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician
  ⚔ "Resistance" may be as much a problem with knowledge, skills and attitudes of clinicians as it is a "patient" problem

As a first step to moving from pathology to participant, consider our attitudes and values about resistance. It is often perceived as pathology that resides within the client, rather than an interactive process or even a phenomenon induced and produced by the clinician.

2. Changing the Concept of Resistance

- In the Glossary (Miller & Rollnick, 2013. page 412): "Resistance – A term previously used in Motivational Interviewing, now deconstructed into its components: sustain talk and discord."
- Notice "previously used" means: "Resistance" as a term and concept will no longer be used as in previous editions- "Rolling with Resistance"; "Responding to Resistance".

Here's a quote from page 197: "*…our discomfort with the concept of resistance has continued to grow, particularly because it seems to place the locus and responsibility for the phenomenon within the client. It is as though one were blaming the client for "being difficult." Even if it is not seen as intentional, but rather as arising from unconscious defenses, the concept of resistance nevertheless focuses on client pathology, under-emphasizing interpersonal determinants.*"

So if you start deleting "resistance" from your clinical vocabulary and focus on "sustain talk" and "discord," you are now in a better position to attract a person into recovery than responding to them as a resistant, non-compliant person in denial.

What is "sustain talk"?
- It is "the client's own motivations and verbalizations favoring the status quo." (p. 197). The person is not interested in changing anything; I am OK with keeping things the way they are – status quo, sustain what I have already got or where I already am.
- "There is nothing inherently pathological or oppositional about sustain talk. It is simply one side of the ambivalence. Listen to an ambivalent person and you are likely to hear both change talk and sustain talk intermingled." (p. 197). "Well maybe I have a drug problem and should do something about it if I don't want to be arrested again." (Change talk). "But it really isn't as bad as they say, they're just overacting." (Sustain talk).

What is "discord"?
- "If we subtract sustain talk from what we previously called resistance, what is left? The remainder …more resembles disagreement, not being "on the same wavelength," talking at cross-purposes, or a disturbance in the relationship. This phenomenon we decided to call discord." (p. 197).
- "You can experience discord, for example, when a client is arguing with you, interrupting you, ignoring, or discounting you." (p. 197).

"Sustain talk is about the target behavior or change" – drinking or drugging, over-eating, gambling etc. "Discord is about you or more precisely about your relationship with the client – signals of discord in your working alliance." – Are you on the same page as your client? Are you more interested in abstinence and recovery than they are? Are you doing more work than them about going to AA or taking medication?

3. Compliance versus Adherence
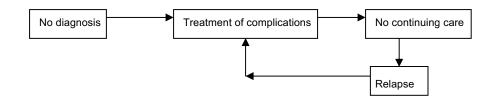
Treatment or medication *compliance* is a term that has had long use in the health care field in general and the addiction and mental health sectors in particular. Webster's Dictionary defines "to comply" as "to act in accordance with another's wishes, or with rules and regulations." By contrast, it defines "adhere" as "to cling, cleave (to be steadfast, hold fast), to stick fast."
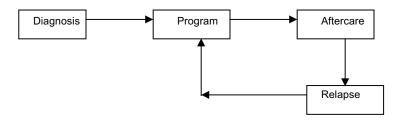
D. **Underlying Principles of The ASAM Criteria**

1. Complications-driven Treatment

- ⚔ No diagnosis of Substance Use Disorder
- ⚔ Treatment of complications of addiction with no continuing care
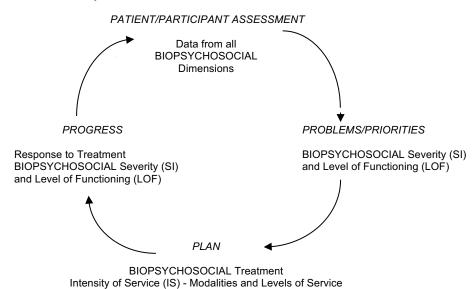- ⚔ Relapse triggers treatment of complications only

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┌──────────────┐      ┌──────────────────────────┐      ┌────────────────────┐
│ No diagnosis │ ───▶ │ Treatment of complications│ ───▶ │ No continuing care │
└──────────────┘      └──────────────────────────┘      └────────────────────┘
                                  ▲                                 │
                                  │                                 ▼
                                  │              ┌─────────┐
                                  └───────────── │ Relapse │
                                                 └─────────┘
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2. Diagnosis, Program-driven Treatment

- ⚔ Diagnosis determines treatment
- ⚔ Treatment is the primary program and aftercare
- ⚔ Relapse triggers a repeat of the program

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┌───────────┐      ┌─────────┐      ┌───────────┐
│ Diagnosis │ ───▶ │ Program │ ───▶ │ Aftercare │
└───────────┘      └─────────┘      └───────────┘
                        ▲                 │
                        │                 ▼
                        │            ┌─────────┐
                        └─────────── │ Relapse │
                                     └─────────┘
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3. Individualized, Clinically-driven Treatment

PATIENT/PARTICIPANT ASSESSMENT

Data from all
BIOPSYCHOSOCIAL
Dimensions

PROGRESS

Response to Treatment
BIOPSYCHOSOCIAL Severity (SI)
and Level of Functioning (LOF)

PROBLEMS/PRIORITIES

BIOPSYCHOSOCIAL Severity (SI)
and Level of Functioning (LOF)

PLAN

BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS) - Modalities and Levels of Service

4. <u>Clinical, Outcomes-driven Treatment</u> – <u>Feedback Informed Treatment</u>

PARTICIPANT ASSESSMENT

Data from all
BIOPSYCHOSOCIAL
Dimensions

PROGRESS

Treatment Response:
Clinical functioning, psychological,
social/interpersonal LOF
*Proximal Outcomes e.g., Session
Rating Scale; Outcome Rating Scale*

PROBLEMS or PRIORITIES

Build engagement and alliance working
with multidimensional obstacles inhibiting
the client from getting what they want.
What will client do?

PLAN

BIOPSYCHOSOCIAL Treatment
Intensity of Service (IS) - Modalities and Levels of Service

5. <u>Assessment of Biopsychosocial Severity and Function</u> *(The ASAM Criteria* 2013, pp 43-53)
The common language of six ASAM Criteria dimensions determine needs/strengths:

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

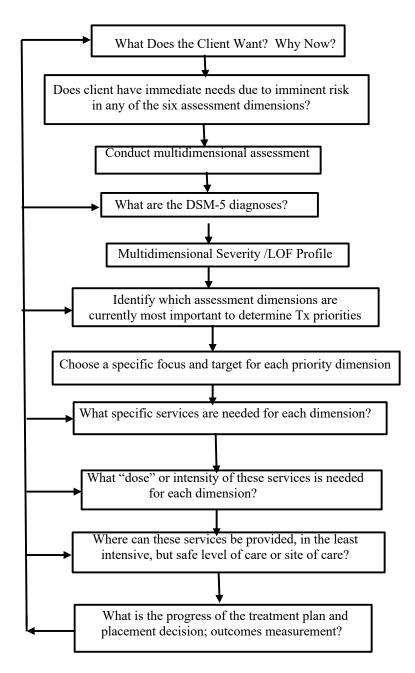7. <u>Biopsychosocial Treatment - Overview: 5 M's</u>
    * Motivate - Dimension 4 issues; engagement and alliance building
    * Manage - the family, significant others, work/school, legal
    * Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone;
       buprenorphine, 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

8. <u>Treatment Levels of Service</u> *(The ASAM Criteria 2013, pp 106-107)*

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

E. **How to Organize Assessment Data** – ASAM Criteria Assessment Dimensions

1. <u>How to Target and Focus Treatment Priorities</u>   *(The ASAM Criteria 2013, p 124)*

Flowchart:
- What Does the Client Want? Why Now?
- Does client have immediate needs due to imminent risk in any of the six assessment dimensions?
- Conduct multidimensional assessment
- What are the DSM-5 diagnoses?
- Multidimensional Severity /LOF Profile
- Identify which assessment dimensions are currently most important to determine Tx priorities
- Choose a specific focus and target for each priority dimension
- What specific services are needed for each dimension?
- What "dose" or intensity of these services is needed for each dimension?
- Where can these services be provided, in the least intensive, but safe level of care or site of care?
- What is the progress of the treatment plan and placement decision; outcomes measurement?

LITERATURE REFERENCES AND RESOURCES

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