Assessment and Treatment Planning for Substance Use Disorder

Learning Objectives

- Develop detailed assessments and treatment plans for fictional clients based on case studies
- Evaluate results of assessments and then apply ASAM Criteria to determine the appropriate level of care
- SMART treatment planning using ASAM and RNR criteria

Introductions

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Module 1

- **ASAM Dimensions**
- https://www.asamcontinuum.org/knowledgebase/what-are-the-six-dimensions-of-the-asam-criteria/

ASAM Dimensions

- **Dimension 1 Acute Intoxication and/or Withdrawal Potential**
  - What risk is associated with the patient's current level of acute intoxication?
  - Is there significant risk of severe withdrawal symptoms/seizures, based on withdrawal history?
  - Is there significant risk of severe withdrawal symptoms/seizures, based on frequency, chronicity, and recency of discontinuation of ATOD use?

ASAM Dimensions

- **Dimension 2: Biomedical Conditions and Complications**
  - Are there current (acute) physical illnesses, other than withdrawal, that need to be addressed because they create risk or may complicate treatment?
  - Are there chronic conditions that affect treatment?

ASAM Dimensions

- **Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications**
  - Are there current psychiatric illnesses or psychological, behavioral, emotional, or cognitive problems that need to be addressed because they create risk or complicate treatment?
  - Do any emotional, behavioral or cognitive problems appear to be an expected part of the addictive disorder, or do they appear to be autonomous?
  - Do they need specific mental health treatment?
  - Can the patient manage daily life activities?

ASAM Dimensions

- **Dimension 4: Readiness to Change**
  - What is the patient's motivation to change?
  - SOCRATES assessment

ASAM Dimensions

- **Dimension 5: Relapse, Continues Use or Continued Problem Potential**
  - Is this person at a high risk to relapse?
  - Is the risk exacerbated by a mental health disorder?
  - Does the patient have any recognition or understanding of, or skills in coping with, his or her addictive or mental health disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior?
  - How aware is the patient of relapse triggers?

ASAM Dimensions

- **Dimension 6: Recovery/Living Environment**
  - Do any of the people in the patient's circle of influence pose a threat to the patient's safety or engagement in treatment?
  - Does the person's environmental factors support recovery (child care, transportation, etc.)?
  - Is the person in treatment because of extrinsic motivations (criminal justice, job, family)?

Module 2

- **Severity Ratings (Chapter 4 of ASAM Criteria, matches severity ratings to Dimensions and advises as to corresponding services and modalities)**
- 0 – No risk, stable
- 1 – Mild
- 2- Moderate
- 3 – Significant
- 4 - Severe

Severity Rating 0

- No current risk found
- Patient may have a history but chronic disorders are stable
- No services needed

Severity Rating 1

- Minimal current difficulty or impairment
- Mild symptoms
- Stabilized or soon to be stabilized
- Treatment Planning to address problem

Severity Rating 2

- Moderate current difficulty or impairment
- Moderate symptoms/signs
- Difficulty in functioning but able to function with clinical intervention or other support services
- Treatment planning to address problem

Severity Rating 3

- Serious current difficulty or impairment
- Serious symptoms or signs
- Serious difficulty coping
- Significant likelihood that problems will interfere with treatment
- Treatment plan needed to address problem
- Regular monitoring of signs/symptoms

Severity Rating 4

- Severe current difficulty or impairment
- Serious symptoms or signs
- Poor ability to cope with problems or difficulties
- Impairment creates serious risk of injury to self or others
- Imminent danger
- Patient should not be leaving your office without intervention
- Immediate action may be necessary (active SI with plan)

Elements of Imminent Danger

- In order to be classified as imminent danger all 3 MUST be present
- 1) Strong probability relapse with addictive behaviors will occur
- 2) Such behaviors will present significant risk to self or others (e.g. impaired driving, neglect of a child)
- 3) Likelihood that such adverse behaviors will occur in the near future(hours/days) rather than weeks or months

Module 2

- **ASAM Levels of Care**
- https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/ and https://www.naadac.org/assets/1959/2012-03-14_understanding_and_utilizing_asam_webinarslides.pdf

ASAM Levels of Care

- **Level 0.5 Early Intervention**
  - Service for specific individuals who are at risk of developing substance-related problems
  - Service for those for whom there is not yet sufficient information to document a substance use disorder
  - **Length of Service: (Depends on)**
    a) individuals ability to comprehend information provided and make behavior changes accordingly or mandated programming
    b) appearance of new problems that require treatment at another level of care

ASAM Levels of Care

- **Level 0.5 Early Intervention**
- There was consideration given to providing criteria for having this be Prevention/Early Intervention
- Decision was made to only have this be Early Intervention because
  1) prevention and early intervention are different and cannot be addressed in the same criteria
  2) primary prevention is not sufficiently clinical to support development of a separate level of care

ASAM Levels of Care

- **Level 0.5 Early Intervention**
- DUI program is early intervention
- If assessment indicates a need for treatment, three possibilities
  1) if in imminent danger, transfer to a clinically appropriate level of care
  2) not in imminent danger, but requires outpatient, should attempt to facilitate a Level 0.5 program
  3) individual is able to wait to Level 0.5 program is completed, complete, then transfer to a higher level of care if needed

ASAM Levels of Care

- **Level 0.5 Early Intervention**
- **Dimensional Criteria**
  1) Any identifiable problems in Dimension 1,2 or 3 are stabilized or being addressed through appropriate services
  2) Meets specifications in one of Dimensions 4,5 or 6

ASAM Levels of Care

- **Level 1 Outpatient Services**
  - Designed to treat individual's level of clinical severity and to effect permanent change in substance behavior and mental health functioning
  - Increased knowledge and application of cognitive behavioral therapy (CBT), motivational interviewing (MI), and other cognitive behavioral therapies has expanded access to the less motivated or unmotivated
  - Level 1 is now seen as appropriate for those assessed at a high severity in Dimension 4 (readiness to change) but not a high severity in other Dimensions
  - How do you decide if a client is unmotivated?

ASAM Levels of Care

- **Level 1 Outpatient Services**
- **Length of Service:**
  - Duration of treatment varies with severity of illness and response to treatment

ASAM Levels of Care

- **Level 2 Intensive Outpatient/Partial Hospitalization Services**
  - Programs provide essential education and treatment while allowing the clients to apply the skills in the "real world"
  - Intensive outpatient (IOP) programs generally require attendance at treatment multiple days per week
  - What have folks seen to be effective in IOP programs?

ASAM Levels of Care

- **Level 2 Intensive Outpatient/Partial Hospitalization Services**
  - **Level 2.1 Intensive Outpatient Services**
    - IOP provides 9 or more hours of structured treatment per week, consisting primarily of counseling and psycho education about substance related and mental health problems
    - Psychiatric and medical services are addressed through consultation and referrals

ASAM Levels of Care

- **Level 2 Intensive Outpatient Treatment/Partial Hospitalization**
  - **Level 2.5 Partial Hospitalization Treatment**
    - Partial hospitalization (PHP) provides 20 or more hours of clinically intensive programming per treatment plan
    - Direct access to psychiatric, medical and laboratory services

ASAM Levels of Care

- **Level 2 Intensive Outpatient/Partial Hospitalization Services**
  - **Length of Service:**
    - Varies with severity of patient's illness and their response to treatment

ASAM Levels of Care

- **Level 2 Intensive Outpatient/Partial Hospitalization Services**
- **Dimensional Criteria:**
  1) Meets specifications for Dimension 2
  2) Meets specifications for one of the Dimensions 4,5 or 6

ASAM Levels of Care

- **Level 3 Residential/Inpatient Services (24 hour live-in setting) (Adult)**
  - Level 3.1 Clinically Managed Low-Intensity Residential Services
  - Level 3.3 Clinically Managed Population – Specific High Intensity Residential Services (unable to use full milieu) (e.g. cognitive impairment)
  - Level 3.5 Clinically Managed High Intensity Residential Services (able to use high milieu)
  - Level 3.7 Medically Monitored Intensive Inpatient Services(patients do not require the full resources of an acute care general hospital or a medically managed inpatient treatment program)
  - Level 3 provides safe and stable environments in order to develop recovery skills

ASAM Levels of Care

- **Level 4 Medically Managed Intensive Inpatient Services**
  - provide a planned regimen of 24-hour medically directed evaluation, care and treatment of mental health and substance-related disorders in an acute inpatient setting
  - 24 hour care with the resources of a general acute care hospital or psychiatric hospital
  - Patients whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care

Module 3

- Review principles of Coerced Addiction Treatment
- Review several articles/research
- Discuss pathways to addiction treatment

Coerced Treatment

- "…court ordered care is a growing element of current drug policy aimed at closing the *denial gap* by exposing people to treatment who might not otherwise seek it"
- National Drug Control Strategy (2004)

Concerns

- O'hare (1996) "most treatment models in social work assume a reasonable amount of volunteerism by the client"
- Fagan (1999) to fully benefit from treatment clients must be motivated to participate in treatment and that the use of coercion largely disregards the importance of motivation in recovery

Research Findings on Coerced Clients

- Coerced clients do as well or better than clients who enter treatment voluntarily (Anglin & Hser, 1990) (Miller and Flaherty, 2000)
- Coerced individuals remained in treatment longer than non-coerced individuals (Leukefeld, Loneck, Garrett & Banks, 1996)
- No difference in use for legally coerced and non-coerced clients (Inciardi, 1988); (Opsal, Kristensen, Vederhus, & Clausen, 2016)

Coerced addiction treatment: Client perspectives and implications of neglect

- Harm Reduction Journal, 2010
- Karen A Urbanoski PhD Scientist with the Centre for Addictions Research of British Columbia, at the University of Victoria.
- Findings - In 2006, 38% of admissions to publicly funded addiction treatment were referred by the criminal just system

Definitions

- Coercion – imposition and an infringement on autonomy, regardless of source of the imposition
- Social Controls – social network pressures have been associated with greater autonomous motivation for abstinence
- Legal Pressures - civil commitment, court-ordered treatment, and diversion-to-treatment programs, such as drug treatment courts
- Formal Non-legal Pressures – pressures placed on the client by non-legal institutions or systems, including mandatory treatment referrals by employers, schools, children's aid or social assistance programs

Outcomes

- Clients under legal pressures show comparable or better short term treatment responses
- In general, the impact of coercion upon individual clients, treatment systems, and population health has not been adequately dealt with by addiction researchers
- However, reviews of studies of those convicted of drunk driving seem to support the evidence of coercion in reducing impaired driving recidivism

Substance Abuse Treatment Outcomes for Coerced and Non-coerced Clients

- Health and Social Work
- February 2007
- Anna C. Burke, PhD Associate Professor of Social Work OSU
- Thomas K. Gregoire PhD Associate Professor of Social Work OSU

Study Methods and Results

- Initial sample, *n* = 289
- Follow up 6 months after treatment 141 or 48.8%
- The inability to locate clients was the main reason that only 48.8% of participants were interviewed
- Legally coerced participants were more likely that non-coerced to report abstaining from alcohol/drugs in the 30 days before their follow up interview
- Also coerced participants had reduced addiction severity

Outcomes of mandated and non mandated New York City jail diversion for offenders with alcohol, drug, and mental disorders

- The Prison Journal
- March, 2005
- Nahama Broner, Senior Research Psychologist at RTI
- Damon W Mayri, graduate client in sociology at the University of California
- Gerald Landsberg, Professor of Social Work at NYU

Data Presented by Study Authors

- 60% to 70% of people arrested in major US cities are using drugs at the time of arrest (Ditton, 1999), more than half are drug dependent or have alcohol problems (Wilson, 2000)
- In a study of a NYC diversion program for felony drug offenders, 40% to 60% of those with a substance use disorder also have mental health disorders (Belenko, Lang and O'Connor, 2003)

Key Distinction

- Mandated vs Non-Mandated diversion
- Mandated - diversion was a condition of court mandates with court sanctions for non-compliance
- Non-mandated diversion - diverted and case managed from jail without court involvement or mandated sanctions

Findings

- Mandated diversions were more effective in
  - 1) reducing the number of days incarcerated in prison
  - 2) increasing number of days spent in the community (not in hospital or incarcerated)
  - 3) reducing drug use during the course of a year
  - 4) effectively creating treatment linkages
  - 5) increased time spent in treatment

Perceived coercion to enter treatment among involuntary and voluntarily admitted patients with substance use disorders

- BMC Health Services Research Journal
- November 2016
- Anne Opsal - University of Agder in Norway
- Øistein Kristensen, John Kåre Vederhus, and Thomas Clausen - Sørlandet Hospital in Norway

Study Question

- Do patients voluntarily admitted to treatment perceive coercion differently than patients admitted involuntarily?
- Perceived Coercion – an individual's perception of the pressure to enter treatment

Patient Characteristics

- Patients admitted to combined substance use and psychiatric wards across three publicly funded treatment centers
- N = 129 patients admitted voluntarily,
  N = 63 patients admitted involuntarily
- Involuntary Patients – higher rate of injected drugs, more females
- Voluntary Patients – higher psychological symptoms per Symptom Checklist 90-R

Results

- Areas of Perceived Coercion Questionnaire
  - A) Self – Voluntary
  - B) Family – Involuntary
  - C) Legal – Involuntary
  - D) Finance – Voluntary
  - E) Health – Voluntary
  - F) Work – Voluntary
- 14% of involuntary clients did not report a perception of coercion on any PCQ areas
- Those voluntarily admitted reported higher levels of coercion from internal sources, while those admitted involuntarily perceived higher levels of coercion from external sources.
- Overall, perceived coercion scores did not differ between the two groups.

Module 4

- Risk, Need Responsivity

One More Thing

- Risk, Need Responsivity

Risk

- The risk principle measures the probability of someone being a recidivist
- Please be aware there is no one standard of recidivism

Criminogenic Need Areas

- Criminal History
- Criminal Attitude/Orientation
- Personality Characteristics
- Accommodations
- Associates
- Substance Abuse
- Emotional/Personal
- Leisure/Recreation
- Education/Employment

Need

- Interventions should be focused on mitigating criminogenic needs to reduce the probability of recidivism

Responsivity

- General
- Specific

Module 5

- Individualized Treatment Planning: SMART Approach

SMART

- **S** = Specific
- **M** =Measurable
- **A** = Attainable
- **R** = Realistic
- **T** = Time-limited

Components

- **Summary** (strengths and permanency plan)
- **Problems** (addressed in this particular plan)
- **Goals** (short term/long term)
- **Objectives** (what the inmate does)
- **Interventions** (what the provider does)

Problems and Goals

- **What are some other examples of problems and goals?**

Measurable

- **Problem and Goal statements: include a way to measure the intervention effects**
  - Problem (example): Client reports sleeping a maximum of 4 hours per day over the last month. He attributes this to anxiety about his current life situation.
  - He rates his anxiety an 8 on a scale of 1 to 10 (1= no anxiety, 10 = unbearable anxiety)
  - Goal (example): Client will increase sleeping to a minimum of 7 hours per night and reduce anxiety to a 5 on a 1 to 10 scale

Objectives and Interventions

- **What are some examples of objectives and interventions?**

Specific

- **Objectives and interventions are specific and goal- focused. Both counselor and client can note progress.**
  - Objective (example): Client will complete an antecedent-behavior-consequence (ABC) log of the issues that are causing him anxiety and effecting his sleep each evening. Client will then practice a minimum of 10 minutes of meditation skills after he completes his ABC work sheets before he goes to bed each evening. Client will keep a log of how long he sleeps each evening and scale his level of anxiety each day.
  - Intervention (example): Clinician will review with the client the ABC skill sheets to help the client develop the skill of disputing irrational beliefs each weekly individual session. Clinician will then review the scores the client documented on how his anxiety scaled at each weekly session.

Attainable

- **Goals, objectives and interventions should be achievable during the length of the treatment plan**
  - If a treatment plan is reviewed every 3 months, the goals, objectives and interventions should be attainable in that time frame.
    - Example: Complete a curriculum that meets 1 x/week over 12 weeks

Realistic

- **Are the goals in the treatment plan realistic?**

Time-Limited

- **The plan specifies <u>time frames</u> used for goals, objectives and interventions**
  - What are some examples of time frames?
  - …
  - …

Reference Material

- ASAM Drug Testing White Paper
- The ASAM Criteria
- Andrews, D.A., Bonta, J., Wormith J.S. (2006) The Recent Past and Near Future of Risk and/or Need Assessment. Crime & Delinquency, Vol. 52 No.1, January 2006, 7 – 27