A. Understanding How People Change and How to Facilitate Change

1. Natural Change and Self-Change


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.” (DeClemente, 2006)

2. What Works in Treatment - The Empirical Evidence
   • Extra-therapeutic and/or Client Factors (87%)
     (a) Treatment (13%):
       ▲ 60% due to “Alliance” (8%/13%)
       ▲ 30% due to “Allegiance” Factors (4%/13%)
       ▲ 8% due to model and technique (1%/13%)


   (a)
   (b)
   (c)

4. 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.”
5. Stages of Change

* 12-Step model - surrender versus comply; accept versus admit; identify versus compare

* 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; 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.
  - **Preparation**: takes person from decisions made in Contemplation stage to specific steps to be taken to solve the problem in Action stage; increasing confidence in the decision to change; 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.
  - **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.
  - **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.

* Readiness to Change - not ready, unsure, ready, trying, (doing what works) (Miller and Rollnick)

B. **Engaging the Participant in Collaborative Care in Justice Services**

1. Developing the Treatment Contract and Focus of Treatment

<table>
<thead>
<tr>
<th>Client</th>
<th>Clinical Assessment</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What?</strong></td>
<td>What does client want?</td>
<td>What does client need?</td>
</tr>
<tr>
<td><strong>Why?</strong></td>
<td>Why now?</td>
<td>Why? What reasons are revealed by the assessment data?</td>
</tr>
<tr>
<td><strong>How?</strong></td>
<td>How will s/he get there?</td>
<td>How will you get him/her to accept the plan?</td>
</tr>
<tr>
<td><strong>Where?</strong></td>
<td>Where will s/he do this?</td>
<td>Where is the appropriate setting for treatment?</td>
</tr>
<tr>
<td><strong>When?</strong></td>
<td>When will this happen?</td>
<td>When? How soon? What are realistic expectations?</td>
</tr>
<tr>
<td></td>
<td>How quickly?</td>
<td>What are milestones in the process?</td>
</tr>
<tr>
<td></td>
<td>How badly does s/he want it?</td>
<td></td>
</tr>
</tbody>
</table>
2. **Criminal Justice’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 thinking by blurring the boundaries between “doing time” and “doing treatment”. For everyone involved with mandated clients, the 3 C’s are:

1. **Consequences** – It is within criminal justice’s mission to ensure that offenders take the consequences of their illegal behavior. If the court agrees that the behavior was largely caused by addiction and/or mental illness, and that the offender 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.

2. **Compliance** – The offender is required to act in accordance with the court’s orders; rules and regulations. 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.

3. **Control** – The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public. While control is appropriate for the courts, 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 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!”
C. 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

2. Diagnosis, Program-driven Treatment
   - Diagnosis determines treatment
   - Treatment is the primary program and aftercare
   - Relapse triggers a repeat of the program

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. Clinical, Outcomes-driven Treatment – Feedback Informed Treatment

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

<table>
<thead>
<tr>
<th>Assessment Dimensions</th>
<th>Assessment and Treatment Planning Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acute Intoxication and/or Withdrawal Potential</td>
<td>Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued addiction services</td>
</tr>
<tr>
<td>2. Biomedical Conditions and Complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services</td>
</tr>
<tr>
<td>3. Emotional, Behavioral or Cognitive Conditions and Complications</td>
<td>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</td>
</tr>
<tr>
<td>4. Readiness to Change</td>
<td>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</td>
</tr>
<tr>
<td>5. Relapse, Continued Use or Continued Problem Potential</td>
<td>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.</td>
</tr>
<tr>
<td>6. Recovery Environment</td>
<td>Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services</td>
</tr>
</tbody>
</table>

6. Criminogenic Factors/ASAM Criteria Dimensions

<table>
<thead>
<tr>
<th>Criminogenic Factors</th>
<th>ASAM Criteria Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial values, attitudes, behavior, personality</td>
<td>Dimensions 3, 4 and 6</td>
</tr>
<tr>
<td>Criminal/deviant peer association</td>
<td>Dimension 6</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Dimensions 1, 4, 5, 6</td>
</tr>
<tr>
<td>Dysfunctional family relations</td>
<td>Dimension 6</td>
</tr>
</tbody>
</table>
7. 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; 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. 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

<table>
<thead>
<tr>
<th>ASAM Criteria Level of Withdrawal Management Services for Adults</th>
<th>Level</th>
<th>Note: There are no separate Withdrawal Management Services for Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Withdrawal Management without Extended On-Site Monitoring</td>
<td>1-WM</td>
<td>Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawal management and to continue treatment or recovery</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management with Extended On-Site Monitoring</td>
<td>2-WM</td>
<td>Moderate withdrawal with all day WM support and supervision; at night, has supportive family or living situation; likely to complete WM.</td>
</tr>
<tr>
<td>Clinically-Managed Residential Withdrawal Management</td>
<td>3.2-WM</td>
<td>Moderate withdrawal, but needs 24-hour support to complete WM and increase likelihood of continuing treatment or recovery</td>
</tr>
<tr>
<td>Medically-Monitored Inpatient Withdrawal Management</td>
<td>3.7-WM</td>
<td>Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete WM without medical, nursing monitoring</td>
</tr>
<tr>
<td>Medically-Monitored Inpatient Withdrawal Management</td>
<td>4-WM</td>
<td>Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASAM Criteria Levels of Care</th>
<th>Level</th>
<th>Same Levels of Care for Adolescents except Level 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention</td>
<td>0.5</td>
<td>Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>1</td>
<td>Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>2.1</td>
<td>9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>2.5</td>
<td>20 or more hours of service/week for multidimensional instability not requiring 24 hour care</td>
</tr>
<tr>
<td>Clinically-Managed Low-Intensity Residential</td>
<td>3.1</td>
<td>24 hour structure with available trained personnel; at least 5 hours of clinical service/week</td>
</tr>
<tr>
<td>Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)</td>
<td>3.3</td>
<td>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</td>
</tr>
<tr>
<td>Clinically-Managed High-Intensity Residential</td>
<td>3.5</td>
<td>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</td>
</tr>
<tr>
<td>Medically-Monitored Intensive Inpatient</td>
<td>3.7</td>
<td>24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability</td>
</tr>
<tr>
<td>Medically-Managed Intensive Inpatient</td>
<td>4</td>
<td>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</td>
</tr>
<tr>
<td>Opioid Treatment Services</td>
<td>OTS</td>
<td>Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication - naltrexone</td>
</tr>
</tbody>
</table>
D. How to Organize Assessment Data – ASAM Criteria Assessment Dimensions

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

   - 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?
2. **What Court Personnel Should Expect from Treatment Providers**

Drug court participants are varied and can present with addiction, mental health and physical health complexity. These diverse clinical presentations highlight the need for individualized approaches that court personnel should see that treatment is pursuing with the client:

1. **Assessment of each client’s multidimensional needs** as per The ASAM Criteria six dimensions. So assessing if a person is developmentally disabled and suffers from an intellectual developmental disorder (previously called Mental Retardation) is important compared with a person who has antisocial personality disorder or lifestyle and is very institutionalized and used to incarceration. The intellectually developmentally disordered person has deficits in reasoning, problem solving, abstract thinking, judgment, learning from instruction and experience etc. The institutionalized antisocial person experiences sanctions like water on a duck’s back.

2. **Assessment and methods to enhance treatment engagement** and good faith effort of the client in treatment. Participants with co-occurring mental and addiction issues will have more difficulty with engagement and have needs that require awareness of their multiple vulnerabilities. Treatment plans need to be assessment-based and person-centered not program and compliance based. Because of different client learning styles and their array of needs, any manualized and evidence-based curriculum may require adaptation to fit each client’s problems and progress/outcomes.

This calls for a level of clinical sophistication to use Evidence-Based Practices (EBPs) in a person-centered and outcomes driven manner rather than a compliance and one-size-fits-all manner. Interactive Journaling is an evidence-based method to facilitate self-change using Motivational Interviewing, stages of change work and CBT. The Change Companies has a Drug Court journal that can be used along with other journals designed for criminal justice populations used by Federal Bureau of Prisons and many others.

3. **Outcomes-driven treatment**. Is the client making progress in real accountable change? Are they demonstrating improved functioning that will increase public safety, decrease legal recidivism and crime and increase safety for children and families? Active credible treatment is not just about compliance with attendance and negative drug screens. Is the client invested in a change process at a pace that fits their assessed abilities and vulnerabilities? Or is the client merely passively complying, which does not translate into lasting change and increased safety? How do we impact the revolving door of repeated episodes of treatment and incarceration, which wastes resources and does not produce the outcomes we all want?

3. **Understanding Continued Service and Discharge Criteria** *(The ASAM Criteria 2013, pp 299-306)*

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

**Continued Service Criteria**: It is appropriate to retain the patient at the present level of care if:

1. The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; or

2. The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient’s new problems can be addressed effectively.
To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the patient’s existing or new problem(s), the patient should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

**Discharge/Transfer Criteria:** It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;

   or

2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;

   or

3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

   or

4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

**E. Systems Issues**

1. **Moving from Punishment to Accountability for Lasting Change – Implications for sanctions and Incentives**
   (Tips and Topics, Volume 12, No. 6, September 2014. www.changecompanies.net; click on Blogs; click on Tips and Topics and go to the Archives on left hand side.)

   1. Sanction for lack of good faith effort and adherence in treatment based on the clinical assessment of the person’s needs, strengths, skills and resources. Don’t sanction for signs and symptoms of their addiction and/or mental illness in a formulaic manner that is one-size-fits-all.

   2. The treatment provider is responsible for careful assessment and person-centered services and to keep the court apprised of any risk to public safety. The court should be informed about the client’s level of good faith effort in treatment; and whether the client is improving in function at a pace consistent with their assessed needs, strengths, skills and resources. The provider should not just report on passive compliance with attendance and production of positive or negative drug screens - passive compliance is not functional change.

   3. If the client is not changing their treatment plan in a positive direction when outcomes are poor e.g., positive drug screens, attendance problems, passive participation, no change in peer group activities and support groups like AA etc., then the client is “doing time” not “doing treatment and change.” Providers need to then inform the judge that the client is out of compliance with the court order to do treatment. The client consented to do treatment not just do time and should be held accountable for their individualized treatment plan. If the client is substantively modifying their treatment plan in a positive direction in response to poor outcomes; and adhering to the new direction in the treatment plan, then the client should continue in treatment and not be sanctioned for signs and symptoms of their illness(es).
4. Incentives for clients can be explored and matched to what is most meaningful to them. For example, incentives that allow a client to choose a gift certificate or coupon for a restaurant may be meaningful for some clients. But others may find assistance in seeing their children; or receiving help with housing; or advocacy to change group attendance times to fit better their work schedule to be more meaningful incentives to be used. This requires an individualized approach recommended to the court by providers who should know their client’s needs, skills, strengths and resources. It is too much to expect the judge can work all this out in a busy schedule of court appearances.

5. A close working relationship between the client, judge, court team and treatment providers is needed to actualize this approach.

Some judges are rightly concerned that treatment providers are not watching for public safety concerns closely enough and take treatment into their own hands. This can result in sanctions or mandates that are not assessment based e.g., mandating 90 days of residential level of care; or 90 Alcoholics Anonymous meetings in 90 days; or ordering sanctions that may be ineffective in producing improved treatment engagement and real client functional change.

2. **Gathering Data on Policy and Payment Barriers** *(The ASAM Criteria 2013, p 126)*

- Policy, payment and systems issues cannot change quickly. However, as a first step towards reframing frustrating situations into systems change, each incident of inefficient or inadequate meeting of a client’s needs can be a data point that sets the foundation for strategic planning and change
- Finding efficient ways to gather data as it happens in daily care provides hope/direction for change:

### PLACEMENT SUMMARY

<table>
<thead>
<tr>
<th>Level of Care/Service Indicated</th>
<th>Insert the ASAM Level number that offers the most appropriate level of care/service that can provide the service intensity needed to address the client’s current functioning/severity; and/or the service needed e.g., shelter, housing, vocational training, transportation, language interpreter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Care/Service Received</td>
<td>ASAM Level number -- If the most appropriate level or service is not utilized, insert the most appropriate placement or service available and circle the Reason for Difference between Indicated and Received Level or Service</td>
</tr>
<tr>
<td>Anticipated Outcome If Service Cannot Be Provided</td>
<td>Circle only one number - 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):</td>
</tr>
</tbody>
</table>

© David Mee-Lee, M.D. 2013 davidmeelee@gmail.com 916.715.5856

### LITERATURE REFERENCES AND RESOURCES

“A Technical Assistance Guide For Drug Court Judges on Drug Court Treatment Services” - Bureau of Justice Assistance Drug Court Technical Assistance Project. American University, School of Public Affairs, Justice Programs Office. Lead Authors: Jeffrey N. Kusher, MHRA, State Drug Court Coordinator, Montana Supreme Court; Roger H. Peters, Ph.D., University of South Florida; Caroline S. Cooper BJA Drug Court Technical Assistance Project. School of Public Affairs, American University. May 1, 2014.


For more information on the new edition: www.ASAMcriteria.org


http://www.addictionreco.org/paradigm/P_PR_W05/paradigmW05.pdf


**RESOURCE FOR ASAM E-LEARNING AND INTERACTIVE JOURNALS**

E-learning module on “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care” – 5 CE credits for each module . “Introduction to The ASAM Criteria” (2 CEU hours) “Understanding the Dimensions of Change” – Creating an effective service plan” – Interactive Journaling “Moving Forward” – Guiding individualized service planning” – Interactive Journaling

To order: The Change Companies at 888-889-8866; www.ASAMcriteria.org

**CLIENT WORKBOOKS AND INTERACTIVE JOURNALS**

The Change Companies’ MEE (Motivational, Educational and Experiential) Journal System provides Interactive journaling for clients. It provides the structure of multiple, pertinent topics from which to choose; but allows for flexible personalized choices to help this particular client at this particular stage of his or her stage of readiness and interest in change.

To order: The Change Companies at 888-889-8866. www.changecompanies.net.

**TRAIN FOR CHANGE Inc ™**

Train for Change Inc ™ is a training and consulting company specializing in customized training on The ASAM Criteria, motivational interviewing and other behavioral health modalities. Train for Change Inc ™ uses expert trainers to provide training on a variety of evidence-based practices. www.trainforchange.net.
FREE MONTHLY NEWSLETTER

“TIPS and TOPICS” – Three sections: Savvy, Skills and Soul and at times additional sections: Stump the Shrink; Success Stories and Sharing Solutions. Sign up on www.tipsntopics.com and click on “Subscribe”.

ELearning Series -“HELPING PEOPLE CHANGE”

"Helping People Change" - A Five Part Series Workshop - Live and Uncut”

These five, approximately 30 minute modules are part of a day-long workshop filmed in Los Angeles, California. It is "live" in front of real workshop participants and not a hand-picked studio audience.

1. The Therapeutic Alliance – Pre-Test Questions and a discussion of answers; Enhancing Self-Change and Forging the Alliance - Disc 1 of a Five Part Series Workshop

2. Understanding and Assessing Stages of Change – Discussion of Compliance versus Adherence; Explanation of Stages of Change Models (12-Step model; Transtheoretical Model of Change; Miller and Rollnick) - Disc 2 of a Five Part Series Workshop

3. Motivational Interviewing and Ambivalence – Principles of Motivational Interviewing; Spirit of Motivational Interviewing; Working with Ambivalence - Disc 3 of a Five Part Series Workshop

4. Establishing the Treatment Contract; Role Play – What, Why, How, Where and When to establish the Treatment Contract; and a role play with a “17 year old young man” to illustrate this technique - Disc 4 of a Five Part Series Workshop

5. Stages of Change; Implications for Treatment Planning – Stage of Change and the Therapist’s Tasks; discussion of Relapse Policies; Using Treatment Tracks to match Stage of Change; discussion of Mandated Clients and relationship to the criminal justice system - Disc 5 of a Five Part Series Workshop

To Buy: www.changecompanies.net/search.php

ASAM Criteria Standardized Assessment – Assisted Clinical Decision-Making

- The ASAM Criteria book and The ASAM Criteria Software now branded as Continuum™ are companion text and application
- The text delineates the dimensions, levels of care, and decision rules that comprise The ASAM Criteria
- The software provides an approved structured interview to guide adult assessment and calculate the complex decision tree to yield suggested levels of care, which are verified through the text

www.asamcontinuum.org; Brendan McEntee at ASAM: bmcentee@asam.org

David Gastfriend, M.D., Chief Architect of The ASAM Criteria Software: gastfriend@gmail.com