What is Early Intervention and Care Coordination? Why Do They Matter in the Overall Service Continuum?

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A. What is ASAM Criteria Early Intervention Level of Care 0.5? *(The ASAM Criteria* 2013, pp 179-183)

(a) Early intervention is an organized service that may be delivered in a wide variety of settings.

- Designed to explore and address problems or risk factors that appear to be related to substance use and addictive behavior; and
- To help the individual recognize the harmful consequences of high-risk substance use and/or addictive behavior.

(b) Level 0.5 constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related or addictive behavior problems or for those for whom there is not yet sufficient information to document a substance use or addictive disorder.

- "Indicated Prevention" as described by the National Institute on Drug Abuse (Kumpfer, K. L., and Baxley, G. B. (1997), "Drug abuse prevention: What works?", National Institute on Drug Abuse, Rockville.) can be considered synonymous with Level 0.5, which is also consistent with the public health's description of "secondary prevention".

(c) Early intervention also encompasses services offered to persons in non-specialty settings:

- Hospital emergency departments or primary care medical clinics (which may or may not be organized as Patient Centered Health Care Homes.)
- In these settings, the presentation may be substance use that is beginning to cause some harmful effects and/or high-risk use. In these settings, Level 0.5 services take the form of Screening, Brief Intervention and Referral to Treatment (SBIRT).

SBIRT attempts to intervene early with non-addicted people; and to identify those who do have a substance use or addictive disorder and need linking to formal treatment. SBIRT is commonly delivered in emergency rooms, trauma centers and other primary care settings. It can also include multi-hour interventions occurring over a few days or a few weeks as is common in impaired driving interventions or in SBIRT's Brief Intervention of one to five short motivational sessions to encourage and promote healthy behaviors, focusing on increasing insight and awareness.

(d) Where Level 0.5 is an impaired driving program (e.g., Driving Under the Influence (DUI), Driving While Intoxicated (DWI), Operating a Motor Vehicle while Intoxicated (OMVI), the length of service may be mandated and determined by program and regulatory rules. Completion of the program may be a prerequisite to reinstitution of driving privileges.

EXAMPLES
Level 0.5 program services encompass one-to-one counseling with at-risk individuals, motivational interventions and educational programs for groups such as DUI (Driving Under the Influence) offenders, family members of those in treatment and other populations with increased risk. Additional services may include those provided in Employee Assistance Programs (EAP), drug-free workplace initiatives,

community-based correctional settings and community mental health clinics; and Screening, Brief Intervention and Referral to Treatment (SBIRT) in hospital emergency departments or primary care medical clinics.

SETTING
Level 0.5 programming may be offered in any appropriate setting, including clinical offices or permanent facilities, schools, work sites, community centers, emergency rooms, primary care settings or an individual's home.

SUPPORT SYSTEMS
At Level 0.5, necessary support systems include:
a) Referral for and linking to ongoing treatment of substance use or addictive disorders treatment if a person is found to meet diagnostic criteria for addiction.
b) Referral for medical, psychological or psychiatric services, including assessment.
c) Referral for community social services.

B. **Care Coordination for Identified Substance Use Disorder** *(The ASAM Criteria* 2013*,* p 179)

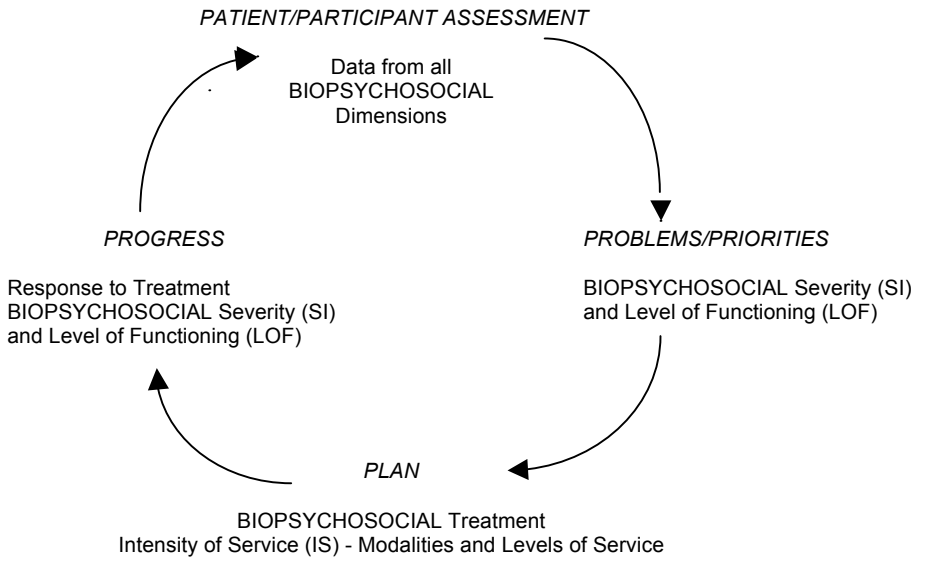
(a) The diagnostic assessment should be performed in conjunction with a comprehensive multidimensional assessment, prior to admission to determine whether the person meets the Diagnostic Admission Criteria of Level 0.5 that requires that a person does not meet diagnostic criteria of a substance use disorder. If new information is identified through the reassessment process that indicates an actual substance use disorder and the need for treatment, there are three possible options:

1. If the individual is in imminent danger, he or she should be transferred to a clinically appropriate level of care, even if that precludes completion of the mandated impaired driving program.

2. If the individual is not in imminent danger but does require formalized treatment services, an attempt should be made to facilitate such treatment with the services of the Level 0.5 program. These services can be provided concurrently, if possible.

3. If the individual can wait to enter formal treatment until after the Level 0.5 program is completed, transfer to the appropriate level of care should be arranged as soon as possible after the Level 0.5 program is completed.

(b) Individualized, Clinically-driven 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 services:

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

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

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; MAT - 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

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

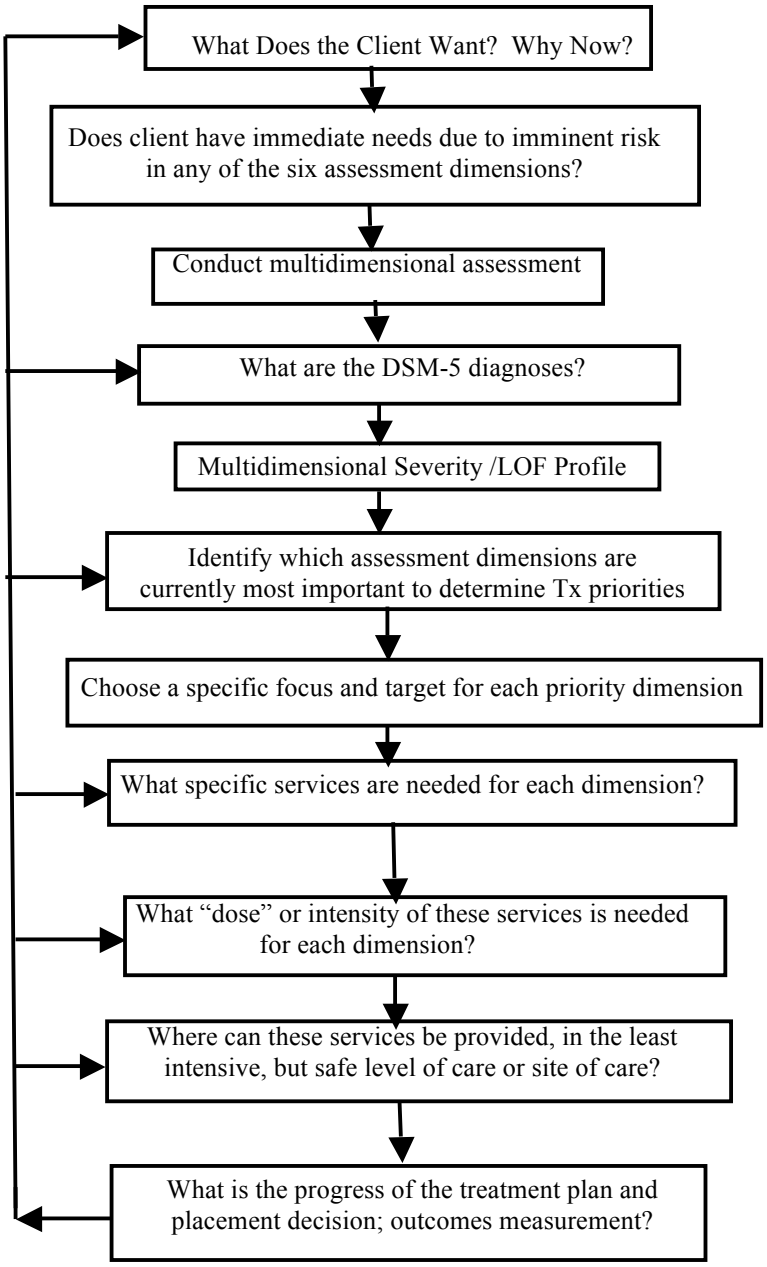
ASAM Criteria Level of Withdrawal Management Services for Adults	Level	Note: There are no separate Withdrawal Management Services for Adolescents
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision; likely to complete 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

5. Length of Service in Level 0.5 *(The ASAM Criteria* 2013*,* pp 180)

Length of service at Level 0.5 varies according to:

(a) an individual's ability to comprehend the information provided and use that information to make behavior changes and avoid problems related to substance use;
(b) the appearance of new problems that require treatment at another level of care; or
(c) regulatory mandated length of service. Length will vary from as little as 15-60 minutes in SBIRT to several weeks as in impaired driving programs.

C. **Applying The ASAM Criteria to Coordinate Care**



(The ASAM Criteria 2013*,* p 124)

1. 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 developmental 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?

2. 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.

These ideas come from my clinical bias and experience, but they are offered with awareness:

- That we need more discussion to make this work in the world of courts and criminal justice.
- That to achieve the public safety outcomes we all want, we have to move treatment from a passive compliance and a 'jumping through the hoops' mentality that allows many clients to "do time" in treatment instead of "doing treatment and change".
- That treatment providers will need to rise to the occasion and improve assessment and person-centered treatment planning that values outcomes-driven services.
- That judges and court personnel can expect treatment providers to design and deliver individualized care; and to keep them well-informed on any threats to public safety. Reports need to be on functional improvement not just compliance with attendance and drug screens.

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

- Finding efficient ways to gather data as it happens in daily care to promote systems change.

PLACEMENT SUMMARY

Level of Care/Service Indicated - 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	
Level of Care/Service Received - 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	
Reason for Difference - Circle only one number -- 1. Service not available; 2. Provider judgment; 3. Client preference; 4. Client is on waiting list for appropriate level; 5. Service available, but no payment source; 6. Geographic accessibility; 7. Family responsibility; 8. Language; 9. Not applicable; 10. Not listed (Specify):	
Anticipated Outcome If Service Cannot Be Provided – 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):	

LITERATURE REFERENCES

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Prochaska, JO; Norcross, JC; DiClemente, CC (1994): "Changing For Good" Avon Books, New York.

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