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

* 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

	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?

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. **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?

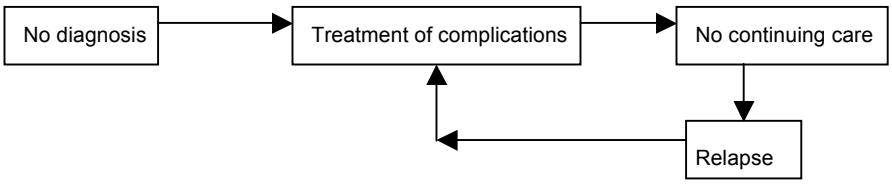
3. Compliance versus Adherence

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**

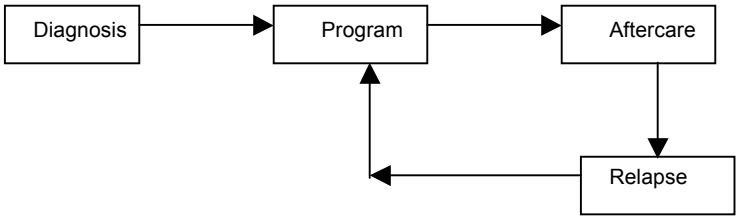
1. Complications-driven Treatment

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

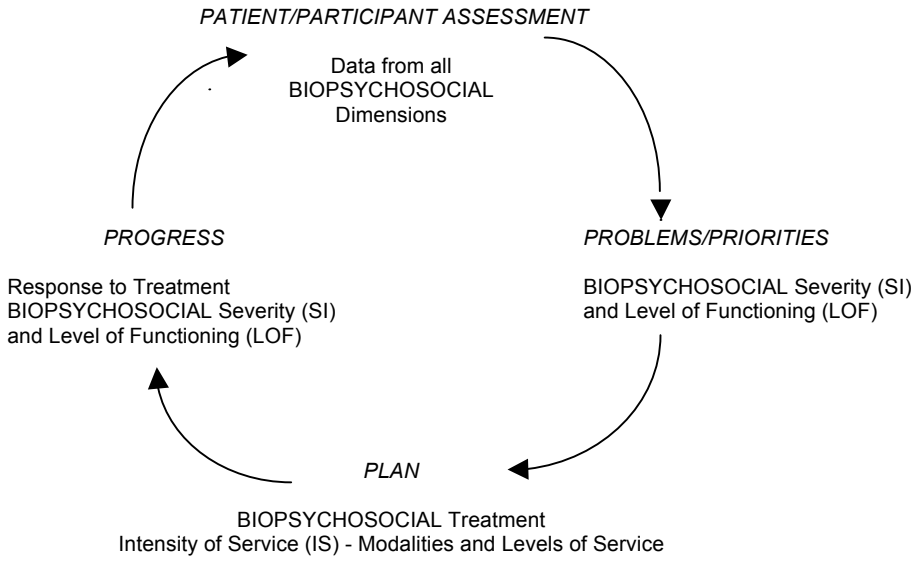


2. Diagnosis, Program-driven Treatment

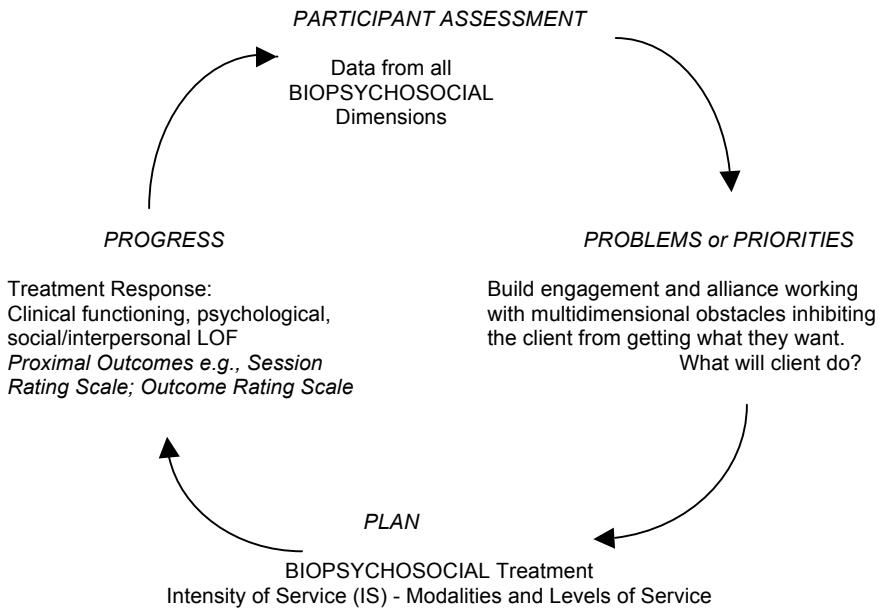
- Diagnosis determines treatment
- Treatment is the primary program and aftercare
- Relapse triggers a repeat of the program



3. Individualized, Clinically-driven Treatment



4. Clinical, Outcomes-driven Treatment – Feedback Informed Treatment



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:

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

6. Criminogenic Factors/ASAM Criteria Dimensions

Criminogenic Factors	ASAM Criteria Dimensions
Antisocial values, attitudes, behavior, personality	Dimensions 3, 4 and 6
Criminal/deviant peer association	Dimension 6
Substance abuse	Dimensions 1, 4, 5, 6
Dysfunctional family relations	Dimension 6

7. Biopsychosocial Treatment - Overview: 5 M's

* 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

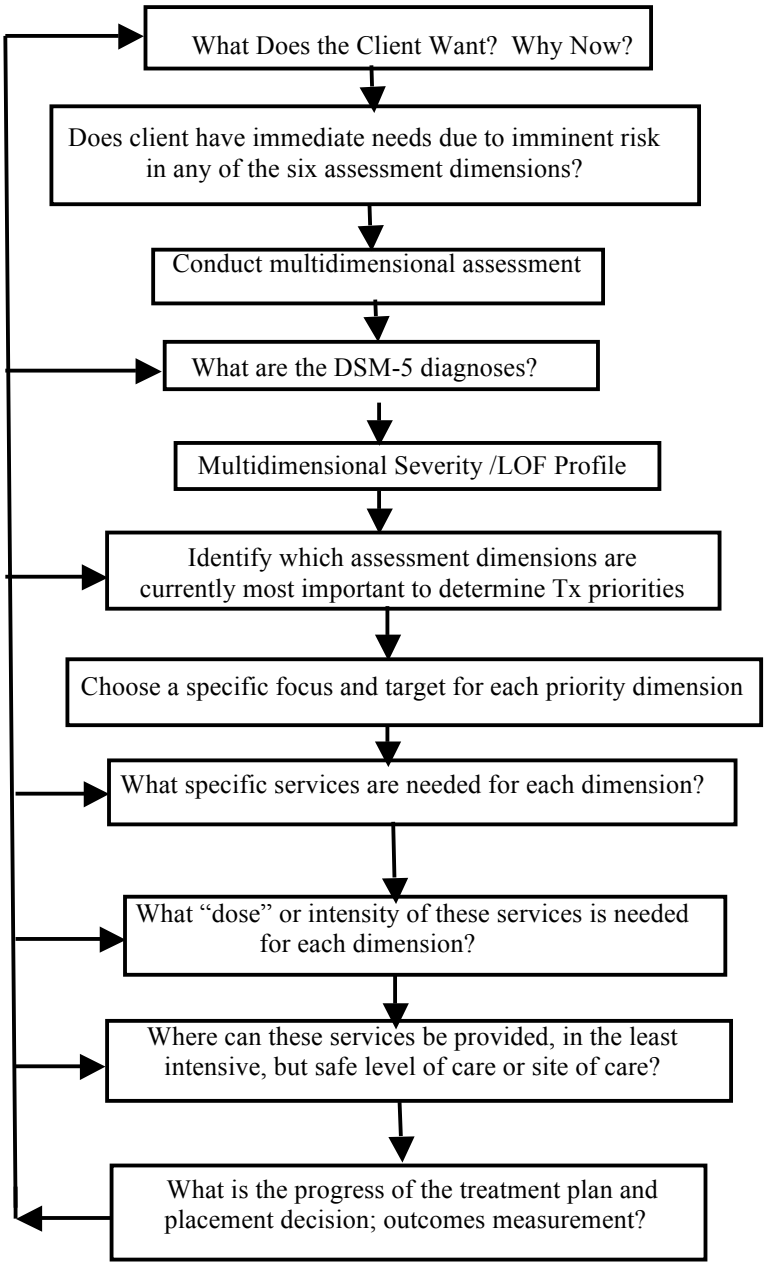
8. Treatment Levels of Service *(The ASAM Criteria* 2013*,* pp 106-107)

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

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

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



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 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?

3. Proximal and Distal Goals

- Traditionally: Abstinence is a "distal" goal for participants with addiction (dependence – they need treatment); but a "proximal" goal for those with Substance Abuse (assumes substance use is voluntary)
- Traditionally: Those with complex needs, "regimen compliance" is "proximal" goal. Better still "treatment adherence"
- Traditionally: Increase treatment for substance use early in treatment for participants with addiction; but punish with sanctions once engaged in treatment and some sustained sobriety
- Traditionally: For non-addicted participants, use escalating sanctions in initial phases to end voluntary use and not "reward" use

Recommendations:

- This all based on a behavior modification approach when addiction is biopsychosocial-spiritual
- If participant has addiction, treatment is needed. If not, education, risk advice and escalating legal consequences (like speeding fines and DUI)
- Abstinence is a "proximal" or "distal" goal for participants with addiction depending on their stage of change regarding abstinence assessed in treatment
- Use escalating sanctions in initial and/or later phases of treatment for lack of good faith effort in treatment. Don't sanction for signs and symptoms of addiction flare-ups and poor outcomes.

4. 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.

F. **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.

3. Dealing with All Stakeholders Who Are at Different Stages of Change

(a) Individualized Staff Development Plans based on what the staff person wants

(b) Individualized Agency Development Plans – expectations for progress and change

(c) Individualized Court Personnel Development Plan – reaching consensus on what is expected from treatment and what is expected from court personnel

(d) Incentives and leverage to facilitate continuing change and development

4. 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 in adequate 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

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):	

Carl

Carl is a 15 y.o. male who you suspect meets DSM criteria for Alcohol and Cannabis Use Disorders, 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 was not using anything. 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 said he is holding for a friend.

LITERATURE REFERENCES AND RESOURCES

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