Education and Intervention

Moving Beyond Compliance to Lasting Change

by David Mee-Lee, M.D.*

Editor's Note: *Dr. David Mee-Lee tackles the intransient problem of how a system can change individuals that are resistant to change. He suggests a model that moves alcoholism prevention education and treatment from a focus on individual compliance to a focus on individual change. He makes a clear distinction between the roles of the criminal justice system and a drinking-driving education and treatment program. He stresses the need for an intervention model over a model of compliance. As one who has facilitated group counseling for mandated clients and sat in on case conferencing in treatment facilities, Mee-Lee's distinction between agents of compliance and agents of change is enlightening. I have observed too many counselors stressing compliance and treatment goals without really working on change towards sobriety. Both drinking-driving programs and outpatient treatment facilities for the DUI/DWI mandated client have in many cases become mirrors of the criminal justice system, especially the probation system.*

Most drunk drivers drive hundreds of times before they are caught. Estimates vary from 250 to 2,000 times. A drunk-driving arrest is not a one-time occurrence. When apprehended, many accept a drinking-driving education and treatment program as a mechanism to keep their license or avoid jail time. Few accept that their alcohol abuse, which led to poor judgment and driving drunk, is their major problem. By challenging the drinking-driving program to move away from a compliance model to an intervention model, Mee-Lee empowers both the client and the counselor. Dr. Mee-Lee places the drinking-driving program into a continuum of care, where it belongs. He removes it from the criminal justice model of control and compliance.

Most people suffering from an alcohol or other drug use condition are the last to fully realize and accept that they have a problem. Even if they begin to realize that they should do something about their abuse or dependency, it is rare that they actually reach out and get the help they need. The National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found some interesting results about people aged 12 years and older who needed treatment for illicit drug or alcohol use. They found that 21.1 million people needed but did not receive treatment in the past year.

Of those 21 million people, 95.5% did not even feel they needed treatment, so they did not reach out and seek it. Three percent felt they needed treatment yet did not make an effort to receive it. Only 1.5% of the people felt they needed treatment and did actually make an effort to get help. (Substance Abuse and Mental Health Services Administration (SAMHSA), "Results From the 2006 National Survey on Drug Use and Health: National Findings" (NSHUH), 2007; *http://www.OAS.samhsa.gov/nsduh/2k6nsduh/2k6Results.pdf.*) Impaired driving education and intervention programs provide an important opportunity to reach many who need not only education and risk advice but also actual treatment. This vast pool of people who need treatment, but do not perceive that they do or who do not make the effort to receive it, is getting increased attention not only in impaired driving programs but also in the screening and brief intervention (SBI) initiatives of the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Lost Opportunity

As good as it is to seize the opportunity of a person's impaired driving arrest to address a person's alcohol or other drug problem, it can be an opportunity lost if the focus is solely on education and compliance with the legal mandates. It is also an opportunity lost in SBI if the focus is only on brief intervention and not on the appropriate referral and treatment that has been traditionally part of previous Screening, Brief Intervention, Referral, and Treatment (SBIRT) initiatives. In impaired driving education and intervention programs, it is an occupational hazard to reinforce most participants' perspectives that they are present only to comply with legal requirements in order to get their driving license back and avoid more onerous consequences. While it is part of the mission of impaired driving programs to help restore people's right to drive and meet their legal obligations, there is a critical provider function that is as equally an important part of the mission.

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Studies estimate that the average impaired driver has driven impaired between 300 and 2,000 times before their first arrest. (W. White, "Managing the High Risk DUI Offender," 2003; *http://cspl.uis.edu/ILAPS/Research/index.htm.*) Accordingly, reducing recidivism requires a change in behavior—whether it is driving behavior, substance use, or both. To accomplish this, educational

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intervention programs are most effective when they are rooted in a behavioral change focus. This highlights the importance of the intervention part of the impaired driving program's mission.

It may be for a relative minority of the impaired drivers arrested that there was a single lapse of judgment that landed them in court. However, given the statistics on how so many have driven impaired multiple times before their first arrest, and given the statistics on how many do not perceive that they have a substance use problem and do not reach out for help, it is clear how important it is to identify, engage, and link people into continuing treatment if clinically warranted.

Criminal Justice Mission

It is appropriate that law enforcement and criminal justice embrace a mission that incorporates the "3 Cs": consequences, compliance, and control. Yet, effective providers in impaired driving programs frequently have a contrasting mission.

Consequences. Offenders of the law should expect to take the consequences of their illegal behavior. The court allows that the dangerous drinking or drug using behavior was possibly caused by a lapse in judgment, and that the offender and the public are best served by providing education and risk advice. The obligation of providers in impaired driving programs is to ensure individuals are exposed to accurate information and practical strategies that can enhance their investment in making behavioral changes. The focus is on screening, brief intervention, referral, and linking with treatment, if necessary, not on enforcing consequences and compliance with court orders.

Compliance. The offender is required to act in accordance with the court's orders, rules, and regulations. Criminal justice system personnel should expect compliance. But providers are offering intervention and at times treatment in which the focus is on behavioral change. Services should be designed to address participant needs along a continuum of care, not to meet compliance with "doing time."

Control. The criminal justice system aims to control, if not eliminate, illegal acts that threaten the public safety. While control is appropriate for law enforcement, impaired driving providers and programs are focused on collaborative intervention and attracting individuals into behavioral change. The only time providers are required to control a participant is if they are in imminent danger of harm to self or others. As soon as that imminent danger is stabilized, the collaborative relationship resumes and participant empowerment replaces compliance.

Implications of Contrasting Missions, Goals

It is easy to view the participant as *having* to be in an impaired driving program to do his or her time because that is how participants view it. For most, their biggest problem is having to be there, not learning about and working on their problem behavior(s). Impaired driving programs can feed into that "victim" position and convey: "I know you don't want to be here, but you have to be, so you might as well try to get something out of it." This immediately reinforces the idea that they had no choice and that "doing their time" here in the program is acceptable to you instead of committing themselves to owning their behavior and taking responsibility for their own safety as well as public safety.

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Focus, Balance. While it may seem they have no choice in the matter, each person did in fact choose to be there, even if all they wanted was to get their license back. Whether they are safe to drive again unencumbered should not depend on having "done time" in a set program. Public safety and decreased recidivism require evidence that lasting change has been initiated and that they have assimilated the intervention into attitudinal, behavioral, and functional improvement. Providers need to be focused on effective change and empowerment. Criminal justice and law enforcement need to be focused on consequences, compliance, and control. Finding the right balance between all stakeholders is necessary to help people make lasting behavioral change.

Opportunity Created. That balance can be achieved by using the leverage of the criminal justice system to create the opportunity for screening, brief intervention, and assessment of whether a person needs to be linked and engaged in continuing care. For those for whom the impaired driving incident was a temporary lapse in judgment, education and risk advice may be all that is necessary to both help the offender and protect public safety. For others, whose arrest was the mere tip of the drinking and drug-using iceberg, it is critical that impaired driving programs be equipped to identify, assess, and intervene to engage that person into ongoing services, including addiction treatment. To allow "doing time" instead of "doing change" is an impending tragedy for the person and his or her family as well as for the public.

Fitting Into Continuum of Care

For nearly 20 years, the *Patient Placement Criteria for the Treatment of Substance-Related Disorders* of the American Society of Addiction Medicine has provided a set of criteria and a broad continuum of multiple levels of care to guide clinicians, payers, and providers of care on which individuals are best treated in what level of care. (American Society of Addiction Medicine, *Patient Placement Criteria for the Treatment of Substance-Related Disorders* (2d 1996) (ASAM *PPC-2*).) The broad levels of service encompass the following:

- Early Intervention, Level 0.5;
- Outpatient Services, Level I;
- Intensive Outpatient and Partial Hospitalization, Level II Services;
- Residential and Inpatient Services, Level III; and
- The most intensive level, Medically-Managed Intensive Inpatient Services, Level IV.

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Table 1: ASAM Assessment Dimensions

ASAM Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Detoxification 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 subdiagnostic 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 continued problems as part of motivational enhancement strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services.

Within these broad levels are further levels of care to individualize treatment even more specifically.

Efficient Use of Resources. Using a multidimensional assessment that addresses all the important areas of how and where alcohol or other drug problems affect an individual and his or her family and significant others, the ASAM criteria promotes efficient use of resources to achieve effective outcomes and lasting change. The six assessment dimensions are shown in Table 1: ASAM Assessment Dimensions.

For some, education, risk advice, and brief intervention may be effective in helping to change their drinking and drug using behavior to their benefit and the public's safety. This level of service is what ASAM calls Early Intervention, Level 0.5 and is what some impaired driving programs offer to first-time offenders. For others, their drinking or drug using behavior may signify a much more ominous prognosis for themselves, their families, and the public safety. For these, careful assessment and individualized treatment is critical. They must not only be referred to continuing care, but proactively linked with the appropriate level of care that best engages them in a process of lasting change. Their care may span everything from outpatient treatment to residential care and even the most intensive level if there is acute imminent danger from severe withdrawal, or physical or mental health problems.

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Impaired Driving National Model. A curriculum which meets the ASAM 0.5 Level of Care Early Intervention requirements allows providers to meet all impaired driving offenders where they are and present the opportunity for more treatment if necessary. For example, The Change Companies® has been a long-time partner to states and local providers in the creation of evidence-based resources that promote behavior change among high-risk populations. One of the defining traits of The Change Companies®' impaired driving programming is its emphasis on change. The Change Companies® has developed an Impaired Driving National Model that outlines the process starting with the identified target population of people who have been arrested for impaired driving related to substance use. The initial step of a triage DUI/DWI assessment incorporates screening for a substance use disorder, which ties in with state-specific curricula depending on whether the person is a first-time offender, or a multiple or youth offender. The curriculum incorporates multiple evidence-based strategies to address the need for change by not only educating offenders but also motivating and guiding them toward positive and

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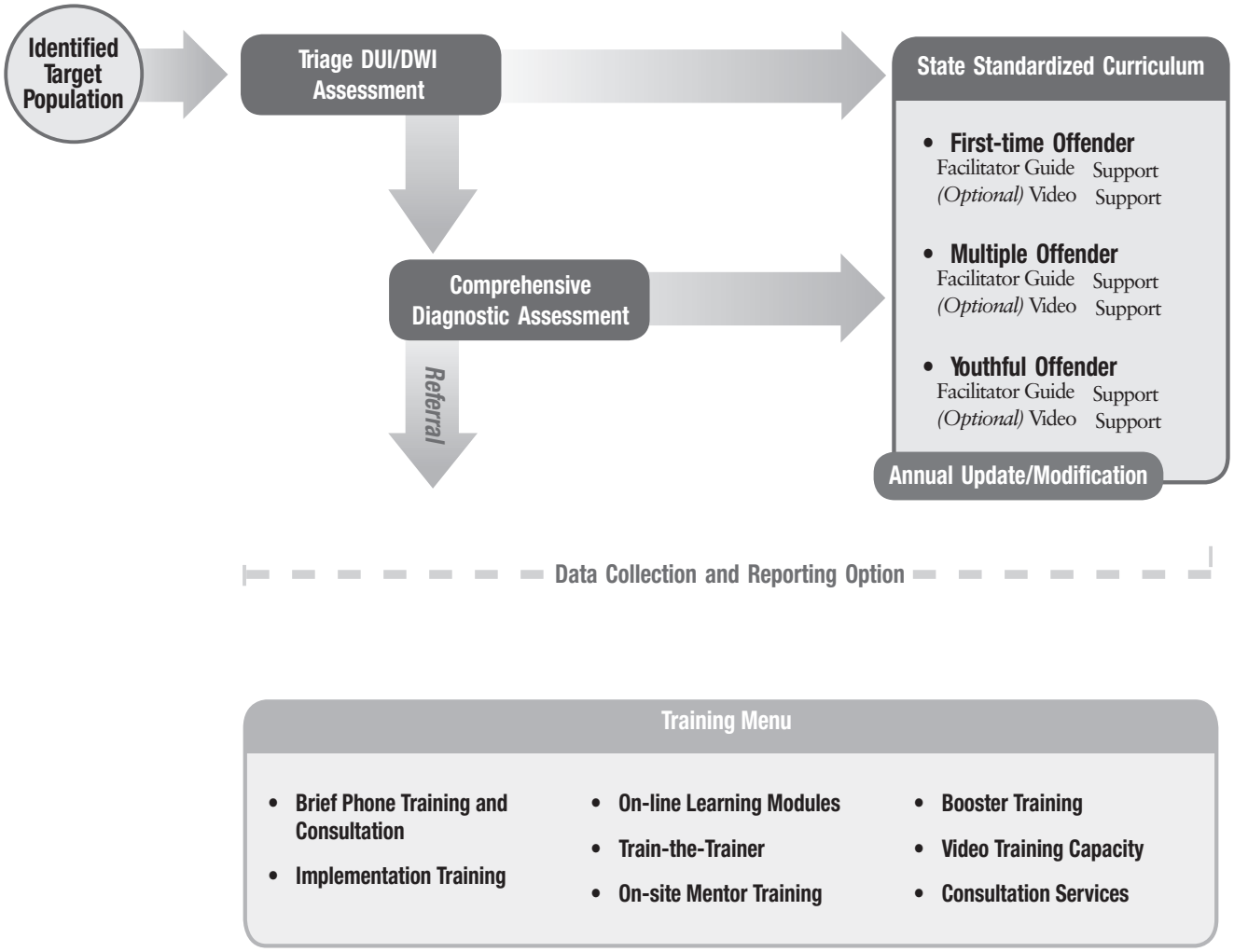
Impaired Driving National Model



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lasting behavioral change. Additionally, if screening and triage findings suggest the presence of a likely substance use disorder, this leads to a comprehensive diagnostic assessment with referral to and linkage with treatment as necessary. (See Impaired Driving National Model.)

Do Change, Not Time

The pool of people with an alcohol or other drug use problem who do not see that they have an addiction problem and who do not seek treatment is enormous. Initiatives in screening and brief intervention recognize this large unmet need and seek to reach these people in the primary health care system. Impaired driving offenses are also opportunities to intervene in a person's problem drinking or drug use. While relatively few may need only education and risk advice to assure their own safety and that of the public, the majority require much more in terms of assessment and behavioral change intervention to achieve lasting change. Impaired driving programs that allow participants to "do time" rather than to "do change" delay a person's engagement and jeopardize public safety with increased recidivism and repeat offenses. Triage, assessment, and ongoing engagement in a continuum of services provide the best hope for reaching

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millions who need help, especially those who are met through impaired driving programs.

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