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 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 DWI/DUI 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 who need treatment actually received it.

Lost Opportunity

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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 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 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.”

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. But providers are offering intervention and at times treatment in which the focus is on behavioral change. However, treatment should be designed to address participant needs along a continuum of care, not to meet compliance with “doing time.”

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 ed 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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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

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**Table 1: ASAM Assessment Dimensions**

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<tr>
<th>ASAM Assessment Dimensions</th>
<th>Assessment and Treatment Planning Focus</th>
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<tbody>
<tr>
<td>1. Acute Intoxication and/or Withdrawal Potential</td>
<td>Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services.</td>
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<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 subdiagnostic 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 continued problems as part of motivational enhancement 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>
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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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25 state attorneys general, Miller-Coors has, for now, canceled production of its 8% alcohol content beverage. The attorneys general expressed their concern regarding the high alcohol content and marketing to underage youth. One argument used was that such a beverage would lead to increased alcohol poisoning and adolescent drunk-driving fatalities.

Miller-Coors’ temporary hold on the introduction of Sparks Red follows Anheuser-Busch’s discontinuation of its line of high alcohol beverages after 11 state attorneys general complained and threatened legal action. Mothers Against Driving Drunk (MADD) hailed the Miller-Coors decision.

**Food for Fuel**

Henry Ford’s first automobile ran on ethanol and Rudolf Diesel’s pioneer revolutionary and supposedly environmental engine ran on peanut oil. However, both mechanics soon realized that petroleum when refined had more energy content than plant fuels. Now the work is engulfed in a debate on the morality and efficacy of growing fuels.

The success of emerging economic power Brazil in turning half of its sugar harvest into ethanol has added fuel to the debate.

Central to the debate is the fact that the amount of fossil energy needed to produce ethanol from corn is as much or more fossil fuel as is produced. Growing corn, for instance, requires nitrogen fertilizer made with natural gas and heavy use of gas or diesel-fueled farm machinery. Also, corn prices, until the recent decline, were at record levels, adding to food inflation.

A recent United Nations report notes that the increased use of food bio fuels will increase world starvation as world food prices rise. The UN estimates 25,000 people die each day due to starvation.

Is there an answer to settle the bio fuel debate? Many believe sun technology is the answer. David Borton, professor of Solar Engineering at Rensselaer Institute of Technology in Troy, NY, notes that 50 square feet of passive solar windows collects in the winter the same amount of energy as an acre of oil-seed crop. He sees irony in the federal government bailout of the financial industry as leading to inflation of currency, while investing in renewable sources of energy will create a sustainable economy based on domestic job growth. For Borton, energy is the twenty-first century’s currency of necessity. Borton argues that investing in solar technology, whose considerable federal developmental programs were removed by a Reagan Administration beholden to the oil industry, can be accomplished by an Apollo-like initiative within 13 years and produce significant results within a decade.

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**References**


