NEW USE PROTOCOL

This protocol[1] reflects best practices for supporting a Journey of Hope Project member through a new episode of substance use. A member's substance use suggests a need to review the treatment or recovery plan and to work with the person to find more effective therapeutic interventions and to build new skills. Our goal is to accurately assess a person's current needs and adjust the treatment plan as indicated. In accordance with JOH mission and values, we use a strengths-based approach and offer options to the member whenever possible.

A participant's substance use may be upsetting and disruptive for the whole program. But because a person is most in need of support when they are experiencing symptoms of their disorder, a range of therapeutic interventions should be tried before discharge is considered. This protocol describes the JOH process for assessing and responding to new use or other substance-related events.

1. Set up a face-to-face meeting with the member as soon as possible.

It's important to meet with the person as soon as possible after the reported use so that you can determine whether any urgent action is needed. Select a meeting format that matches the member's comfort level. For example, some individuals may not respond well in large groups, so a one-one meeting with the therapist may be more productive than bringing the whole clinical team together.

2. Ensure the safety of the member and the community.

2a. Ensure the safety of the member.

Screen for severe problems and identify new issues using the six ASAM dimensions:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change (use Stages of Change as a guide)
5. Relapse, continued use, or continued problem potential
6. Recovery or living environment

Acute intoxication or withdrawal. If behavioral presentation and clinical assessment suggest concerns about acute intoxication or withdrawal, the individual may require medical services at an ER or a rapid UDS/vitals assessment from a CRC or Assessment Center to determine stability. If possible, avoid sending the person elsewhere for assessment.

No urgent concerns: If the person is intoxicated but you have no urgent concerns, monitor the person to observe any changes in their condition, and provide additional support.

2b. Ensure the safety of your JOH community.

When the member is safe or in the process of stabilization, address the need for community safety. Search for paraphernalia, and check in with other members and staff about their response to the event. While acknowledging the experience of others, keep a neutral, nonjudgmental stance to allow for the member's reintegration back into the program, and create opportunities to build community resilience and coping skills.

JOURNEY OF HOPE PROJECT

1. This protocol is based on work by David Mee-Lee. See D. Mee-Lee, *How to Deal with Relapse, Continued Use and Continued Problems: Working Together to Promote Recovery*, Conference Breakout Session, November 3, 2016, The Change Companies. Available online.

3. Talk with the person about what contributed to this episode of substance use.

When engaging the person in conversation, practice the following:

- Withhold judgment. If needed, process your own reactions to the participant's use before engaging in the discussion. Seek support in understanding your own emotions before addressing the situation. It's ok to ask for help!
- Allow the member to describe what happened and what they were going through.
- Don't dismiss the person's experience.
- Use ASAM criteria or chain analysis to identify what led to using.
- Avoid lecturing the member about the program rules.

3a. The current lapse is one of several.

If this current use is one of several that have occurred over the course of the participant's time at Journey of Hope, or if it seems to be a slide back into continued use, take another look at what the person wants and their goals for treatment.

Alert JOH senior leadership when participants have more than one substance-related event.

3b. The member appears to have deliberately used.

If the member appears to have willingly used (for example, if they say they "just wanted to get high") or expresses no interest in creating or adhering to a new treatment plan, explore their understanding of their treatment plan and review their goals and steps. Work with the person to assess their current stage of change, and use this information to tailor interventions to their current stage. For example, if the member has moved from the action stage of change to the contemplation stage, working through a decisional balance exercise may help explore their ambivalence. Do they still wish to be in a structured treatment program?

4. Collaborate with the member to develop a therapeutic agreement, adjust the treatment plan, or create some other therapeutic response to the behavior.

The therapeutic response should address any new areas of need that emerged during the multidimensional assessment. You may want to consider the following:

- What part of the treatment plan worked? For example, did the person effectively use skills in some instances?
- What didn't go according to plan? Take time to identify barriers as well as the participant's strengths and tools the person can draw on to overcome threats to their wellbeing in the future.
- What are some realistic, attainable steps the person could take? Identify new skills or strategies to try.
- How can the program help? New or revised agreements should include steps for the program as well as for the member. Document how we will adjust our approach to help the person bounce back and build skills.
- Is the current level of care a good fit? Can the person accomplish their goals in their current level of care, or is a different level of care clinically indicated? The appropriate level of care is based on the individualized treatment plan and on the member's agreeing to move to a different level of care.
- Would the member do better in a different JOH program? If you and the member believe this is the case, please reach out to the JOH management team to proceed.

5. At the point specified in the treatment plan, work with the member to assess the effectiveness of the revised plan.

Shortly after implementation of a revised plan, the treatment team and the member should meet to look at whether the new plan has been helpful in increasing motivation and facilitating behavior change.

5a. The person is motivated and has not continued to use.

If the clinical team determines that the person is invested in changing their behavior, continue the person's treatment.

5b. Person appears to be unmotivated and not invested in their recovery.

If the problematic behavior continues or the clinical team determines that the person is not invested in their recovery, the treatment team may continue to work with the person (starting at step 2), or may consider involuntary discharge (see discharge process).

Discharge Process

Discharge from a JOH program should be a last resort that is considered only after all other possibilities have been exhausted. Discharge is at the discretion of each Journey of Hope program.

D1. Discuss discharge with the person.

The discussion with the member about involuntary discharge should include the smaller clinical team. When preparing for this discussion:

- If JOH senior management has not been alerted to the situation yet, include them before proceeding.
- Ensure that considering discharge is not an emotional reaction to your own feelings. If needed, allow some time to understand your own reactions to the situation. Seek support to manage your emotions before talking with the person about discharge.
- Consider whether the behaviors were observed and by whom, or were based on hearsay.

When discussing discharge with the person, you must:

- Let the person know that they are at risk for an involuntary discharge from the Journey of Hope Program
- Be clear, concrete, and concise about the specific behavior that is leading to the possible discharge; and
- Offer the person a 24-hour window in which to appeal.

In addition:

- Respect the participant's experience and point of view even when it differs from that of the clinical team.
- Highlight the person's progress in treatment.

D2. After discussing the involuntary discharge, offer the person an opportunity to appeal within 24 hours.

- Let the person know how they should submit their appeal. If person isn't a strong writer or prefers to express themselves in other ways, account for their preference in the appeal assignment. Also consider the person's capacity for insight and self-reflection, and remember to be understanding of a person's strengths and weaknesses.
- Schedule the appeal decision meeting at the end of the first meeting so the participant knows exactly when the deadline is for submitting the appeal.

- Be sure to consider the timing of the potential discharge. If the appeal deadline is a Friday at 4:00 and the team decides to move forward with discharge, placement options may be limited. Consider scheduling the intervention earlier in the week and avoid evening and weekend appeal deadlines.

D3. Review the appeal with the participant.

Using substances on program property, bringing paraphernalia into the program, dealing, or encouraging others in the program to use with them are unsafe for the community and harmful to the milieu. These types of behaviors should be taken into account as when assessing the person's continued stay in the program. Discharge for paraphernalia excludes new admissions into JOH coming directly from the street, a shelter, a CRC, or the Assessment Center.

How a person conducts themselves in the 24-hour window of appeal may offer additional information about the person's stage of change.

D3a. If the appeal is honored, continue treatment.

Ensure the member understands the severity of the situation, and increase motivation to change.

D3b. If discharge is the outcome, set up an aftercare plan.

The program is responsible for securing an aftercare plan for the member in all instances of discharge. It is up to the member whether they accept the placement that was secured.

- Discharge planning should include continuity of care, such as MAT, IOP, and Partial Program.
- Individuals supporting the person such as their ICM, TCM, or recovery coach should be alerted to the discharge and informed about the aftercare plan.
- Based on available resources, secure a stable place for the person to be discharged to, and use a warm handoff to this setting.
- DBHIDS does not endorse discharges to the street.