ARTICLE

Lowering Your Residential ASA Rate: A Practical Guide

RSI Recovery Systems Institute
RECOVERY PROGRAMS

Against staff advice (ASA) and absent without leave (AWOL) discharges are antithetical to good outcomes. A patient who leaves ASA can't be considered a treatment success, and a high ASA rate is sure to damage a program's reputation.

Analysis and preventive action can lower your rate of ASA discharges. Here are a few simple suggestions.

Start with Routine Analysis of ASA Discharges

Begin collecting data about ASAs. Look at age and gender, then variables such as:

Date ASA occurred	AWOL or signed out ASA?
Drug(s) of Preference	Stated Reason for leaving (if available)
Length of stay prior to ASA	Number, type, name of staff on duty
Scheduled date for discharge	Legal status (court-referred, etc)
Time of day & day of week	History of prior ASA
Medical & psychiatric status	History of relapse after treatment
Referral source	Area of residence
Assigned case manager	Subjective reports of discomfort

We want to know:

1. When during the treatment stay most ASAs occur.
2. If certain clients leave ASA more frequently than others.
3. If ASA is more likely on certain shifts, at certain times of day, or on certain days of the week.
4. If there is a correlation between ASA and particular staff on duty
5. If there are other common features that might help us understand ASA.

Once you have some data to review, look for patterns. Here are some common examples:

First Week Blues

Characterized by a preponderance of ASAs in the first days of treatment, here's how this looks on a data collection form:

	Case One	Case Two	Case Three	Case Four	Case Five
Drug(s)	Heroin	Heroin PolyDrug	Heroin	Alcohol	Heroin Inhalants
Adm. Date	4/11	4/10	4/11	3/31	4/3
Sched. DC	4/24	4/23	4/24	4/13	4/18
Left ASA	4/14	4/14	4/15	4/12	4/12
Time	5P	5P	12A	2P	9A
LOS	3	4	3	13	9
Counselor	Moore	Weiss	Glenn	Moore	Simms
Stated Reason	Felt sick from Withdrawal	Home emergency	Depression over job loss	Outside business concerns	Worry over court problems
Comments	Complaints re: discomfort, craving	Same as Case One	No WD complaints, but extreme mood swings	Legitimate worry about job loss, boss had threatened to fire him.	Called back that night, high, and asked for readmit

Cases 1-3 entered and left in the same brief span. Two signed out at the same time, with similar complaints.

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Community Hostility

Here, it seems as if one person feeds off another's rebellion, and they encourage one another to leave.

Drug(s)	Alcohol	PolyDrug	Marijuana Hallucinogens	PCP	Heroin
Adm. Date	5/11	5/10	5/11	4/31	5/3
Sched. DC	5/24	5/22	5/24	5/20	5/18
Left ASA	5/14	5/14	5/15	5/12	5/12
Time	6P	9A	1A	3P	9A
LOS	3	4	4	13	9
Counselor	Jackson	Smith	Louis	Jackson	Louis
Stated Reason	Complained about excess drug addicts	Conflicts with roommate	AWOL	Other patients out to get him	Home problems
Comments	Conflict in earlier activity, intimidated by ex-con	Bonded closely with #1, left next morning early	Didn't sleep well, avoided others, snuck off.	Increasingly paranoid about tension with others	Mother called, told him she wouldn't pay his rent.

Patients are telling us that something in the patient community is disturbing them.

Late stage ASAs

Here ASA seem to cluster in the later days of the stay — even shortly before scheduled discharge.

	Case One	Case Two	Case Three	Case Four	Case Five
Drug	Opiates	Cocaine	Poly Drug	Heroin Cocaine	Poly Drug
Adm. Date	5/11	4/28	5/17	5/18	5/23
Sched. DC	6/1	6/11?	6/12	5/31?	Unknown
Left ASA	5/30	5/29	5/29	5/29	5/23
Time	12:15 AM	12:30 AM	5 PM	5 PM?	9 PM
LOS	19 days	31 days	12 days	11 days	1 day
Counselor	Davis	Grant	Davis	Grant	Dell
Stated Reason	c/o insomnia; ready to go	Already in AA; Tx "defocusing" him	Threats since 5/21; 3 hr. ASA block failed	none; told other pts. he would do drugs	c/o no $ to pay for second tx in 3 mos.
Comments	left in own car; may have arranged to have it dropped off	Wife picked him up	Male friend got her; gave ride to #4	AWOL with ride from #3	Girlfriend came with gear, he got her to give ride.

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Step Two: devise solutions

Take the **First Week Stampede.** Some possible explanations:.

Inadequate medication: There's a fine distinction between medicating to provide safe detoxification, and medicating to suppress drug hunger. It's easy to undermedicate an addict, especially when the physician or nurse is naturally concerned about oversedation. The addict begins to panic. "Oh God," he says to himself, "I'm going cold turkey." Soon his fear of withdrawal is a bigger problem than withdrawal itself, and he signs out ASA. **Suggestion:** By making adjustments in the detox regimen, you can directly reduce the risk of ASA.

Irritable staff: Addicts often make inordinate demands for staff attention. If busy nurses perceive patient demands as attempts to manipulate, and ignore them, or become critical, patients often bolt. **Suggestion:** Train staff on alternate ways to deal with demanding patients. Using some of the motivational enhancement techniques can help. Develop a group of detox volunteers to sit with patients and meet demands for attention.

The patient isn't engaged quickly enough: Crisis drives addicts into treatment, providing a small window in denial that rapidly closes. Ironically, the addict's motivation to remain in treatment decreases as he feels better. Other worries come to the fore, and he may decide he no longer needs help. That's why you need motivational work in the initial days of treatment. If the staff is too busy to engage the patient, risk of ASA goes up. **Suggestion:** Maintain activities on weekends, especially after a cluster of admits, when staff is easily swamped with paperwork. Be careful to monitor visitors — they often provide assistance to ASAs.

The program is just too chaotic: For all their rebelliousness, addicts respond best to order and structure. If a program becomes disorganized, the resulting tension and disarray activate the fight-flight response. It may literally drive clients out of treatment. **Suggestion:** Stick to a schedule. Make sure activities occur on time. Take a 'no big deal' approach to minor complaints and problems. Strive for order and calm.

Another common pattern: Community Hostility

Every so often, an inpatient community gets really angry about something. The cause is usually a negative group process.

Inpatients generally go through four stages. At first, they are quite dependent, needing constant direction. Later they become angry or frustrated with staff, complaining the program isn't doing enough for them. Eventually they stabilize and accomplish most of the 'work' of treatment. There may be a regression to anger or dependence in the days immediately prior to discharge, just because of anxiety. If a patient community features a disproportionate number of people who are in either the angry or regressed stage, the client community as a whole can enter the **Hostile Mode**, bonding around the belief that treatment is a waste of time, the staff are incompetent or uncaring, and ASA is the only reasonable response. Staff can inadvertently provoke this by responding to client anger with confrontation or punishment. **Suggestion:** train staff to better manage patient hostility. Instruct evening or night staff to contain problem patients but pass decisions about punishment or therapeutic discharge onto the day supervisors. Everything looks clearer (and calmer) in the light of day.

The Third Pattern: Late stage ASAs

When patients leave at an advanced point in treatment, it's often one of the following:

Lingering resistance – the nature of the inpatient experience causes resistance to coalesce around an obvious point of conflict: the discharge date. Some patients leave early as a way of reasserting control. Example: two patients scheduled for discharge Monday team up to sneak away from the facility on Saturday night.

Reaction to something going on in the patient community (often hidden from staff) – Inpatient environments are particularly vulnerable to three behavioral "viruses": violence, sexual acting out, and drug/ alcohol use. We understand how patients who use drugs leave treatment, but often, patients who are not using, also leave. They may have fallen into the trap of expecting staff to somehow divine that something destructive is going on. If the staff doesn't figure it out, the "innocent" patients feel entitled to regard treatment as a sham. An example: two patients leave ASA in their last week of treatment, then complain of drug use by other patients to their probation officer. Solution: If a community seems to be acting strangely, start pulling patients aside and asking them if something is going on. An alert staff can use leverage to dissuade ASA. Example: "Remember, your goal is a favorable report to the Court"