Brief Addiction Monitor (BAM)

Manual for Use in SUD Group Treatment

For non-VA clinicians

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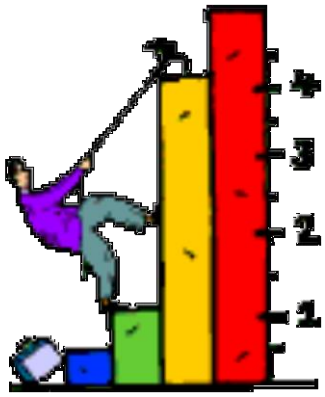

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Brief Addiction Monitor (BAM): Manual for Use in SUD Group Treatment

What is the BAM?

The Brief Addiction Monitor (BAM) (Cacciola et al., 2013) is comprised of 17 items that assess three functional domains in a group member's life: (1) RISK factors associated with relapse or worsening addiction severity, (2) PROTECTIVE factors associated with the initiation and maintenance of sobriety, and (3) USE of alcohol and other substances. Items were selected for inclusion in the BAM because of their empirically-derived relationship to substance misuse. With repeated administrations of the BAM, the group member and clinician can evaluate the degree to which change in the item-level data correlates with change in substance misuse. Furthermore, the presence of Risk factors and absence of Protective factors can inform treatment adaptations to reduce Risk and augment Protection with the goal of reducing substance misuse. The BAM and support materials are available at the following web address:
http://www.mentalhealth.va.gov/communityproviders/clinic_sud.asp#sthash.6tfFySV6.dpbs – Click on Assessing for a Substance Use Problem and then Assessing Addiction Problem Severity for information on the BAM.

How is the BAM used in treatment planning?

The BAM can be used in both treatment planning and progress monitoring. An initial BAM can help identify appropriate foci of treatment. The provider and group member are then able to generate problem statements and goals based on BAM data. For example, if a BAM indicates that the drank alcohol on 15 days in the past 30, a treatment goal might be that the group member will indicate he/she will not drink more than 4 days in the next 30 days, and if the BAM shows that the group member was in risky situations 8 times in the past month, the goal would be to reduce that number. Interventions can then be selected that are appropriate for those goals, such as Contingency Management (Petry, 2012) to initiate and maintain abstinence from substances and 12 Step Facilitation (Nowinski & Baker, 2003) to increase self-help group attendance. Providers and group members should select the most relevant BAM items to individualize the treatment plan for that particular group member. The document "Treatment Planning with the BAM" contains further details on using BAM data to identify strengths, problem statements, goals and interventions. Subsequent BAM data then also allows the provider and group member to assess progress the group member is making toward stated goals. A treatment plan informed by the patient's BAM data helps make the plan individualized, measurable, time-bound, and strengths-based (all of which are The Joint Commission (TJC) concerns).

How is the BAM used in progress monitoring?

To use the BAM as a progress monitoring tool, the BAM would be administered at the initial visit and then at subsequent visits. The original BAM is designed to assess progress every 30 days, while the BAM-IOP is intended to assess on a weekly basis [For a copy of the BAM-IOP or 7-day BAM, contact: Dominick.DePhilippis@va.gov. The data from the BAM is then entered into a spreadsheet that generates either a graph or numerical data chart.

A group member's BAM data can be represented in graphs that illustrate change in the item level data. For example, Graph #1 depicts that in the 30 days preceding each of the first two monthly BAM administrations, the group member reported drinking on 25 days and 28 days (of which 20 and 24 days, respectively, were heavy-

drinking days). Likewise, Graph #2 indicates that the group member has participated in self-help groups on 6 and 5 days in the 30 days preceding each of the first two monthly BAM administrations.

Sharing these graphs with the group member, the clinician can elicit the group member's perspective on the clinical implications of the data, e.g. what changes, if any, the group member is considering. Moreover, the clinician and group member could consider hypothesized relationships between these variables that can be tested via treatment plan adaptations, e.g. does increasing his/her participation in self-help correlate with decreased drinking. Graph #3 depicts how such a hypothesized relationship between a group member's alcohol use and self-help involvement might be confirmed by subsequent BAM administrations.

How are graphs or tables prepared from BAM data?

Graphs:

BAM data can be summarized by creating graphs in Excel that allow Group members to see the changes in scores over time. See the "BAM Scoring Template Standard Operating Procedures (SOPs)" document for guidelines on entering BAM data into Excel and generating graphs of changes in BAM item scores over time. Graphs 1, 2, and 3 below show examples of graphed results. In focus groups, group members have indicated that they find the graphs very helpful in examining changes over time (Drapkin et al., 2010). Graphs can be generated for each question on the BAM (e.g., Graph 2 below), or one graph can show multiple questions together (e.g., Graph 3 below). Some group members might find more complex graphs too confusing.

Our recommendation is to run the graphs for each question (or questions that go together such as Graph 1 below), and ideally show them on the computer rather than printing them out each session (save time and paper!). If you do not have access to a computer in the group session, group members could fill in their own graphs at each time point. The group leader should provide blank graphs for each question and then ask the group members to use their BAM responses to put a dot on the graph corresponding to the ir answer, and then draw a bar around it or just link the dots with lines. Group members or group leaders can hold onto these charts and have group members fill in the graphs after each BAM.

Depending on which type of BAM you are using (30-day vs. 7-day), you will need different types of blank graphs for group members to fill in. (For the BAM Soring Template for the 7-day BAM, contact: Dominick.DePhilippis@va.gov).

Tables/Charts:

BAM data can also be summarized in a chart or table using Excel that shows all of the data in numerical form. See "BAM Scoring Template" Excel file.

Given the amount of numbers on the chart, group members may be overwhelmed by the amount of data. The chart view can be simplified by placing a blank piece of paper over the items not being discussed at the time and sliding it down to examine each item in turn.

The chart can also be filled in by hand if a computer is not available in the group meeting, or for quicker turnaround of results. A blank chart (Tables 1 and 2 below- choose which style you prefer) can be given to each group member, who can then fill in the numerical responses he/she gave on the BAM.

Each group should be consistent in what style it uses, so group leaders should choose the style they feel most comfortable working with, which in turn will help group members feel more comfortable with it.

THE BAM IN GROUP THERAPY

How can the BAM be used in group therapy?

The BAM can be either **one aspect of an ongoing group**, within your existing curriculum, or it can become the **central theme of an ongoing group**, wherein group members complete the BAM, discuss results and changes over time, and then focus psycho-education and group discussion on particular risk and protective issues that group members are dealing with or need work on. Counselors can keep a set of resources and materials prepared to address various topics such as sleep hygiene, coping with cravings (e.g., Carroll, 1998), communication skills, etc. Addressing each risk or protective factor on the BAM would comprise a strong recovery program. However the BAM is used in group, an introduction to the BAM is vital for generating group members' buy-in to the idea and importance of it.

An introduction to the BAM should include:

1) Description of the instrument (17 questions; topics -e.g., use, cravings, health, support; completion time: 5-10 minutes)
2) Frequency of administration (i.e., weekly or monthly)
3) Barriers to completion (e.g., literacy, visual impairment)
4) Rationale for using it (helps us evaluate your progress, suggests areas of need, helps identify risks before a relapse occurs)

When the BAM is the central component of the group, the BAM-IOP version (covering the prior 7 days) should be used and BAM feedback should be provided within the same session. It is thus extremely helpful to have access to a computer in the group room. If there is no such access, it is feasible that each group member could enter their own data into a graph or chart that they then use to examine their results (see above for graph/table creation information).

How is the BAM used as a central component in a group?

The BAM can serve as the central or core component of an ongoing group, with complementary topics addressed in relation to BAM items relevant to group members at a given time.

1) Orientation to the BAM: Prior to enrollment in the group, the therapist meets with each group member to explain the BAM, how the BAM will be used in group (including the sharing of data among group members), and group rules and schedule. The therapist and group member also discuss the group member's expectations of treatment and his/her perspective on customized treatment as well as being in group with members who might not share their values in recovery, i.e. members who have not yet initiated or even committed to abstinence.

2) During this orientation session, the group member would complete his/her first BAM assessment (examining the group member's past 30 days) and receive the results in graph or table format. The data (fed back to the group member in an MET-consistent manner; see Miller, 1995) helps inform initial treatment planning. Since the data at this time consists of only one data point, the group leader could share a de-identified example of graphs or a table with multiple data points to show how BAM data can change over time (See graphs 1-3).
3) Completing the BAM: For each group meeting, group members spend the first 5 to 10 minutes of group completing a hardcopy of the BAM-IOP (providing data relevant to the past 7 days). The group members hand in their completed BAMs to the group leader who then enters their data into the Excel Scoring Template. Data entry may be done by an assistant or by the group leader during check-in (see step 4). For group members with reading/visual impairments, the BAM is conducted as an interview with data entered directly into the Excel Scoring Template. If no computer is available during group, when group members have completed the BAM, they can then transfer their responses to graphs or tables provided by the group leader. It is critical that group members receive immediate feedback when using the BAM-IOP.
4) Check-in: As group members complete their BAMs, they also complete a verbal check-in – announcing to the group how their recovery has proceeded since the prior meeting. The check-in might include how they are feeling, any substance use, what good coping skills they used, and following up on things discussed in the prior group. Check-ins also allow for group members to raise issues that might not be covered on the BAM, such as legal involvements. These issues should be attended to during each group member's progress review. Group leaders might keep track of additional topics by noting them on a flip chart or white board.
5) Sharing results: Graphs of each group member's data are shared among members of the group, one at a time. A group rule should be established for the order of sharing, which might be by volunteer, by order of severity, alphabetically, etc. Discussion is then begun about each group member's results. Together, the group can examine what is going up, what is coming down. Motivational Interviewing (MI; Miller & Rollnick, 2013) is a useful means of having group members talk about their responses. Over the course of the group session, each group member shares his/her results, with interactive discussion about each person's progress and challenges, and how that might relate to others' experiences.
    - One of the main benefits of a group is having the power of people facing similar challenges. Harness this power by letting group members provide support for each other and help teach each other from their own successes. Channel discussion and provide structure, but allow group members to learn from each other. This helps increase buy-in and also builds self-efficacy in those who help "teach."
    - Group members may decline to share their weekly data, but those that consent have their graphs displayed for discussion by the group. For those that decline to share their data, an individual therapy session subsequent to the group meeting may be convened.

6) Using a blend of MI and CBT skills, the therapist facilitates a group process focusing on social support for change, problem solving, and goal-setting.
   Several techniques can be deployed in this effort:

a. Brainstorming
    i. Group members brainstorm ideas for coping with situations such as contact with friends who still use (risky situations), how to attend more 12-step meetings (self-help attendance), how to get involved in more meaningful activities
b. Decisional balance (Miller & Rollnick, 2013)
    i. Examine the pros and cons of changing and not changing for behaviors such as use, continued participation in treatment, medication adherence.
c. MI importance and confidence rulers (Miller & Rollnick, 2013)
    i. Used to examine and build motivation for change
d. Discussion of goals and values supportive of change
    i. Discuss short and longer term life goals in terms of use, work, relationships, etc.
e. Values card sort technique (Miller, C'de Baca & Matthews, 2001)
    i. Helps identify discrepancy between group member's values and behaviors in order to increase motivation for change
f. Functional analyses of behavior (Carroll, 1998)
    i. Examining what emotions and situations trigger and reinforce certain behaviors such as cravings, using, arguments with others
g. Psychoeducation regarding sleep hygiene, physical health and affect management, and coping with craving, nature of addiction, physiology of addiction and recovery
    i. Clinician can provide psycho-education, use opportunities when they arise to address relevant topics, for example teaching breathing and progressive muscle relaxation techniques
    ii. Group members can also share what they have learned about certain topics and what has helped them
    iii. Resources: Matrix model
h. Homework
    i. CBT (Carroll, 1998)
    ii. functional analysis (Carroll, 1998)
    iii. self-monitoring
    iv. journaling
    v. consider progress on homework as a Check-in item

How is the BAM used as a component in a group?

The BAM can be used as a supporting element in an existing group curriculum, ideally on a monthly basis to maximize the utility of the 30 day timeframe of the original BAM. Ideally, feedback is provided within the same group session. If no computer is available, BAM graphs or charts may be completed in group by the group members themselves (see above for information on creating graphs and tables). If the BAM is given monthly, it is acceptable, if not ideal, that feedback be provided the week after the BAM is completed.

1) Orientation to the BAM: Prior to enrollment in the group, the therapist meets with each group member to explain the group, including the BAM, how the BAM will be used in group (including the sharing of data among group members), and group rules and schedule, as well as any other expectations or group

procedures. At the start of each BAM-focused group session, an orientation to the BAM would be provided to those who are new to the group and as a refresher for those continuing in the group.

2) Completing the BAM: The group leader would distribute paper copies of the BAM for group members to complete
3) Feedback: Ideally, feedback would be available within that same group session (perhaps by having group members complete their own graphs or tables). Otherwise, before the next group session, the group leader would enter BAM data into Excel. The group leader would then prepare handouts of group member's results, either in graph or table form.
4) In the same session or at the start of the following group session, the clinician distributes to each group member the graphs or table of his/her BAM data. The group leader should next explain how to understand and interpret the results and demonstrate how to set goals based on their results.
5) Group members would then be invited to share their thoughts on the implications of their data and solicit support from the group with respect to Risk-reduction and augmentation of Protective factors. Interventions targeting specific needs could be included within a menu of options from which group members might select for inclusion in their treatment plans (see below for suggested treatment/referral options for each item). If the group does a Check-in, group members can relate the Check-in to discussion of their progress on the goals that were generated from the BAM.
6) The remainder of the group session or any part thereof can be dedicated to discussing changes in BAM scores since the last month, setting goals, discussing progress toward goals, or providing education on relevant topics of risk management/recovery skills. Using a blend of MI and CBT skills, the therapist facilitates a group process focusing on social support for change, problem solving, and goal-setting. Various techniques can be deployed in this effort (see #6 in the above section for details).
7) BAM data can be referred to in intervening sessions to support other curriculum elements.

EXPLORING THE RELATIONSHIP OF BAM ITEMS TO RECOVERY

End users are strongly encouraged to attend to the item-level data because they have direct implications for treatment planning. That is, they identify specific areas of need or resources the patient brings to bear in his/her recovery. Although each functional domain (i.e. Risk, Protective, & Use) has an associated composite score which serves as cross-sectional marker of clinical status, additional psychometric evaluation of these scores is needed before they can be more extensively applied to clinical decision-making.

Below are some suggested questions that might help move discussion forward on particular BAM items:

Item #1 (Physical Health), #2 (Sleep Problems), and #3 (Mood Problems):

What are the group member's specific concerns in each area?
In what ways are the group member's concerns related to his/her substance misuse?
(Consider a graph that tracks change in each.)
What steps has the group member already taken to address his/her physical health, sleep, and/or mood concerns?
What other options are available for the group member to consider in having his/her physical health, sleep, and/or mood concerns addressed?

Items #4 (Alcohol Use), #5 (Heavy Alcohol Use), #6 (Other Drug Use), and #7 (Specific Substances):

What are the good and not-so-good things about your use?
What will happen if your use doesn't change?
What will happen if you decrease your use?
To what do you attribute any increases and decreases you've seen in your use?
How have you cut down successfully in the past?

Item #8 (Craving):

What is your understanding about how craving works?
(With the group member's permission, the clinician can provide some education on how craving is a conditioned response).
In what ways have you responded successfully (with abstinence) to your craving in the past?
The clinician could provide a menu of options for craving management, e.g. CBT-based skills training, pharmacotherapies (naltrexone, disulfiram, acamprosate, Suboxone®, methadone), other EBT-based tools such as 12-step sponsorship.

Item #9 (Confidence to be Abstinent)

What makes the group member confident?
What could help increase the group member's confidence?
Evaluate episodes of success from the group members past.

Item #10 (Self-help Involvement)

What self-help groups has the group member experienced?
What is the group member's perspective on the 12-step approach to recovery?
In what ways has self-help participation assisted the group member with his recovery?
How might the group member benefit further from self-help involvement?

Item #11 (Risky Situations)

What is the group member's understanding of triggers/cues?
(With the group member's permission, the clinician can provide some education on how triggers emerge and can be managed).
What are the group member's triggers?
In what ways has the group member responded successfully (with abstinence) to triggers in the past?

Item #12 (Spirituality)

What is the group member's spiritual belief system?
In what ways is substance misuse discrepant with the group member's spiritual beliefs?
In what ways does spirituality contribute to the group member's recovery?
How has the group member's spiritual beliefs assisted with his/her recovery in the past??

Item #13 (Gainful Activities)

How does the group member spend his days?
What is the group member's perspective on the role of structured daily activities in sobriety?
What are the group member's vocational, educational, and volunteering interests?
What has the group member done in pursuit of these interests?
If disabled, how might the group member structure his day if not via employment?

Item #14 (Legal Income)

What are the group member's sources of legal financial support?
How does the group member's involvement in illegal sources affect his recovery?
How important is it to the group member to be legally self-sufficient?
How confident is the group member in achieving legal self-sufficiency?

Item #15 (Interpersonal Conflict)

What is the relationship between the group member's interpersonal conflicts and his/her substance misuse?
How has the group member successfully managed interpersonal conflicts in the past?

Item #16 (Interpersonal Support)

Who does the group member identify as members of his sober support network and what is the nature of the support they provide, i.e. assistance with practical needs, sources of encouragement, assistance with environmental control, etcetera?
In which functional domains (physical health, mental health, vocational/financial, housing, legal, recreational, spiritual) do social support appear to be lacking?
How might the group member increase the number of and/or frequency of contact with of network members?

Item #17 (Recovery Satisfaction)

With which elements of the group member's recovery is the group member satisfied and dissatisfied?
What is the discrepancy between the present status of those elements and how the group member would prefer them to be?

Clinical guidelines/treatment indications:

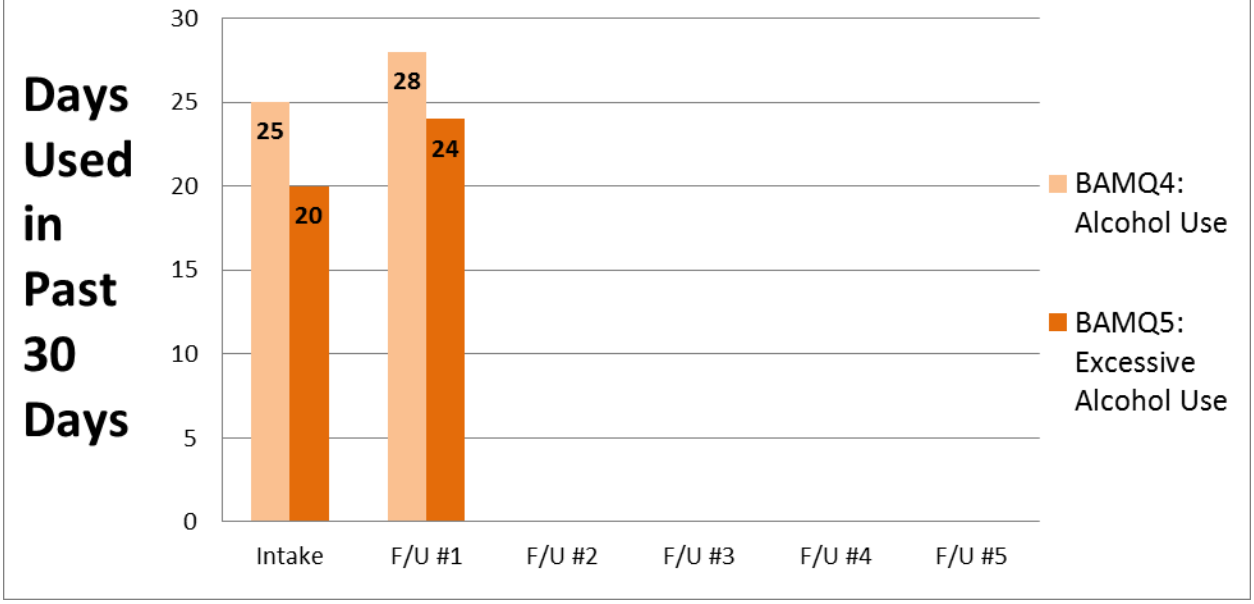
Specific BAM items might indicate modifying treatment in particular ways. Below are some recommended treatment and referral ideas for each BAM item.

- Use:
  - Any alcohol use (item #4)
  - Heavy alcohol use (item #5)
  - Any drug use (item #6)
    - Any increases or plateaus in the item scores should be functionally analyzed for existing triggers and contingencies, while decreases should be acknowledged and praised.
    - pharmacotherapy
    - higher level of care
    - motivational interviewing (Miller & Rollnick, 2013)
    - functional analysis (Carroll, 1998)
    - harm reduction work (Marlatt, Larimer, & Witkiewitz, 2011)
    - Contingency Management to assist the group member with initiating and maintaining early abstinence (Petry, 2012)

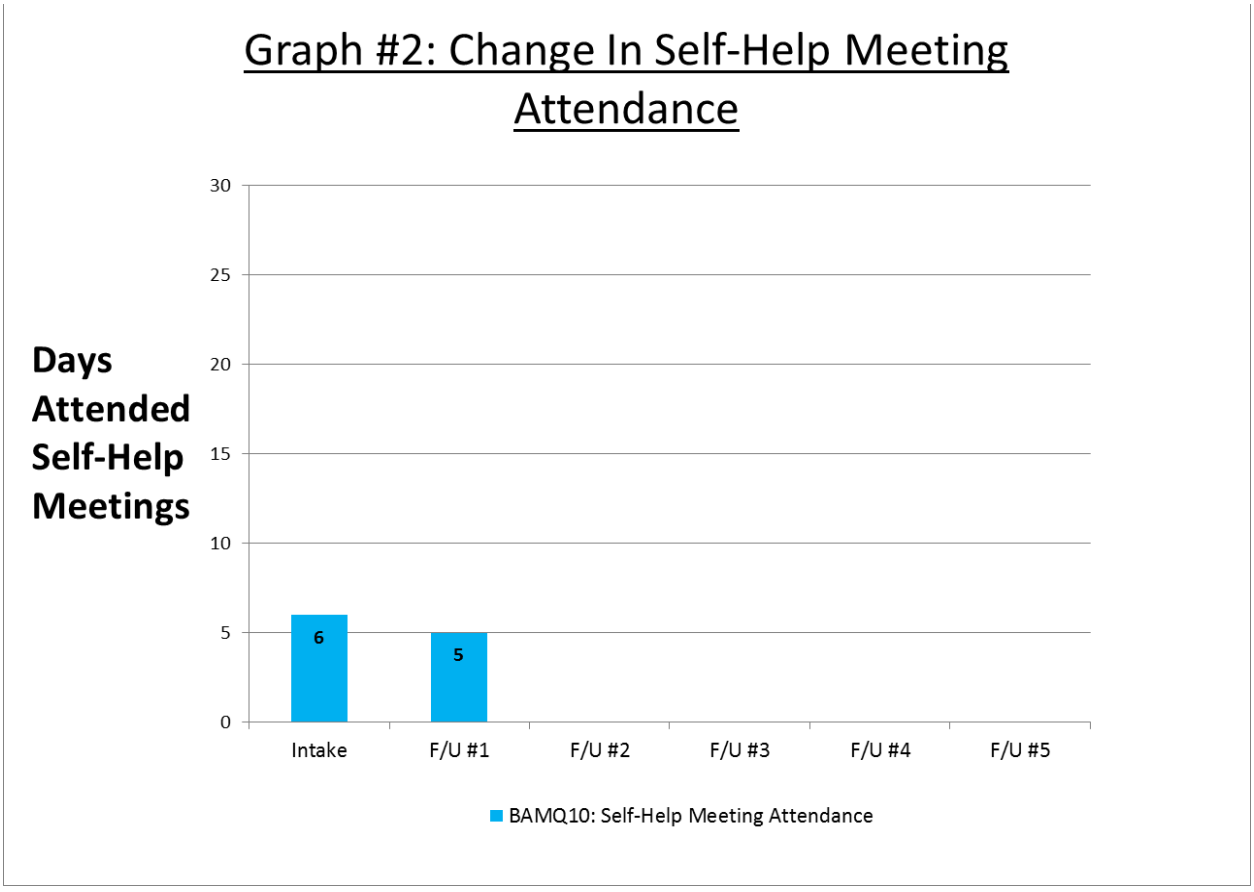
- Risk Factors: High scores or rising scores might call for further examination and clinical attention, e.g. refer for medical or mental health consulation, add CBT or relapse prevention skills training.
    - Cravings (item #8)
        - Medications can help reduce cravings, consider referral to psychiatry
        - CBT skills training for craving management (e.g. Carroll, 1998)
        - Cue exposure (Drummond, Tiffany, Glautier, & Remington, 1995)
    - Physical Health (item #1)
        - Referal to primary care
    - Sleep (item #2)
        - CBT-I (Edinger & Carney, 2008);
        - Referral to primary care
        - Referral to psychiatry
    - Mood (item #3)
        - Assess suicidality
        - Referral to mental health
        - Referral to psychiatry
    - Risky situations (item #11)
        - Cue exposure (Drummond, Tiffany, Glautier, & Remington, 1995)
        - CBT (Carroll, 1998)
    - Family/social problems (item #15)
        - Communication skills training
        - Assertiveness training
        - BCT (O'Farrell & Fals-Stewart, 2006)

- Protective Factors: Low scores or decreasing scores might call for further examination and clinical attention, e.g. treatment plan might include building sober support networks, 12 step facilitation, or work with a case manager for work or income assistance.
    - Self-efficacy (item #9)
        - Assertiveness training
        - Communication skills
    - Self-help behaviors (item #10)
        - 12-step facilitation (Nowinski, Baker, & Carroll, 1992)
    - Religion/spirituality (item #12)
        - Exploring how religion/spirituality interacts with recovery
    - Work/school participation (item #13)
        - Employment assistance
        - CWT
    - Adequate Income (item #14)
        - Income assistance- social work
    - Sober support (item #16)
        - Helping build sober support network

Graph #1: Change in Alcohol Use



Graph #2: Change In Self-Help Meeting Attendance



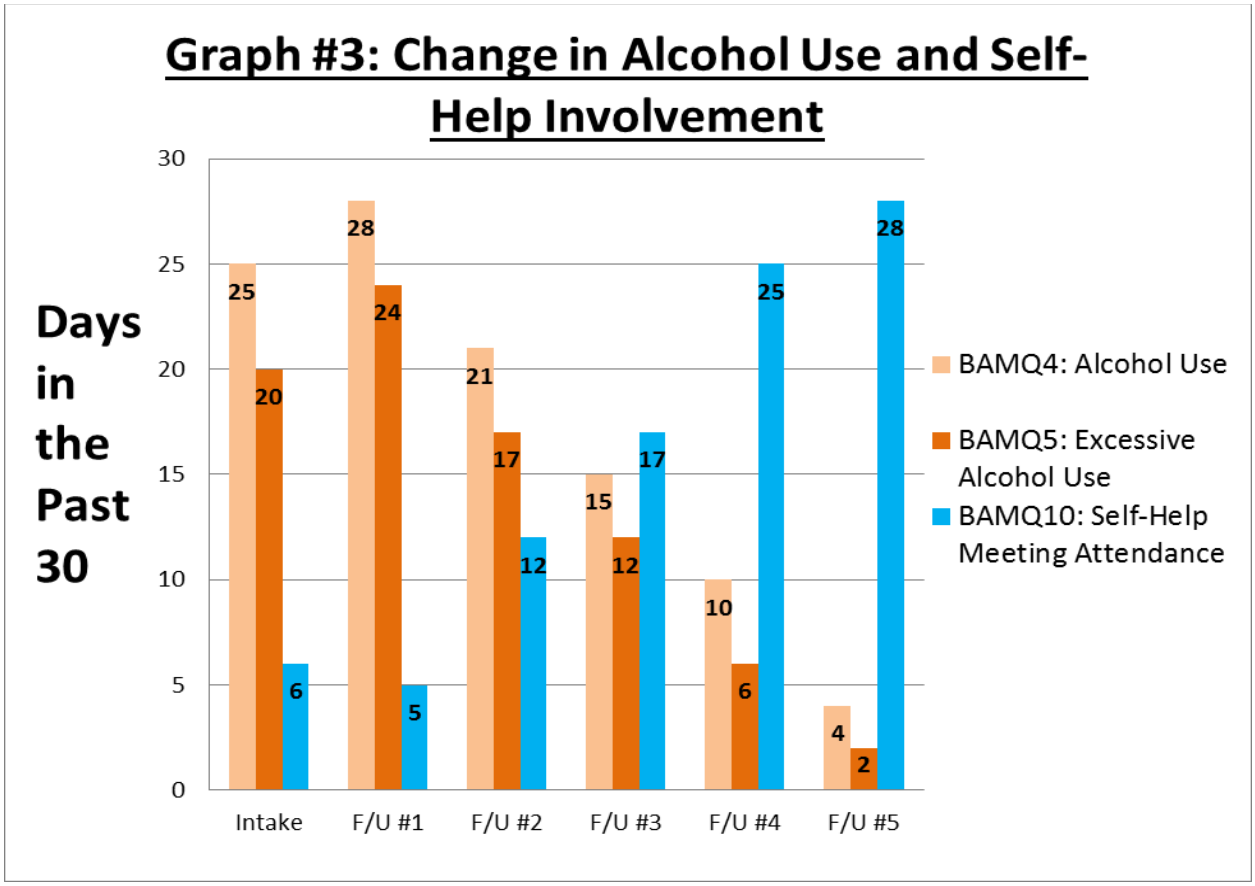

Graph #3: Change in Alcohol Use and Self-Help Involvement
Days in the Past 30
30
25
20
15
10
5
0
25
20
6
28
24
5
21
17
12
15
12
17
10
6
25
4
2
28
Intake
F/U #1
F/U #2
F/U #3
F/U #4
F/U #5
BAMQ4: Alcohol Use
BAMQ5: Excessive Alcohol Use
BAMQ10: Self-Help Meeting Attendance

Table 1. Chart for BAM data entry.

Name:	Intake	F/U #1	F/U #2	F/U #3	F/U #4	F/U #5	F/U #6	F/U #7	F/U #8
DATE:									
BAMQ1: Health Problems									
BAMQ2: Sleep Problems									
BAMQ3: Mood Problems									
BAMQ4: Alcohol Use									
BAMQ5: Excessive Alcohol Use									
BAMQ6: Illicit Drug Use									
BAMQ7A: Marijuana Use									
BAMQ7B: Sedative/Tranquilizer Use									
BAMQ7C: Cocaine/Crack Use									
BAMQ7D: Other Stimulant Use									
BAMQ7E: Opiate Use									
BAMQ7F: Inhalant Use									
BAMQ7G: Other Drug Use									
BAMQ8: Cravings									
BAMQ9: Confidence to be Abstinent									
BAMQ10: Self-Help Meeting Attendance									
BAMQ11: Risky Situations									
BAMQ12: Spirituality									
BAMQ13: Work, School, or Volunteering									
BAMQ14: Enough Legal Income									
BAMQ15: Arguments with Family/Friends									
BAMQ16: Spent Time with Supportive Family/Friends									
BAMQ17: Satisfied with Recovery									
RISK for USE									
PROTECTION from USE									
USE									

Note: the color coding is used to show which items correspond to each composite score.

Table 2. Chart for BAM data entry, sorted by factor.

Name:	Intake	F/U #1	F/U #2	F/U #3	F/U #4	F/U #5	F/U #6	F/U #7	F/U #8
DATE:									
BAMQ4: Alcohol Use									
BAMQ5: Excessive Alcohol Use									
BAMQ6: Illicit Drug Use									
USE									
BAMQ7A: Marijuana Use									
BAMQ7B: Sedative/Tranquilizer Use									
BAMQ7C: Cocaine/Crack Use									
BAMQ7D: Other Stimulant Use									
BAMQ7E: Opiate Use									
BAMQ7F: Inhalant Use									
BAMQ7G: Other Drug Use									
BAMQ1: Health Problems									
BAMQ2: Sleep Problems									
BAMQ3: Mood Problems									
BAMQ8: Cravings									
BAMQ11: Risky Situations									
BAMQ15: Arguments with Family/Friends									
RISK for USE									
BAMQ9: Confidence to be Abstinent									
BAMQ10: Self-Help Meeting Attendance									
BAMQ12: Spirituality									
BAMQ13: Work, School, or Volunteering									
BAMQ14: Enough Legal Income									
BAMQ16: Spent Time with Supportive Family/Friends									
PROTECTION from USE									
BAMQ17: Satisfied with Recovery									

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