Moving Away from Cookie Cutter Care:
What Individualized Treatment Really Means

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A. What is Addiction?

Addiction is a brain disease and biopsychosocial-spiritual in nature.

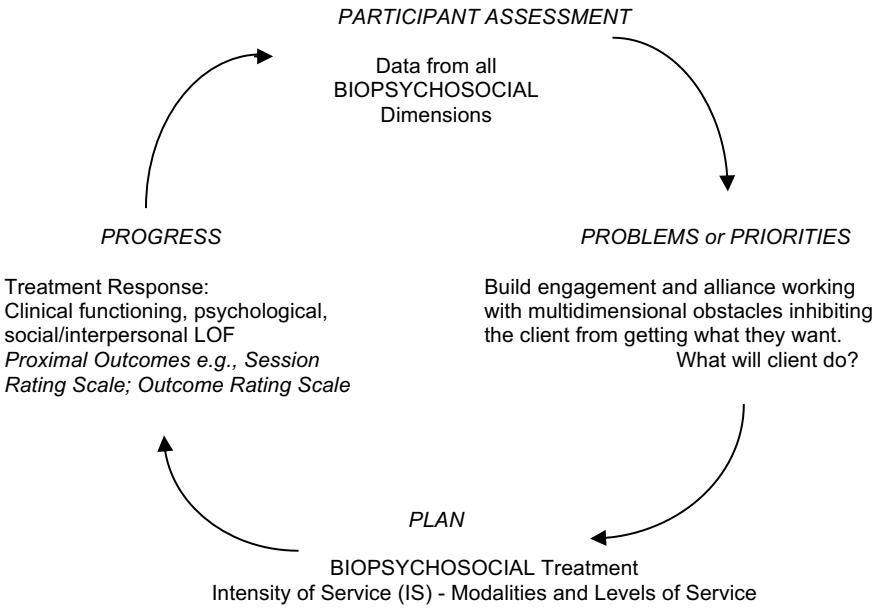
(a) American Society of Addiction Medicine (ASAM) definition of addiction:
"Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.

Prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases."
https://www.asam.org/resources/definition-of-addiction September 15, 2019.

(b) Biopsychosocial in etiology, expression and treatment

B. Definitions of Terms

1. Individualized, Outcomes-driven Treatment - The ASAM Criteria



(a) Assessment of Biopsychosocial Severity and Function *(The ASAM Criteria* 2013*,* pp 43-53)
The common language of six ASAM Criteria dimensions determine needs/strengths:

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Withdrawal management 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 sub-diagnostic 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 problems with motivational strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

(b) Biopsychosocial Treatment - Overview: 5 M's

* Motivate - Dimension 4 issues; engagement and alliance building
* Manage - the family, significant others, work/school, legal
* Medication – withdrawal management; HIV/AIDS; MAT - anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
* Meetings - AA, NA, Al-Anon; SMART Recovery, Dual Recovery Anonymous, etc.
* Monitor - continuity of care; relapse prevention; family and significant other

(c) Treatment Levels of Service *(The ASAM Criteria* 2013*,* pp 106-107)

0.5 Early Intervention
1 Outpatient Services
2 Intensive Outpatient/Partial Hospitalization Services
3 Residential/Inpatient Services
4 Medically-Managed Intensive Inpatient Services

C. **Stages of Change -** Transtheoretical Model of Change (Prochaska and DiClemente):

Pre-contemplation: not yet considering the possibility of change although others are aware of a problem; not actively interested in change; seldom appear for treatment without coercion; could benefit from non-threatening information to raise awareness of possible "problem" & possibilities for change.

Contemplation: ambivalent, undecided, vacillating between whether he/she really has a "problem" or needs to change; wants to change, but this desire exists simultaneously with being satisfied with the status quo; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong discord and defensive behaviors; many Contemplators have indefinite plans to take action in the next six months or so.

Preparation: takes person from decisions made in Contemplation stage to the specific steps to be taken to solve the problem in the Action stage; increasing confidence in the decision to change; certain tasks that make up the first steps on the road to Action; most people planning to take action within the very next month; making final adjustments before they begin to change their behavior.

Action: specific actions intended to bring about change; overt modification of behavior and surroundings; most busy stage of change requiring the greatest commitment of time and energy; care not to equate action with actual change; support and encouragement still very important to prevent drop out in readiness to change.

Maintenance: sustain the changes accomplished by previous action and prevent relapse; requires different set of skills than were needed to initiate change; consolidation of gains attained; not a static stage and lasts as little as six months or up to a lifetime; learn alternative coping and problem-solving strategies; replace problem behaviors with new, healthy life-style; work through emotional triggers of relapse.

Relapse and Recycling: expectable, but not inevitable setbacks; avoid becoming stuck, discouraged, or demoralized; learn from relapse before committing to a new cycle of action; comprehensive, multidimensional assessment to explore all reasons for relapse.

Termination: this stage is the ultimate goal for all changers; person exits the cycle of change, without fear of relapse; debate over whether certain problems can be terminated or merely kept in remission through maintenance strategies.

D. **Skill-Building in Engaging and Developing Collaborative, Individualized Treatment**

1. What to Do with Poor Outcomes – ACCEPT

(April 2019 Tips and Topics https://tipsntopics.com/april-2019/)

Assess what is and is not working

Change treatment plan to improve outcomes

Check treatment contract if participant reluctant to modify the treatment plan

Expect effort in a positive direction – "do treatment" not "do time"

Policies that permit mistakes and honesty; not zero tolerance

Track outcomes in real time – functional change (attitudes, thoughts, behaviors) not compliance

2. If they don't stop using, treatment is fine but at some point enough is enough and you have to kick them out of drug court and lock them up?

If you just look at the behavior of a person with addiction, you may see a person who lies, cheats, breaks laws and appears to lack good moral values.

- An understandable (but counterproductive) reaction of society is to punish such antisocial behaviors and approach a person with addiction as "a bad person" to be punished.
- The productive attitude to achieve public safety and real lasting change is to "realize that good people can do very bad things, and the behaviors of addiction are understandable in the context of the alterations in brain function."

3. If you do individualized treatment, won't participants scam the system? If we don't treat them with all the same expectations, won't they all try to get around the rules as much as they can?

If you think "individualized treatment" means just allowing participants to pick and choose what parts of the program they will participate in; and not have any expectation of accountability to follow a treatment plan, then I can understand your concern. But "individualized treatment" is about collaborating on a treatment plan that matches the specific needs of the participant, makes sense to the participant, and therefore has the best chance to actually work and succeed.

Treatment isn't about rules, phases, behavior control and punishment. It is about holding a person accountable for changing their beliefs, attitudes and lifestyle such that they are:

- Better parents if getting their children back is what they want
- Better citizens if getting out of jail or off probation is what they want
- Less impulsive and out of control if not getting arrested is what they want
- Mentally stable, sober and in recovery if getting housing or a job or happiness is what they want
- Better workers or partners if keeping a job or relationship is what they want

4. These people have criminogenic thinking and antisocial behavior, how will they change if you are soft on them in treatment? Don't they need to know who's the boss?

Helping people change their thinking and behavior only has lasting, sustainable results if the person is an actual participant in the process. Good treatment isn't being "soft" on people; it is expecting good faith effort to work on thinking and behaviors that are prosocial at a pace that brings actual change, not passive compliance.

The judge, treatment court, probation and parole, and any mandating agency certainly has the power of the "boss"; and should use that power:

- Not to prescribe and define the treatment e.g., level of care, length of stay, numbers of AA meetings etc. That is outside their scope of practice.
- To enact graduated sanctions for lack of good faith effort in treatment as evidenced by passive compliance, active or passive non-adherence to individualized treatment plans. Partnership with treatment providers ensures that treatment is accountable and not "soft".

5. What is to Say to Engage People

"Thank-you for choosing to come to treatment."

"I didn't choose you. They made me come."

"What would happen if you hadn't come today?"

"I'd do more time, or won't get off probation."

"Would that be OK with you if that happened?"

"Hell no, that's why I'm here."

"Well then thank-you for choosing to work with me so I can help you do less time or get off probation."

6. What to Say to Orient Participants

"Thank-you for choosing to enter join Drug Court. The reason you have been given the opportunity to get treatment rather than be incarcerated is that you have addiction that is related to your charges. We believe that if you get addiction treatment and establish recovery, this will not only be good for your life, but society will benefit from increased public safety, decreased crime and spending resources on treatment rather than incarceration, which is much more expensive.

But you are accountable for doing treatment, not time; for working on changing your attitudes, thinking and behavior; not just complying with a program and graduating.

7. What to Say to Check on Progress

"Tell me about your treatment plan." (Pause to see what the participant says and monitor if they are working on anything in particular to improve functioning for public safety; or whether they are just "doing time" e.g., "I just have to be here and have another three months.")

"What you are working on to change your attitudes, thinking or behavior that has gotten you into trouble with crime, restricted your freedom and threatened public safety?"

8. What to Say to Track Treatment Engagement

"What would you like to do in this session or in group today to advance your treatment plan?" (Pause to see what the participant says and monitor if they are working on anything in particular to improve functioning for public safety; or whether they are just "doing time" e.g., "I just have to be here" Or "What do you want me to say?") What you would hope they would say is: "I don't have an anger problem, but I am trying to get off probation so I'm going to ask someone to role play with me an angry situation. Others would get into a fist-fight but not me. I have good anger management skills and am going to demonstrate to the group how to handle that in assertive but nonviolent way. You will note that down and let my PO know that I am doing well."

9. What to Say to about Positive Drug Screens

"In addiction treatment, it's not OK to use any unauthorized substance. But if this didn't happen and everyone had perfect control over using, they wouldn't have addiction and wouldn't need treatment. You can learn skills and use supports to never have to use again, so it is not inevitable that you will have a flare up and use.

But if it happens to you or anyone else in treatment with you, it is your responsibility for your safety and your fellow participants to immediately address any attitudes, thinking or behavior building up to any use substance use; or any actual use. Reach out to a team member just like you would if experiencing a heart attack. They will then work with you to find out what went wrong and how to improve your treatment plan to prevent another flare-up.

If substance use happens in a residential setting there will be a community meeting ASAP to help anyone who used with you. If you or anyone else is not interested in finding what went wrong and how to fix it, then anyone has the right to choose no further treatment and take the legal consequences of their criminal offense."

10. What *not* to say to about Positive Drug Screens

"In addiction treatment, it's not OK to use any unauthorized substance. You are mandated to be abstinent and if you use and it is found on a drug screen, you will be sanctioned and could be set back a phase in your treatment program. If it happens more than once, you could be incarcerated for a brief period and it may even be grounds for discharge from the drug court program.

In order to advance through the phases of the Drug Court program and eventually graduate, you must demonstrate full abstinence. If you do not, there are escalating sanctions, but there are also incentives for those who do stay abstinent."

"Now be honest, did you use or not?!!"

11. What to Say in Individual, Group, or an Emergency Community Meeting

"Please share what happened that led up to and triggered the substance use so we can figure out what went wrong and help you get back on track. If others used with you, please identify them so we can do the same process with them ASAP.

If you are willing to change your treatment plan and work on fixing the mistakes with commitment and effort in good faith, then treatment continues. If you are not interested in doing that, you have a right to choose no further treatment and be discharged from the program."

12. What to Say to a Person who says they don't want to go to Alcoholics Anonymous

It is not unusual for clients to object to having to attend AA/other such groups. Here is how to address such clients:

"There are AA meetings and groups that appeal to different members in different ways. If you haven't tried a number of different groups, it may be that just haven't yet found the meeting that works for you.

Now if you are saying you just don't want to go to AA for whatever reason, I don't want to push that on you. Maybe you have another self/mutual help group that works better for you. But before you give up on AA, let's discuss where else can you find a support group where:

1. You can have access to regular meetings every day and even more than once a day if you really need them – and all for free?
2. You can have a coach like an AA sponsor, who is ready to have you call them at all hours of the day and week if you really need them?
3. You can be with a whole group of people and have sober fun while there are temptations and triggers all around you on New Year's Eve, Mardi Gras, or St. Patrick's Day?
4. You can have many friends who have been exactly where you have been with addiction; understand what you are going through from deep personal experience; and will be there for you if you reach out?

Maybe you have a group like that at your church, synagogue, community of faith, or some other group. If you get support from that group with all the same effective features of what AA has to offer, then by all means embrace that group. This is about getting you the ongoing support and guidance you need to establish and maintain recovery and well being, not pushing AA on you."

E. **Systems Issues**

1. Moving from Punishment to Accountability for Lasting Change – Implications for Sanctions and Incentives

(Tips and Topics, Volume 12, No. 6, September 2014. Tipsntopics.com)

1. Sanction for lack of good faith effort and adherence in treatment based on the clinical assessment of the person's needs, strengths, skills and resources. Don't sanction for signs and symptoms of their addiction and/or mental illness in a formulaic manner that is one-size-fits-all.

2. The treatment provider is responsible for careful assessment and person-centered services and to keep the court apprised of any risk to public safety. The court should be informed about the client's level of good faith effort in treatment; and whether the client is improving in function at a pace consistent with their assessed needs, strengths, skills and resources. The provider should not just report on passive compliance with attendance and production of positive or negative drug screens - passive compliance is not functional change.

3. If the client is not changing their treatment plan in a positive direction when outcomes are poor e.g., positive drug screens, attendance problems, passive participation, no change in peer group activities and support groups like AA etc., then the client is "doing time" not "doing treatment and change." Providers need to then inform the judge that the client is out of compliance with the court order to do treatment. The client consented to do treatment not just do time and should be held accountable for their individualized treatment plan. If the client is substantively modifying their treatment plan in a positive direction in response to poor outcomes; and adhering to the new direction in the treatment plan, then the client should continue in treatment and not be sanctioned for signs and symptoms of their illness(es).

4. Incentives for clients can be explored and matched to what is most meaningful to them. For example, incentives that allow a client to choose a gift certificate or coupon for a restaurant may be meaningful for some clients. But others may find assistance in seeing their children; or receiving help with housing; or advocacy to change group attendance times to fit better their work schedule to be more meaningful incentives to be used. This requires an individualized approach recommended to the court by providers who should know their client's needs, skills, strengths and resources. It is too much to expect the judge can work all this out in a busy schedule of court appearances.

5. A close working relationship between the client, judge, court team, all stakeholders and treatment providers is needed to actualize this approach.

Some judges are rightly concerned that treatment providers are not watching for public safety concerns closely enough so take treatment into their own hands. This can result in sanctions or mandates that are not assessment based e.g., mandating 90 days of residential level of care; or 90 AA meetings in 90 days; or ordering sanctions that may be ineffective in producing improved treatment engagement and real client functional change.

2. What Court Personnel Should Expect from Treatment Providers

Treatment court participants are varied and can present with addiction, mental health and physical health complexity. These diverse clinical presentations highlight the need for individualized approaches that court personnel should see that treatment is pursuing with the client:

1. Assessment of each client's multidimensional needs as per The ASAM Criteria six dimensions. For example, assessing if a person is developmentally disabled and suffers from an intellectual developmental disorder (previously called Mental Retardation) is important compared with a person who has antisocial personality disorder or lifestyle and is very institutionalized and used to incarceration. The intellectually developmental disordered person has deficits in reasoning, problem solving, abstract thinking, judgment, learning from instruction and experience etc. The institutionalized antisocial person experiences sanctions like water on a duck's back.

Or if a participant has co-occurring Posttraumatic Stress Disorder (PTSD); or chronic pain, those needs have to be addressed to achieve good outcomes.

2. Assessment and methods to enhance treatment engagement and good faith effort of the client in treatment. Participants with co-occurring mental and addiction issues will have more difficulty with engagement and have needs that require awareness of their multiple vulnerabilities. Treatment plans need to be assessment-based and person-centered not program and compliance based. Because of different client learning styles and their array of needs, any manualized and evidence-based curriculum may require adaptation to fit each client's problems and progress/outcomes.

This calls for a level of clinical sophistication to use Evidence-Based Practices (EBPs) in a person-centered and outcomes driven manner rather than a compliance and one-size-fits-all manner. For example, Interactive Journaling is an evidence-based method to facilitate self-change using Motivational Interviewing, stages of change work and CBT.

3. Outcomes-driven treatment. Is the client making progress in real accountable change? Are they demonstrating improved functioning that will increase public safety, decrease legal recidivism and crime and increase safety for children and families? Active credible treatment is not just about compliance with attendance and negative drug screens. Is the client invested in a change process at a pace that fits their assessed abilities and vulnerabilities? Or is the client merely passively complying, which does not translate into lasting change and increased safety? How do we impact the revolving door of repeated episodes of treatment and incarceration, which wastes resources and does not produce the outcomes we all want?

REFERENCES AND RESOURCES

ADULT DRUG COURT BEST PRACTICE STANDARDS VOLUME II 2018, Text Revision, National Association of Drug Court Professionals, Alexandria, VA.

"A Technical Assistance Guide For Drug Court Judges on Drug Court Treatment Services" - Bureau of Justice Assistance Drug Court Technical Assistance Project. American University, School of Public Affairs, Justice Programs Office. Lead Authors: Jeffrey N. Kushner, MHRA, State Drug Court Coordinator, Montana Supreme Court; Roger H. Peters, Ph.D., University of South Florida; Caroline S. Cooper BJA Drug Court Technical Assistance Project. School of Public Affairs, American University. May 1, 2014.

Bureau of Justice Assistance (BJA) training video on The ASAM Criteria that can be viewed by creating an account and going to the Adult Drug Court Lessons. The system can be found at www.treatmentcourts.org and this video was initiated by Dennis Reilly at the Center for Court innovation.

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