Cutting Cookie Cutter Care: Why Individualized Treatment and Harm Reduction Makes Sense

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A. What is Addiction?

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

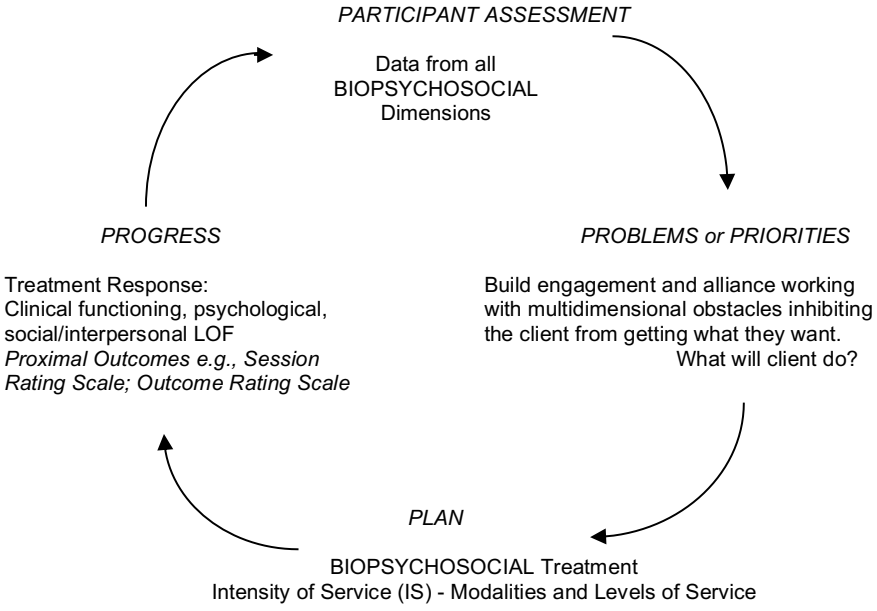
(a) American Society of Addiction Medicine (ASAM) definition of addiction
There is a "short version" definition of addiction (shown below), as well as a "long version" definition (available at http://www.asam.org/for-the-public/definition-of-addiction).

- Short Definition begins: **"**Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry." (August 15, 2011)
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- Pathologically pursuing reward and/or relief by substance use and other behaviors.

(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

2. Harm Reduction

Principles of Harm Reduction (Harm Reduction Coalition, HRC)

"Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs."

Harm reduction incorporates a spectrum of strategies from:

- safer use
- managed use to abstinence to meet drug users "where they're at"
- addressing conditions of use along with the use itself.

Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

However, HRC considers the following principles central to harm reduction practice.

- Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being–not necessarily cessation of all drug use–as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

http://harmreduction.org/about-us/principles-of-harm-reduction/

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. **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."

E **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

F. **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".

REFERENCES AND RESOURCES

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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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