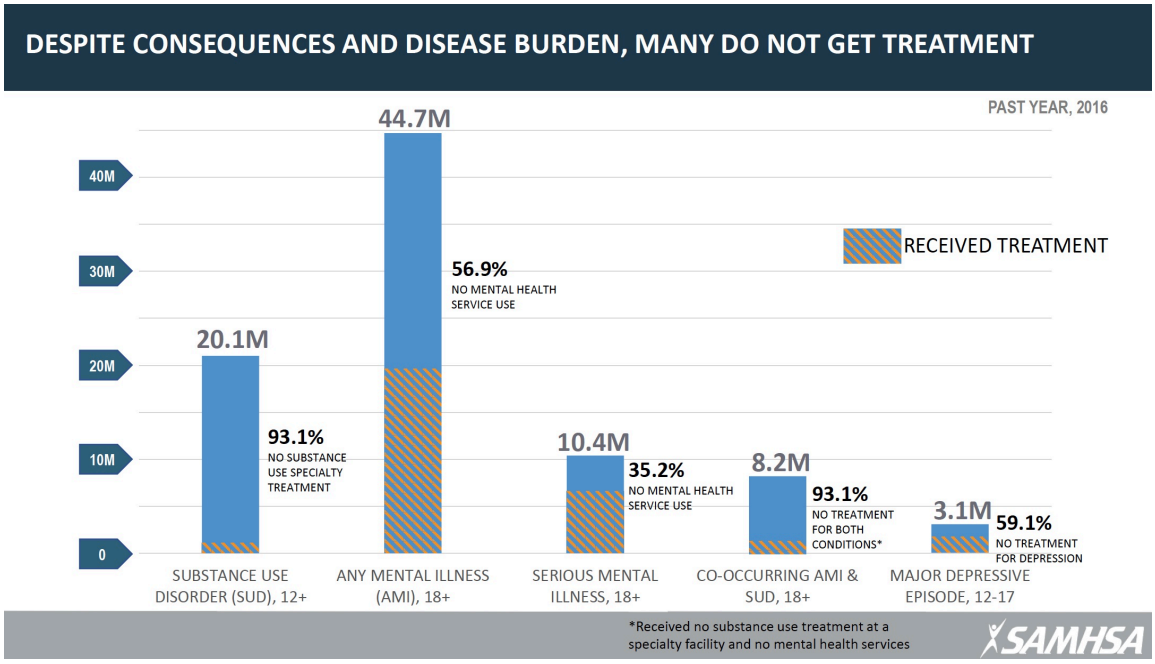
Addiction: It Isn't Just a Brain Disease or Behavioral Disorder: Implications for Assessment, Treatment, Relapse and Discharge

David Mee-Lee, M.D. Davis, CA
(530) 753-4300; Mobile (916) 715-5856
davidmeelee@gmail.com davidmeelee.com
tipsntopics.com instituteforwellness.com

Plenary October 29, 2019 8:30 AM – 10 AM; Part 2 Discussion 10:15 -11:30 AM
CACC 2019 Conference Sacramento, CA

A. Current Trends that Focus on Addiction as a Brain Disease or Behavioral Disorder or Biopsychosocial Disorder

- New and emerging information about neurobiology, medication assisted treatment and recovery. Addiction affects neurotransmission and interactions within reward structures of the brain, including the nucleus accumbens, anterior cingulate cortex, basal forebrain and amygdala.
- Google - "Addiction as a Brain Disease": About 95,300,000 results (0.41 seconds) 3/25/19
- Google - "Addiction as a Behavior Disorder": About 67,600,000 results (0.40 seconds) 3/25/19
- Google - "Addiction as a Biopsychosocial Disorder": About 1,130,000 results (0.36 seconds) (3/25/19); and George Engel first introduced "biopsychosocial" in 1977 – 40 years ago.



B. Attitudes about Substance Use and Addiction

1. Experiences Shaping Attitudes
   - antisocial, self –destructive
   - non-compliant
   - out of control

2. Factors Contributing to Negative Attitudes
   - past experience with difficult clients
   - negative societal attitudes
   - inadequate education and skills training
   - over exposure to chronic, relapsing clients
   - lack of exposure to successfully recovering clients
   - lack of accessible treatment resources

3. Negative Attitudes Towards Substance Misuse
   - anger
   - avoidance
   - discouragement
   - fatalism
   - frustration
   - futility
   - hopelessness
   - judgmentalism

4. Consequences of Negative Attitudes
   - at-risk persons not recognized and screened
   - affected persons not diagnosed and treated
   - denial of existence of substance use problems
   - enabling behavior (prescriptions, social supports etc.)
   - punitive management
   - patronizing, nagging behavior

C. Key Concepts About Addiction Not Taught in Professional School

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

(a) American Society of Addiction Medicine (ASAM) 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.
- Addiction is about brains – not just about behaviors.
- A major thrust of the ASAM definition is that it is not the substances a person uses that makes them an addict, nor is it even the quantity or frequency of use. It is about what happens in a person's brain when they are exposed to rewarding substances or rewarding behaviors.
- "Many people do not realize that addiction is a brain disease. While the path to drug addiction begins with the act of taking drugs, over time a person's ability to choose not to do so becomes compromised and seeking and consuming the drug becomes compulsive. This behavior results largely form the effects of prolonged drug exposure on brain functioning. Addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior." (Nora D. Volkow, M.D., Director NIDA – Preface Principles of Drug Addiction Treatment, Second Edition, 2009")
- New breakthroughs in anti-addiction medication, vaccines and biological interventions
- Attempts to improve the public's acceptance of addiction as a primary, chronic disease.
- A change in attitudes away from addiction as willful misconduct.

(b) Biopsychosocial in etiology, expression and treatment

- consider in the differential diagnosis
- ask questions to make the diagnosis

(c) Drug, Set, and Setting - The Basis for Controlled Intoxicant Use - Norman E. Zinberg, M.D. (http://www.psychedelic-library.org/zinberg.htm)

"Set" is the mental state a person brings to the experience, like thoughts, mood and expectations.

"Setting" is the physical and social environment. Social support networks have shown to be particularly important in the outcome of the psychedelic experience. They are able to control or guide the course of the experience, both consciously and subconsciously. Stress, fear, or a disagreeable environment, may result in an unpleasant experience (bad trip). Conversely, a relaxed, curious person in a warm, comfortable and safe place is more likely to have a pleasant experience.
(https://en.wikipedia.org/wiki/Set_and_setting)

2. "Denial/resistance" – Sustain Talk (Motivational Interviewing) is a major sign and symptom characteristic of addiction

- conscious lying
- organic amnesia
- unconscious survival mechanism
- implications for history-taking and treatment planning

(a) From Pathology to Participant

- Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician
- "Resistance" may be as much a problem with knowledge, skills and attitudes of clinicians as it is a "patient" problem

As a first step to moving from pathology to participant, consider our attitudes and values about resistance. It is often perceived as pathology that resides within the client, rather than an interactive process or even a phenomenon induced and produced by the clinician.

(b) Models of 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; no active interest in changing; seldom appear for treatment without coercion; could benefit from non-threatening information and information to raise awareness of a possible "problem" and 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 resistance to it; may seek professional advice to get an objective assessment; motivational strategies useful at this stage, but aggressive or premature confrontation provokes strong sustain talk and discord; 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 and regression 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.

3. The family disease concept of addiction emphasizes that all members of the identified client's social system are affected and in need of active intervention and treatment.
   - children of alcoholics/addicts
   - spouse or significant other
   - maintain and prolong addiction
   - affected by addiction
   - personal recovery

4. Treatment/Recovery is a process, not an event.
   - motivational strategies
   - relapse policies
   - levels of care

5. While there are many common diagnostic and treatment factors in substance-related and addictive disorders, there is also significant individual variability.

D. **Advantages and Disadvantages of Addiction as a Brain Disease**

- Clinical and policy implications

1. **Advantages**

Common and counterproductive attitudes and beliefs about addiction and about those afflicted and affected by addiction that can be addressed by seeing addiction as a brain disease:

(i) 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.

- The *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 have 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." (ASAM Definition Frequently Asked Questions, Question #3).

(ii) So if you say a person has the disease of addiction, are they not still responsible for their behaviors? Or in other words are you letting them off the hook by saying they have a disease?

- The *counterproductive* reaction to understanding addiction as a primary disease is for a person with addiction to say, "Don't blame me, it was my disease that made me go into the bar and relapse." They may not be as blatant as that, but even addiction treatment professionals are ambivalent about how to balance responsibility for relapses with addiction as a relapsing disease
- The *productive* attitude to have is to recognize "personal responsibility is important in all aspects of life, including how a person maintains their own health…..You are not responsible for your disease, but you are responsible for your recovery." Just as people with diabetes and heart disease need to take personal responsibility for how they manage their illness, those with addiction need to do the same. (ASAM Definition Frequently Asked Questions, Question #4).

(iii) If healthcare professionals, facilities and insurance benefits packages only focus on the substance use and related complications, the underlying addiction illness is not treated. As a result, people with addiction keep presenting with complications and can switch in search of other rewarding substances and/or addictive behaviors.

- The *counterproductive* result of focusing just on the substance use and associated complications is that physicians and other healthcare professionals think their work is done when they manage withdrawal symptoms and detox a person. Or stabilize a person's substance-induced psychosis. Or fix the broken leg from injuries in a drunk driving accident. Insurance benefits may cover only detoxification in a medical facility, as if addiction is an acute illness needing just stabilization of the substance use rather than ongoing treatment like other chronic diseases.
- The *productive* attitude to have is to see the need for comprehensive addiction treatment of the "underlying disease process in the brain that has biological, psychological, social and spiritual manifestations." (ASAM Definition Frequently Asked Questions, Question #8).

2. **Disadvantages**

- Overemphasis on anti-addiction medications as the major intervention when medication is just one tool in the clinical toolkit
- Overemphasis on the brain as the *cause* of addiction when there are public health, social, cultural, psychological and psychiatric origins, not just as *results* of addiction as a brain disease.

E. **Advantages and Disadvantages of Addiction as a Behavioral Disorder**

1. **Advantages**

(i) Behavioral therapy seeks to identify and help change potentially self-destructive or unhealthy behaviors. It functions on the idea that all behaviors are learned and that unhealthy behaviors can be changed.

(ii) Applies principles of learning to substitute desirable responses and behavior patterns for undesirable ones.

(iii) Developed by B.F Skinner, operant conditioning is a way of learning by means of rewards and punishments. This type of conditioning holds that a certain behavior and a consequence, either a reward or punishment, have a connection which brings about learning.

2. **Disadvantages**

(i) Assumes addiction is only a behavioral disorder explained by one theory – learning theory – when it is more complex and multidimensional than that.

(ii) Learning by means of rewards and punishments is compatible and familiar for justice services that has also tried to rehabilitate offenders by rewards and punishments. But success in increasing public safety and decreasing legal recidivism and crime has employed many other initiatives and models rather than a unidimensional application of learning theory. So too, must treatment courts.

(iii) Because of the complex nature of addiction in etiology, clinical and social manifestations, treatment and policies that focus on sanctions and incentives; punishments and rewards will not have the outcomes needed for many treatment court participants who have multiple problems not just a single theory behavior problem.

F. **Biopsychosocial in Etiology, Clinical Presentation and Treatment**

- Addiction is not just a brain disease or behavior disorder. It is biopsychosocial in the etiology of addiction; the way addiction manifests itself and affects people and families; and in promoting treatment that is holistic and person-centered that touches the physical, mental, social and spiritual aspects clients.
- There are genetic and biochemical origins to addiction. But there are psychiatric and psychological underpinnings to addiction as well as public health principles that contribute to addiction e.g., the more available a drug and the lower the price, the more widespread are the health and social costs of addiction to those drugs.
- Who crosses the line into addictive illness depends on their own recipe of biopsychosocial factors. Some people can have little genetic predisposition and family history of addiction but succumb to overwhelming psychosocial factors. Others can have a strong genetic predisposition, multiple family problems and role models for using substances as a way of living; live in a drug "ghetto" with drugs on every corner; and at 20 years old now has a 5-year history of heavy drug problems.
- A holistic, multidimensional perspective in understanding and treating addiction. The American Society of Addiction Medicine's (ASAM) Criteria describes six assessment dimensions that are holistic, biopsychosocial and multidimensional.

1. Balance the "bio" with the "psychosocial-spiritual"

Most of us lean towards one side of the biopsychosocial continuum. This may be by the influence of formal training; personal heath and recovery history; family history and attitudes; and clinical experience or lack of it. If you agree that addiction is a multidimensional disorder and that individualized treatment is needed, then consider the following points and practices:

(i) If you have a visceral negative reaction to give people in addiction recovery medication, it's time to learn more about the "brain disease" aspect of addiction

(ii) If you have you have a visceral negative reaction to 12-Step programs like AA or NA, it's time to attend an open meeting and see for yourself.

(iii) If you think of medication as just "Medication Assisted Treatment or Recovery" (MAT or MAR), as if real treatment is psychosocial treatment and ideally drug-free treatment, then it's time to consider medication one of a menu of treatment options. Medication is in the menu of services along with individual, group, family sessions; cognitive behavioral therapy; motivational enhancement therapy; 12-Step facilitation therapy; multisystemic therapy etc. We don't say "medication-assisted diabetes or hypertension treatment" as if the real treatment is diet, exercise and lifestyle change with medication just assisting the "real treatment". We don't think of antipsychotic medication for schizophrenia treatment as just an adjunct to the "real" psychosocial treatment. Medication is just medication to be used with some clients and not with others. Think of "MAT" as "Medication in Addiction Treatment", not a philosophy.

(iv) If you are holding out for the someday biomedical treatment that will find the right medication injection, medicine patch or long acting vaccine or medical breakthrough, then it's time to learn more about the power and necessity of social support networks and self/mutual help programs.

G. **Diagnostic Strategies**

DSM-5 – Substance-Related and Addictive Disorders (Gambling Disorder)
Substance use disorder is defined by the following criteria in DSM-5.

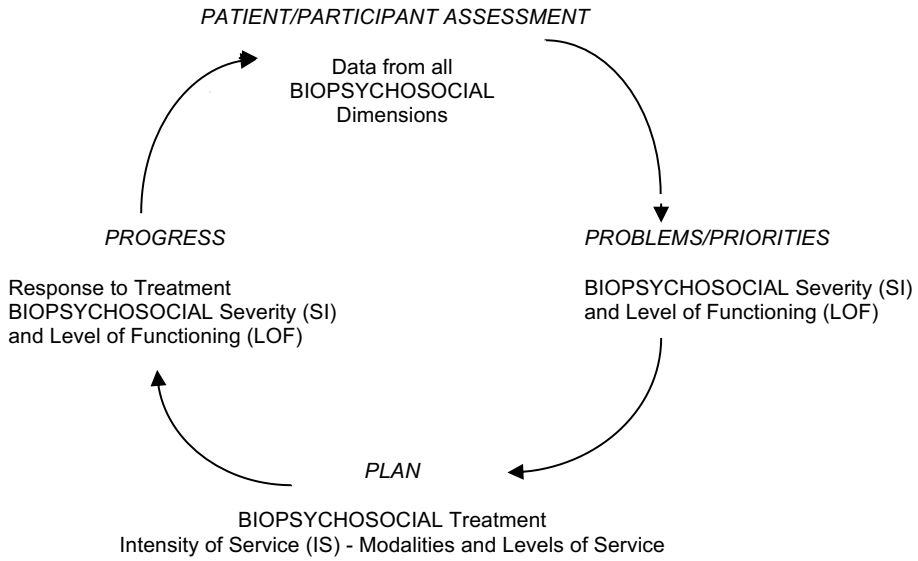
A. A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following occurring in a 12-month period:

1. Substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to obtain substance, use, or recover from the substance's effects.
4. Craving or a strong desire or urge to use the substance.
5. Recurrent substance use resulting in failure to fulfill major role obligations at work, school, home.
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational, or recreational activities are given up or reduced because of substance use.
8. Recurrent substance use in situations in which it is physically hazardous.
9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of substance to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for substance.
    b. Substance is taken to relieve or avoid withdrawal symptoms.

Severity Scale DSM-5 - The Severity of each Substance Use Disorder is based on:
- 0 criteria or 1 criterion: No diagnosis
- 2-3 criteria: Mild Substance Use Disorder
- 4-5 criteria: Moderate Substance Use Disorder
- 6 or more criteria: Severe Substance Use Disorder

H. **The ASAM Criteria**

1. Individualized, Clinically and Outcomes-driven Treatment



2. Assessment of Biopsychosocial Severity and Function *(The ASAM Criteria* 2013, pp 43-53)

The common language of six ASAM Criteria dimensions determine needs/strengths in behavioral health:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

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

3. 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; anti-craving anti-addiction meds MAT; 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 others

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

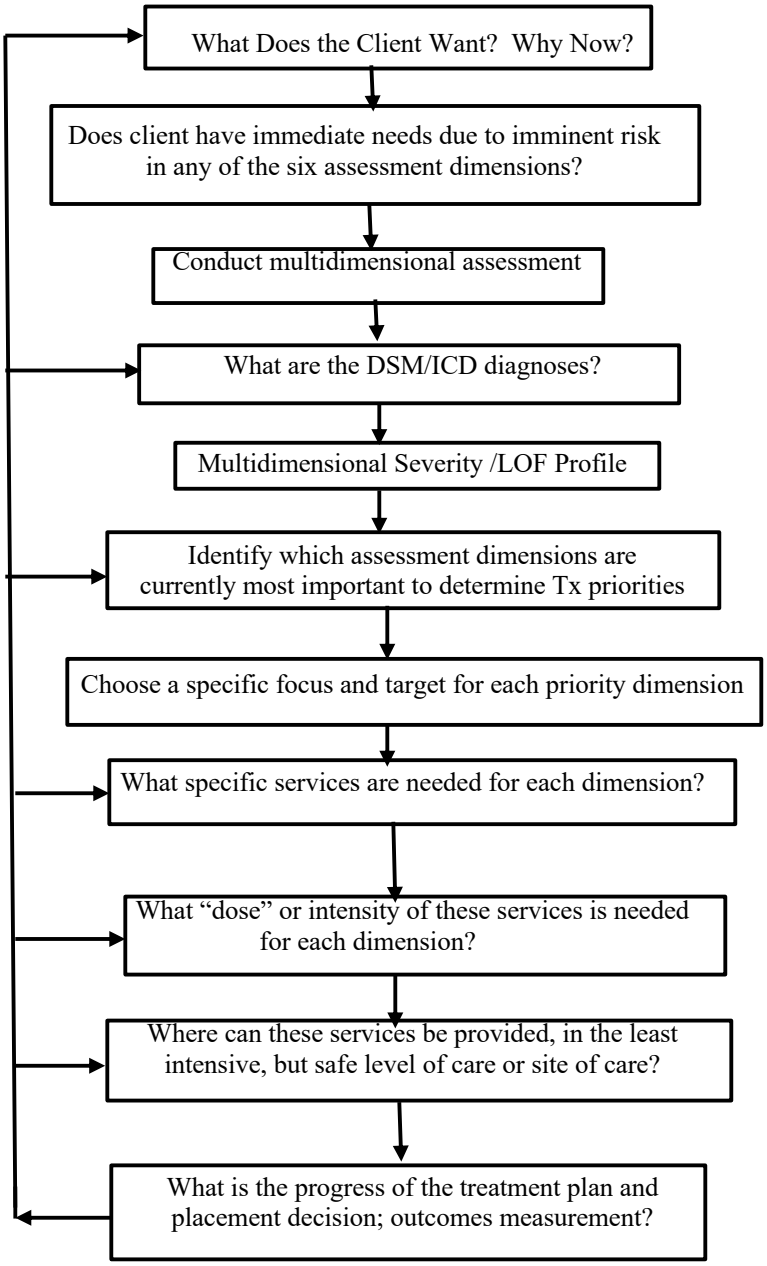
0.5 Early Intervention
1 Outpatient Services
2 Intensive Outpatient/Partial Hospitalization Services
3 Residential/Inpatient Services
4 Medically-Managed Intensive Inpatient Services

ASAM Criteria Levels of Care	Level	Same Levels of Care for Adolescents except Level 3.3
Early Intervention	0.5	Assessment and education for at risk individuals who do not meet diagnostic criteria for Substance-Related Disorder
Outpatient Services	1	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/ strategies
Intensive Outpatient	2.1	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
Partial Hospitalization	2.5	20 or more hours of service/week for multidimensional instability not requiring 24 hour care
Clinically-Managed Low-Intensity Residential	3.1	24 hour structure with available trained personnel; at least 5 hours of clinical service/week
Clinically Managed Population-Specific High-Intensity Residential Services (Adult criteria only)	3.3	24 hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
Clinically-Managed High-Intensity Residential	3.5	24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
Medically-Monitored Intensive Inpatient	3.7	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
Medically-Managed Intensive Inpatient	4	24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment
Opioid Treatment Services	OTS	Opioid Treatment Program (OTP) – agonist meds: methadone, buprenorphine; Office Based Opioid Treatment (OBOT); antagonist medication – naltrexone

I. **How to Organize Assessment Data to Match Level of Care**

1. Developing the Treatment Contract *(The ASAM Criteria* 2013*,* page 58)

	Client	Clinical Assessment	Treatment Plan
What?	What does client want?	What does client need?	What is the Tx contract?
Why?	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
How?	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
Where?	Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
When?	When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?



(The ASAM Criteria 2013, p 124)

J. **Consider the respective roles and responsibilities of each member of the treatment court team*, the mandates of the systems and the policies, programs and practices within those agencies.**
https://tipsntopics.com/may-2019/

[* The "treatment court team" includes but not limited to a judge or judicial officer, program coordinator, prosecutor, defense counsel representative, treatment representative, community supervision officer, and law enforcement officer. (Adult Drug Court Best Practice Standard VIII (2018)]

- The power of drug and treatment courts is the balance between the mission of the justice system with the mission of treatment. A collaborative, interdisciplinary court and treatment team can achieve the goals we all want: accountable, lasting change in participants to achieve public safety and foster recovery and well-being.

- The justice system's appropriate mission to enforce the law, ensure public safety and apply penalties such as fines or serving time under incarceration and ensure fair and impartial administration of justice, may at times appear to conflict with a treatment provider's mission of helping people change through collaboration on treatment goals and motivational enhancement. https://www.justice.gov/about

- However high rates of incarceration for drug use, high costs of incarceration, high rates of relapse and recidivism, and the effectiveness of mandated treatment have guided many criminal justice administrators and policymakers to embrace the habilitative/rehabilitative role of addiction treatment among criminal justice populations.
(The ASAM Criteria (2013) Pages 350-351)

- Setting supervision conditions that prohibit some addiction-related behaviors is something that should happen routinely in drug court. As long as the consequence of failure is not too harsh, such prohibitions makes it clear to the participant that it is time to get serious about getting help. These supervision conditions engage the participant to make positive changes and start right away doing real work with treatment to meet supervision conditions.

- It is the treatment community's role, and challenge, to assist the justice system in applying the guidelines in a manner that offers the best match to the treatment options for this population within the guidelines they operate under. For example, to focus on mandating comprehensive assessment and ongoing treatment adherence, so that participants can learn from mistakes and develop new attitudes, thoughts and behaviors to increase public safety.

- The justice system's role, and opportunity, is to assist the treatment community in understanding the guidelines they operate under and the behaviors they must eventually see in a participant. The justice system provides information that will help clinicians assess and address the nature and extent of substance use and those criminogenic risk and need factors. It is those factors that contributed to the participant's behaviors that initially brought them to the attention of the justice system in the first place.

- Supervision conditions and expectations such as abstinence, honesty, and non-association with justice-involved peers is not inconsistent with treatment goals if communicated respectfully and with a focus on the participant working in treatment to begin showing progress. Such conditions and expectations are only counter-therapeutic if failure to meet expectations is met with immediate, harsh responses like revoking the participant's probation and sending them to prison; or sanctioning them to jail right away, even if for a few days until they can see the judge. (Most drug courts are not required to respond to violations in that way.) If their guidelines don't require these kinds of zero tolerance, automatic responses, then merely setting the expectation regarding what kind of behavior must begin to be exhibited can actually support treatment progress.

- This support of treatment progress is particularly true if the court overtly and reliably reinforces and incentivizes a participant's progress e.g., public praise in court for successful progress. The expectation for honesty or abstinence is not the problem. The supervision condition is not the problem. The problem is if the court or probation is required to respond to failing to meet the expectations right away too harshly and without being able to consider treatment perspectives, effort, and progress. Most drug courts have this kind of flexibility in how they respond.

- It is critical to involve all parties (e.g., judges, probation and parole officers, law enforcement and other court officials) as well as the justice-involved individual in the decision making process. It is also important to create learning opportunities for criminal justice personnel to understand more about substance-related and addictive disorders and also co-occurring mental health conditions. (The ASAM Criteria (2013) Pages 350-351)

- The treatment court recognizes and acknowledges the nature and extent of substance use disorder as a chronic, relapsing brain disease characterized by compulsive drug seeking and use despite harmful consequences. Such a complex disorder, that is often found co-occurring with other conditions, requires the work of multiple disciplines and collaboration between multiple systems to provide individuals suffering from this complex condition the opportunity to achieve long-term recovery and wellbeing.

K. **What to do with poor outcomes as applied to lying and dishonesty**

https://tipsntopics.com/may-2019/

First, an overview of ACCEPT © David Mee-Lee 2019.

A ssess what is and is not working in the treatment plan

C hange the treatment plan to address those identified problems or priorities

C heck the treatment contract if the participant is reluctant to modify treatment plan

E xpect effort in a positive direction – "do treatment" not "do time"

P olicies that permit mistakes and honesty; not zero tolerance

T rack outcomes in real time – functional change (attitudes, thoughts, behaviors) not compliance with a program.

ACCEPT as applied to lying and dishonesty:

Treatment Provider	Treatment Court Team
ASSESS • Why did you lie? What was going on that you chose to lie rather than be honest? • Do you and I understand how lying is an indication that something has gone wrong in the therapeutic alliance? • When has lying and lack of integrity manifested itself in your life before and how has it gotten you into more trouble?	**ASSESS** • Collaborate with the treatment provider (in the Pre-court meeting) to assess if the participant is working in good faith treatment or not. • Does the treatment provider recommend a sanction for a participant who is not taking treatment seriously and is just "doing time"? • Does the treatment provider

• Do you even see dishonesty as an issue you need to work on? If so, why; and if not, why? • What can we do to make it easier for you to be honest and open? • What are you fears or obstacles if you were to be honest? **CHANGE** • What are you going to do in your treatment plan to address dishonesty? • How could you use individual or group sessions to work on a tendency to lie and con? • Change goals or strategies in the treatment plan in a positive direction e.g, practice being totally honest for one day in treatment and see what feels good or bad about that and report back to group; e.g., when someone asks "How are you?" practice pausing and answer honestly rather than a quick automatic "Fine". • Changing the treatment plan about lying is a learning opportunity to be embraced and expected of the participant.	recommend that the judge admonish the participant (sanction) that lying is not acceptable, but then praise them (incentive) for the new treatment plan s/he has embraced to work on lying. **CHANGE** • The judge gives a clear message to the participant that lying is not acceptable in a court of law nor in treatment if it is to be effective. • However the judge also engages in a dialogue with the participant to determine if they are clear on the expectation and can articulate what s/he is working on in an updated treatment plan to address lying. • If the participant is not changing the treatment plan in a positive direction and working on lying as a treatment priority, then escalated sanctions will be forthcoming. • Treatment providers, probation/parole and other court team members should work together and share any information on the participant's functioning in the community e.g., continued active association with justice-involved people or people who are known substance-users. Such behaviors inform needed changes in the treatment plan. • All treatment court team members reaffirm the message delivered by the judge (lying is not acceptable in a court of law nor in treatment if it is to be effective) as appropriate and during their on-going, day-to-day interaction with the participant.

CHECK • If you are doing more work than the client e.g., putting more energy in urging the client to be honest than they are; chasing the client to be sure they follow through with treatment plans while they watch you passively, as they just go through the motions. • The participant should be as active in figuring out changes in the treatment plan as you are. • If they are not, then check whether they are really committed to do treatment or not.	**CHECK** • The treatment court team checks that the participant is actively working in treatment not passively complying with court mandates. • The participant should be active in figuring out changes in the treatment plan to address lying; and be able to explain to the judge and probation or parole officer what they are doing to prevent or decrease lying and dishonesty.
EXPECT • Continued treatment after lying or conning is dependent on whether the participant is changing their treatment plan in a positive direction and putting in a good faith effort. • If, after using Motivational Interviewing and Motivational enhancement treatment, the participant continues passive involvement in treatment, that is "doing time" not "doing treatment and change". An escalated sanction is then recommended to the Court team.	**EXPECT** • A judge could ask a participant: **"To what extent have you assessed with your treatment provider what went wrong that you ended up lying?"** • "What are you working on in your treatment plan to address lying?" • If the participant is unable to answer such questions, check whether the treatment provider has done an adequate assessment and changed the treatment plan to address lying. Is it a treatment provider's lack of skill? Or is the client not working in good faith?
POLICIES • Examine policies that inadvertently encourage dishonesty that disincentivizes participants to be open and honest with mistakes, substance urges and actual use; and pushes illicit use by themselves and others underground. • Fellow participants are then more focused on "snitching" and	**POLICIES** • Examine policies that inadvertently encourage dishonesty that disincentivizes participants to be open and honest with mistakes, substance urges and actual use; and pushes illicit use by themselves and others underground. • Examine how the judge and probation/parole address lying.

antisocial, criminogenic behavior to scam the system than on learning how to be honest and confronting others when they see lying. **TRACK** • Track whether participants are actually working on attitudes, thoughts and behavior that have contributed to lying and dishonesty. • Track whether outcomes are improving - Is there is less lying or successful full honesty? • If participants aren't able to explain what attitudes, thoughts and behaviors they are working on to avoid further lying, then they are not doing treatment in good faith.	Do they reinforce the need for the participant to take responsibility and work on this in treatment? Or just impose an immediate sanction? **TRACK** • Track whether participants are making progress on lying; and improving in their active participation in good faith effort or are not. • Collaborate in the interdisciplinary team of judge, attorneys, probation/parole, treatment providers and law enforcement to gather all data on level of function in the community. • Is the participant improving in attitudes, thoughts and behaviors that threaten public safety and lying not at all or less frequently?

L. **Relapse/Continued Use/Continued Problem Potential** - **Dimension 5** *(The ASAM Criteria* 2013*,* pp 401-410)

A. Historical Pattern of Use

1. Chronicity of Problem Use

- Since when and how long has the individual had problem use or dependence and at what level of severity?

2. Treatment or Change Response

- Has he/she managed brief or extended abstinence or reduction in the past?

B. Pharmacologic Responsivity

3. Positive Reinforcement (pleasure, euphoria)
4. Negative Reinforcement (withdrawal discomfort, fear)

C. External Stimuli Responsivity

5. Reactivity to Acute Cues (trigger objects and situations)
6. Reactivity to Chronic Stress (positive and negative stressors)

D. Cognitive and behavioral measures of strengths and weaknesses

7. Locus of Control and Self-efficacy

- Is there an internal sense of self-determination and confidence that the individual can direct his/her own behavioral change?

8. Coping Skills (including stimulus control, other cognitive strategies)
9. Impulsivity (risk-taking, thrill-seeking)
10. Passive and passive/aggressive behavior

- Does individual demonstrate active efforts to anticipate and cope with internal and external stressors, or is there a tendency to leave or assign responsibility to others?

Example Policy and Procedure to Deal with Dimension 5 Recovery/Psychosocial Crises

Recovery and Psychosocial Crises cover a variety of situations that can arise while a patient is in treatment. Examples include, but are not limited to, the following:

1. Slip/ using alcohol or other drugs while in treatment.
2. Suicidal, and the individual is feeling impulsive or wanting to use alcohol or other drugs.
3. Loss or death, disrupting the person's recovery and precipitating cravings to use/impulsive behavior.
4. Disagreements, anger, frustration with fellow patients or therapist.

The following procedures provide steps to assist in implementing the principle of re-assessment and modification of the treatment plan:

1. Set up a face-to-face appointment as soon as possible. If not possible in a timely fashion, follow the next steps via telephone.

2. Convey an attitude of acceptance; listen and seek to understand the patient's point of view rather than lecture, enforce "program rules," or dismiss the patient's perspective.

3. Assess the patient's safety for intoxication/withdrawal and imminent risk of impulsive behavior and harm to self, others, or property. Use the six ASAM assessment dimensions to screen for severe problems and identify new issues in all biopsychosocial areas.

    1. Acute intoxication and/or withdrawal potential
    2. Biomedical conditions and complications
    3. Emotional/behavioral/cognitive conditions and complications
    4. Readiness to Change
    5. Relapse/Continued Use/Continued Problem potential
    6. Recovery environment

4. If no immediate needs, discuss the circumstances surrounding the crisis, developing a sequence of events and precipitants leading up to the crisis. If the crisis is a slip, use the 6 dimensions as a guide to assess causes. If the crisis appears to be willful, defiant, non-adherence with the treatment plan, explore the patient's understanding of the treatment plan, level of agreement on the strategies in the treatment plan, and reasons s/he did not follow through.

5. Modify the treatment plan with patient input to address any new or updated problems that arose from your multidimensional assessment in steps 3 and 4 above.

6. Reassess the treatment contract and what the patient wants out of treatment, if there appears to be a lack of interest in developing a modified treatment plan in step 5 above. If it becomes clear that the patient is mandated and "doing time" rather than "doing treatment and change," explore what Dimension 4, Readiness to Change motivational strategies may be effective in re-engaging the patient into treatment.

7. Determine if the modified strategies can be accomplished in the current level of care, or a more or less intensive level of care in the continuum of services or different services such as Co-Occurring Disorder Enhanced services. The level of care decision is based on the individualized treatment plan needs, not an automatic increase in the intensity of level of care.

8. If, on completion of step 6, the patient recognizes the problem/s, and understands the need to change the treatment plan to learn and apply new strategies to deal with the newly-identified issues, but still chooses not to accept treatment, then discharge is appropriate, as he or she has chosen not to improve his/her treatment in a positive direction. Such a patient may also demonstrate his/her lack of interest in treatment by bringing alcohol or other drugs into the treatment milieu and encouraging others to use or engage in gambling behavior while in treatment. If such behavior is a willful disruption to the treatment milieu and not overwhelming Dimension 5 issues to be assessed and treated, then discharge or criminal justice graduated sanctions are appropriate to promote a recovery environment.

9. If, however, the patient is invested in treatment as evidenced by collaboration to change his/her treatment plan in a positive direction, treatment should continue. To discharge or suspend a patient for an acute reoccurrence of signs and symptoms breaks continuity of care at precisely a crisis time when the patient needs support to continue treatment. For example, if the patient is not acutely intoxicated and has alcohol on his/her breath from a couple of beers, such an individual may come to group to explore what went wrong to cause a recurrence of use and to gain support and direction to change his/her treatment plan. Concerns about "triggering" others in the group are handled no differently from if a patient was sharing trauma issues, sobbing and this triggered identification and tearfulness in other group members. Such a patient with Posttraumatic Stress Disorder would not be excluded from group or asked to leave for triggering others. Group members and/or other patients in a residential setting are best helped to deal with such "triggering" with the support of peers and a trained clinician. To protect fellow patients from exposure to relapse or recurrence of signs and symptoms excludes the opportunity to learn new coping skills, In addition, it jeopardizes the safety of the patient at the very time he or she needs more support and guidance in such a crisis, rather than rejection, discharge, or transfer.

10. Document the crisis and modified treatment plan or discharge in the medical record.

LITERATURE REFERENCES AND RESOURCES

Engel GL (1980): The clinical application of the biopsychosocial model. Am J Psychiatry 137:535-544.

Fava, G.A. and Sonino, N. (2008):The Biopsychosocial Model Thirty Years Later. Psychother Psychosom 2008;77:1-2
http://www.sciencedaily.com/releases/2008/01/080121115422.htm

Frankel RM, Quill TE, McDaniel SH (Eds.) (2003): The Biopsychosocial Approach: Past, Present, Future.University of Rochester Press, Rochester, NY.

Borrell-Carrió F, Suchman AL, Epstein RM (2004): The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. Ann Fam Med 2004;2:576-582.
Cohen J, Brown Clark S: John Romano and George Engel (2010): Their Lives and Work. University of Rochester Press, Rochester, NY, and Boydell and Brewer Limited, Suffolk UK.
"Disease Model of Addiction versus – Biopsychosocial Model of Addiction" August 9, 2010
http://articlime.com/article091043-disease-model-addiction-verses-biopsychosocial-model-addiction.html

Donovan, DM (1988): "Assessment of addictive behaviors: Implications of an emerging biopsychosocial model". In DM Donovan & GA Marlatt (eds.) *Assessment of Addictive Behaviors*.

Griffiths, Mark (2005): "A 'components' model of addiction within a biopsychosocial framework" Journal of Substance Use, 2005, Vol. 10, No. 4 : Pages 191-197
http://informahealthcare.com/doi/abs/10.1080/14659890500114359

Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Third Edition. Carson City, NV: The Change Companies.
For more information on the 2013 edition: asam.org and changecompanies.net

Miller, S.D., Mee-Lee, D., Plum, B. & Hubble, M (2005): "Making Treatment Count: Client-Directed, Outcome Informed Clinical Work with Problem Drinkers." In J. Lebow (ed.). *Handbook of Clinical Family Therapy*. New York: Wiley.
Reprinted in Psychotherapy in Australia, Vol.11 No. 4 August 2005.
www.scottdmiller.com/uploadedFiles/documents/MakingTreatmentCountPsychOz.pdf

National Institute on Drug Abuse. "Principles of Drug Addiction Treatment: A Research Based Guide" (Second Edition). April 2009.
www.nida.nih.gov/podat/Principles.html

American Society of Addiction Medicine (ASAM) – "The Definition of Addiction" Adopted April 12, 2011. https://www.asam.org/resources/definition-of-addiction

Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. Third Edition. Carson City, NV: The Change Companies.
For more information on the 2013 edition: changecompanies.net 888-889-8866.

Mee-Lee, David with Jennifer E. Harrison (2010): "Tips and Topics: Opening the Toolbox for Transforming Services and Systems". The Change Companies, Carson City, NV

Mee-Lee, David (2005): "Helping People Change – What Families Can Do to Make or Break Denial" *Paradigm.* Vol. 10, No. 1 Winter 2005. pp. 12-13, 22.
http://www.addictionrecov.org/paradigm/P_PR_W05/paradigmW05.pdf

Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY. Guilford Press.

Miller, WR, Mee-Lee, D. (2010): "Self-management: A Guide to Your Feelings, Motivations and Positive Mental Health" Addiction Treatment Edition.
Miller, WR, Mee-Lee, D. (2012): "Self-management: A Guide to Your Feelings, Motivations and Positive Mental Health" To order: The Change Companies at 888-889-8866. changecompanies.net.

Prochaska, JO; Norcross, JC; DiClemente, CC (1994): "Changing For Good" Avon Books, New York.

Volkow, Nora D (2018): "What Does It Mean When We Call Addiction a Brain Disorder?" Scientific American blog March 23, 2018.
https://blogs.scientificamerican.com/observations/what-does-it-mean-when-we-call-addiction-a-brain-disorder/?wt.mc=SA_Twitter-Share

Zinberg, N. E. (1984). Drug, Set, And Setting: The Basis for Controlled Intoxicant Use. New Haven: Yale University Press. ISBN 0-300-03110-6. http://www.psychedelic-library.org/zinberg.htm

RESOURCE FOR ASAM E-LEARNING AND INTERACTIVE JOURNALS

E-learning module on "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care"– 5 CE credits for each module . "Introduction to The ASAM Criteria" (2 CEU hours)
"Understanding the Dimensions of Change" – Creating an effective service plan" – Interactive Journaling
"Moving Forward" – Guiding individualized service planning" – Interactive Journaling

To order: The Change Companies at 888-889-8866; changecompanies.net

CLIENT WORKBOOKS AND INTERACTIVE JOURNALS

The Change Companies' MEE (Motivational, Educational and Experiential) Journal System provides Interactive journaling for clients. It provides the structure of multiple, pertinent topics from which to choose; but allows for flexible personalized choices to help this particular client at this particular stage of his or her stage of readiness and interest in change.
To order: The Change Companies at 888-889-8866. changecompanies.net.

FREE MONTHLY NEWSLETTER

"TIPS and TOPICS" – Three sections: Savvy, Skills and Soul and at times additional sections: Stump the Shrink; Success Stories and Sharing Solutions tipsntopics.com