How to Track Treatment Progress and Adherence with ASAM's Criteria for Team Members

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Definition of Addiction

- “Addiction - primary, chronic disease of brain reward, motivation, memory and related circuitry
- Dysfunction in these circuits - characteristic biological, psychological, social and spiritual manifestations.
- Pathologically pursuing reward and/or relief by substance use and other behaviors.”

Modified from ASAM’s Definition of Addiction: www.asam.org/for-the-public/definition-of-addiction

Addiction is a *Brain* Disease

- Prolonged substance use changes the brain in fundamental, lasting ways.
- Addiction is about brains – not just about behaviors.
- Consider medications - necessary to address pathologic changes in brain circuitry; improve outcomes along with comprehensive psychosocial treatment.

Medication-Assisted Treatment (MAT)

- Scientifically supported treatment shown to reduce drug use and foster meaningful recovery. When appropriately dosed, should result in neither euphoria (“high”) nor sedation.
- Can help participants feel normal and prepares them for working on their recovery.
- Reduces cravings and helps participant focus on their ongoing recovery. Participants should be supported in understanding and taking medication.
- Is **not** substituting one addictive drug for another.
- Has specific actions on neurotransmitter receptor sites to decrease cravings to use, shortens length of any relapses improves overall addiction and recovery outcomes; saves lives.
- Significantly increases treatment entry and retention among individuals on probation and parole.
- Combined with addiction counseling is essential for typical drug court participant; provides best hope for recovery.
- Not to preclude drug court program progression or completion when used by participant in ongoing addiction treatment.

Medication for Initial & Continued Treatment of OUD

- Medication in addiction treatment is effective and recommended for prisoners and parolees with opioid use disorder (OUD) regardless of the length of their sentenced term.
- Individuals with OUD within the criminal justice system should have integrated care and most should be treated with some type of medication in addition to psychosocial treatment.

Agonists (methadone)	Partial agonists (buprenorphine)	Antagonists (naltrexone)
Act on the opioid receptor with less intense, slower, and longer lasting effects than opioids like heroin.	Produce effects similar to but weaker than those of full agonists.	Work by blocking the action of receptors. For participants in treatment with antagonist-type medication who relapse or use the formerly misused opioid, that drug's power to trigger receptors will often be blocked or greatly diminished.
All participants, including those in drug courts, should have access to all three types of medication with treatment individualized based on participant preference and clinical assessment.		

Medication for Initial and Continued Treatment of OUD (cont.)

- Buprenorphine and naltrexone can be prescribed in an office-based setting and also dispensed in an Opioid Treatment Program (OTP) setting.
- Methadone can only be dispensed in regulated settings (i.e., OTPs).
- As with medication for other illnesses needing ongoing treatment, there is no recommended length of time for addiction medication. Treatment continues depending on severity of illness, outcomes and response to treatment. Continued medication should not preclude drug court program progress or completion.
- When addiction medication is indicated, it should be initiated a minimum of 30 days prior to release from prison and be accompanied by assertive efforts of reentry or other drug court case managers to find providers to continue such treatment post release.
- "Decisions about the appropriate type, modality and duration of treatment should remain the purview of the treatment provider and the patient, working in collaboration to achieve shared treatment goals." (ASAM Public Policy Statement)

The ASAM Criteria, 2013, Opioid Treatment Services (pp. 290 - 298).

NIDA Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide

Identifies 13 principles, including:

Principle #2 Recovery from drug addiction requires effective treatment, followed by management of problem over time.

Principle # 5 Indicates the need to tailor services to fit needs of individual as an important part of effective addiction treatment for criminal justice populations.

Principle # 12 Identifies that medications are an important part of treatment for many people in the criminal justice system suffering from addiction.

https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles

The ASAM Criteria and Dimension 4 – Readiness to Change

The ASAM Criteria assesses Readiness to Change (Dimension 4); promotes individualized treatment using Evidence-Based Practices (EBPs); assesses stages of change; applies motivational enhancement strategies with flexible lengths of stay (LOS).

- However, there is sometimes an expectation in drug courts and elsewhere in the criminal justice system that participants should be in the Action stage when they begin treatment to manifest healthy, pro-social behaviors and remain in compliance with court orders.

- In addition, this may be mistakenly thought to be attainable in addiction drug court treatment programs by designing fixed length of stay and non-individualized program completion/graduation phases and targets. Furthermore, predetermined lengths of stay are often too brief to achieve reasonable public safety and clinical outcome goals, including goals for motivational enhancement interventions.

- Central goal of treatment for substance use disorder is to support the individual's internal motivation for recovery. Often, there is ambivalence. Motivational interviewing can reinforce people's internal desire for recovery.

The ASAM Criteria and Dimension 4 – Readiness to Change (cont.)

- Competent, person-centered, individualized, and outcomes-driven treatment can initiate accountable lasting change within timeframes typically afforded to treatment courts (i.e., within 18 to 24 months).

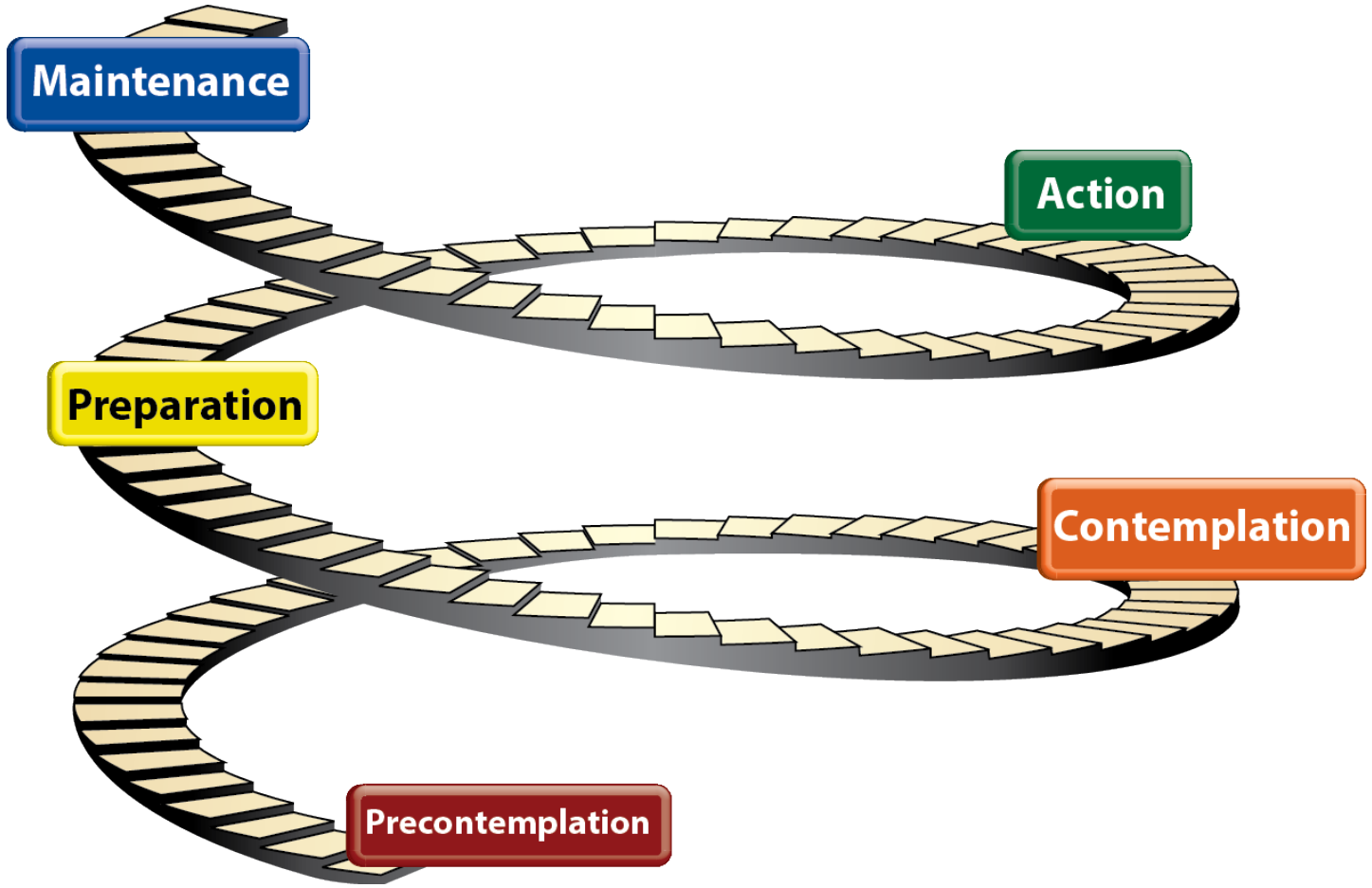
- Rather than mandating specific levels of care (e.g., residential treatment) and lengths of stay (e.g., 1 year), judges, other court officials, and probation and parole officers should focus on mandating comprehensive assessment and ongoing treatment adherence based on the treatment plan.

- Treatment plans require ongoing updates depending on the participant's severity of illness, outcomes, and response to treatment. Treatment adherence is not defined by compliance with a predetermined set of program rules, but accountable work on collaborative treatment plan.

Transtheoretical Model of Stages of Change

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse and Recycling
- Termination

The Stages of Change



James Prochaska, Ph.D., John Norcross, Ph.D., and Carlo DiClemente, Ph.D.

Dimension 4 – Readiness to Change

Participants may be at different stages of Readiness to Change as it relates to their substance use disorder and related behaviors.

• Clinicians should identify strengths, resources, and abilities that may increase hope, motivation, and commitment to change, which may include family, children, self-sufficiency, self-efficacy (the optimism and confidence that change is possible), meaning, and purpose.

• For participants in community settings, gather collateral data, including probation, parole, or court terms. If participant's main goal is to "get off paper," (finish probation or parole) connect this to probation and parole plan and use Motivational Interviewing techniques to identify steps the participant can and is willing to take to accomplish his or her goals.

• Such an approach meets the participant where they are in their interest in change and harnesses the participant's strengths to attract them into recovery and positive change.

Compliance in contrast to Adherence

Compliance:

- Compliance focuses on following rules in treatment program (e.g., attendance at Alcoholics Anonymous meetings, doing urine drug screens and attending all prescribed groups, etc.). While mere compliance is preferable to non-compliance and is to be expected for those entering treatment in the Precontemplation and Contemplation stages of change, individuals must move beyond compliance to achieve lasting positive outcomes.

- Compliance is often “doing time” in a treatment setting rather than “doing treatment and change” which is needed to achieve lasting, accountable, positive change in service of public safety, decreased legal recidivism and crime and safety for children and families.

- Treatment providers and other team members should view moving beyond compliance as essential to progress. A focus on compliance with treatment allows participant to “go through the motions” in a program, not being held accountable for working on whatever is needed to change attitudes, thoughts, and behaviors to advance public safety.

Compliance in contrast to Adherence (cont.)

Adherence:

• Adherence suggests moving beyond compliance to actual commitment driven by factors important to the individual.

• Treatment adherence allows for individualization of treatment plans and interventions matched to the participant's stage of change to facilitate accountable, lasting change.

• Meaningful adherence improves when participant has some choice, even if choices are limited (e.g., choosing from among drug court-approved providers).

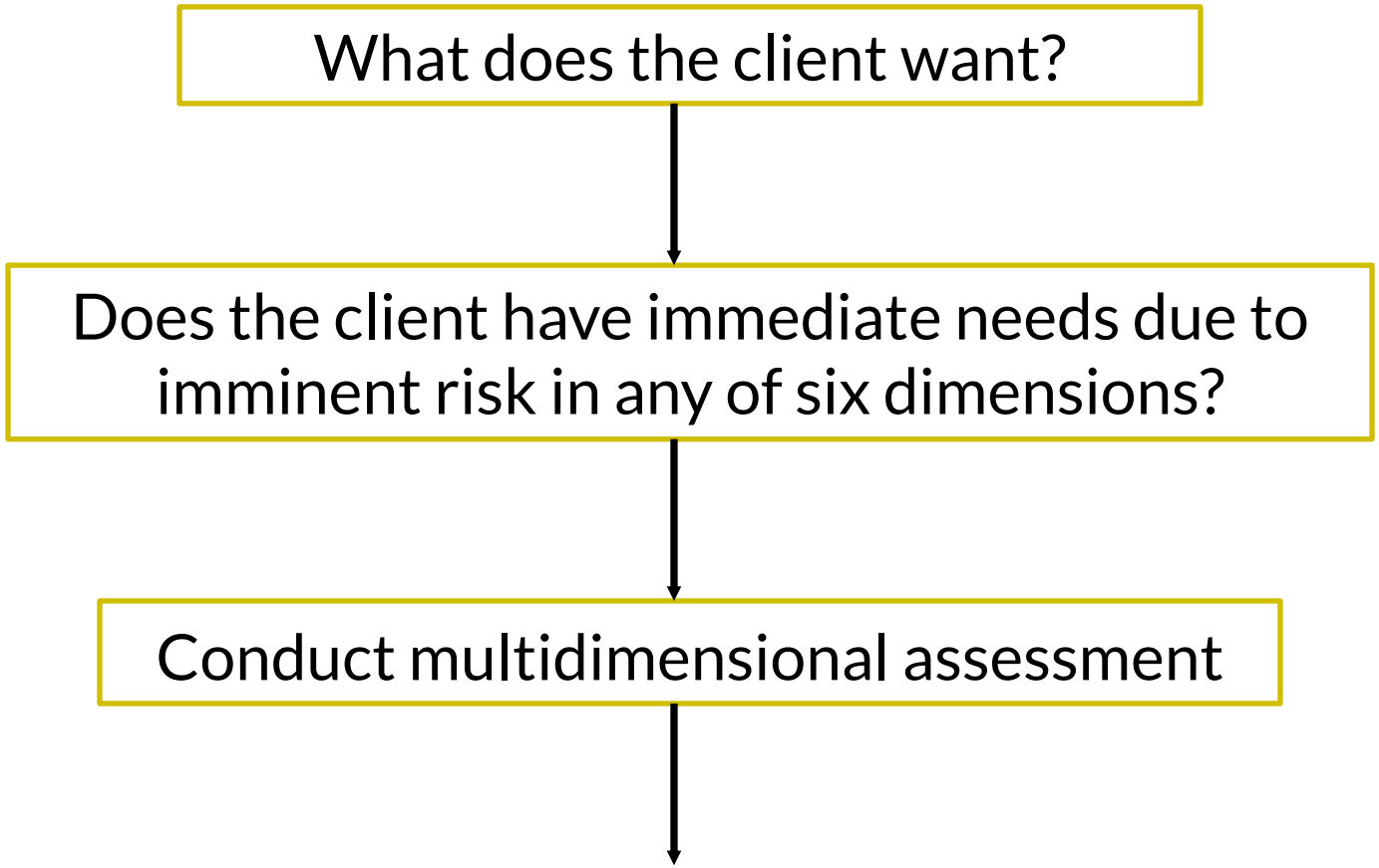
• Motivational interviewing represents a scientifically proven method for improving adherence and instilling hope for recovery.

• Successful recovery and genuine adherence depends on an individual's motivation from external factors ("judge is forcing me to do this") to internal motivation ("I want recovery").

• Beyond stabilizing the brain with addiction medication and skillfully utilizing Motivational Interviewing, three approaches can support this gradual shift in motivation: 1) Treating all individuals with respect and dignity; affirming their steps toward recovery while avoiding shaming 2) Offering choices however constrained 3) Providing treatment based on best science that teaches person the skills they need to manage their condition.

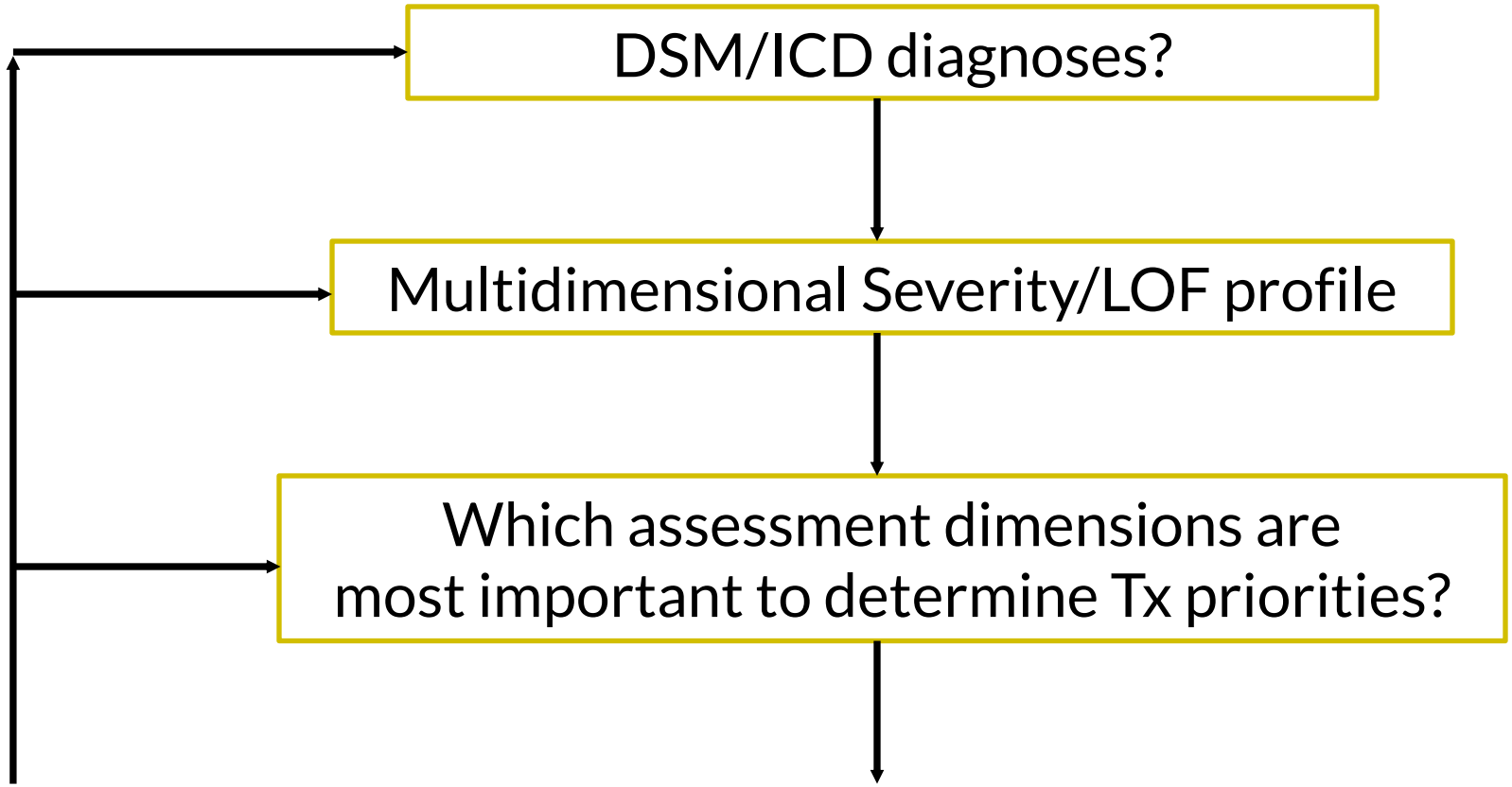
Ogden, J. (1999). Compliance versus adherence: just a matter of language? The politics and poetics of public health. In J. D. Porter & J. M. Grange (Eds.), Tuberculosis: An interdisciplinary perspective (pp. 213-234). London: Imperial College Press

Focus Assessment and Treatment



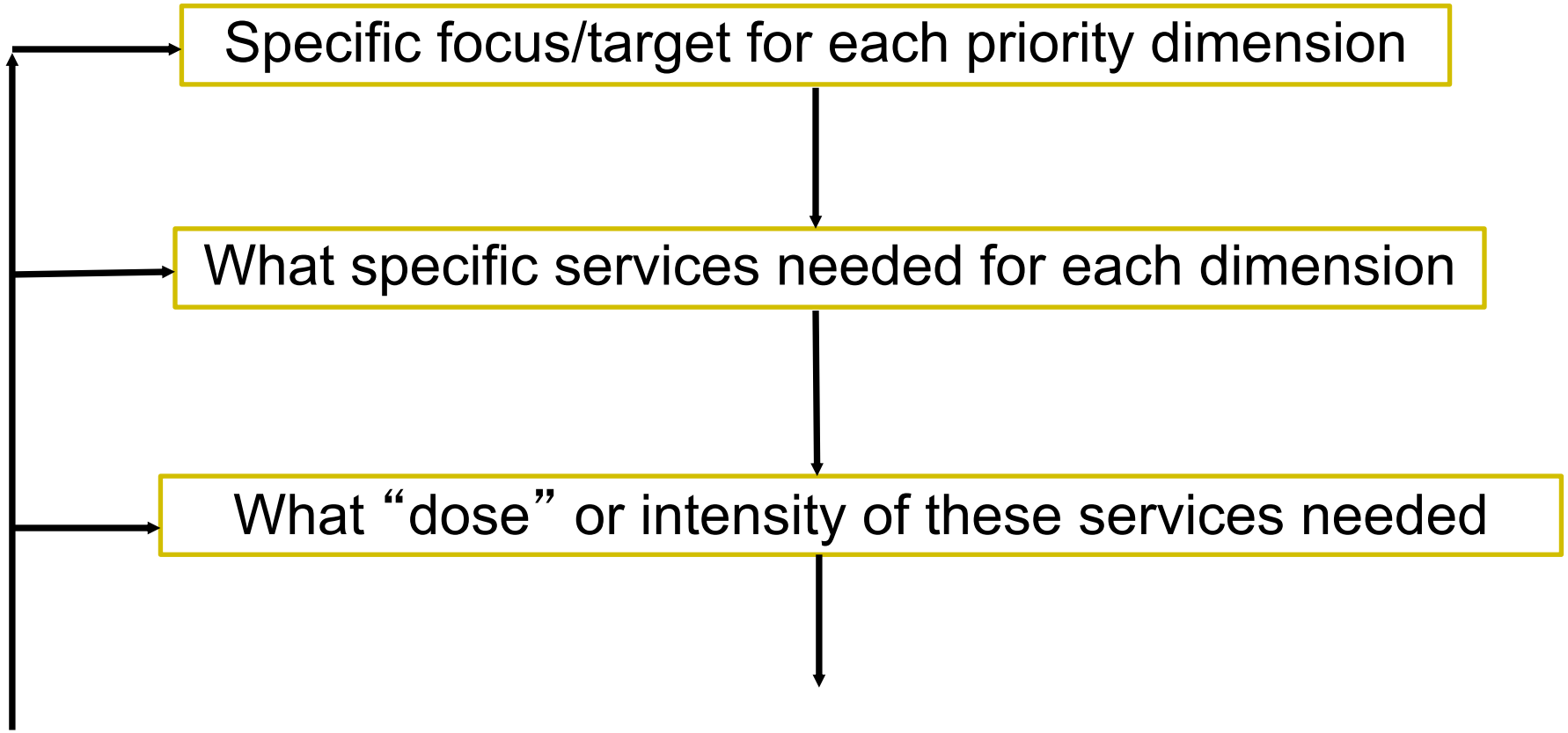
The ASAM Criteria, 2013, p. 124

Focus Assessment and Treatment (continued)



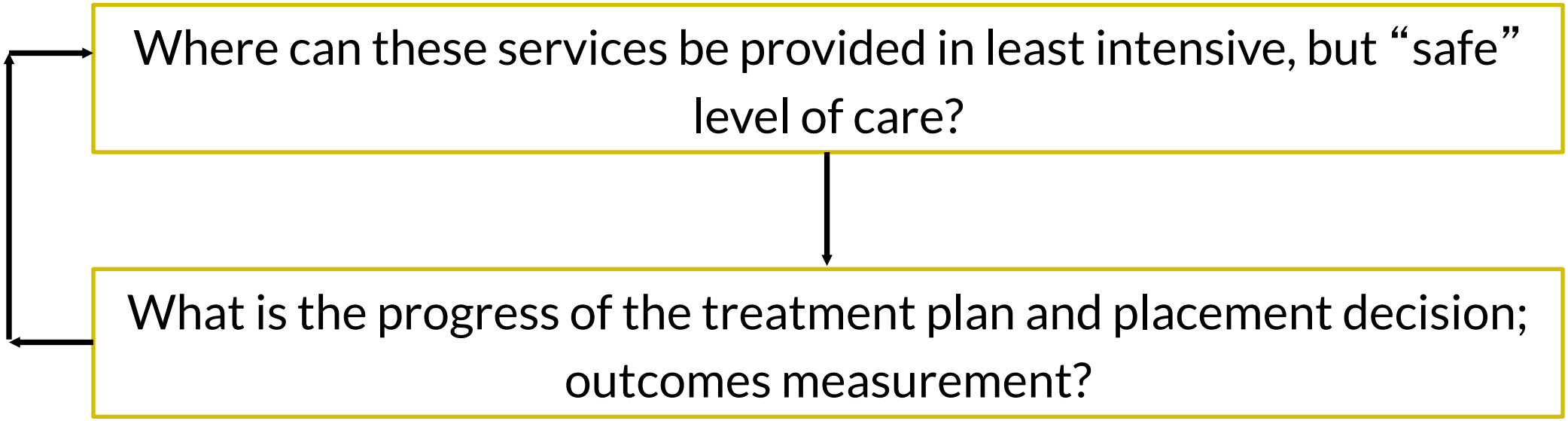
The ASAM Criteria, 2013, p. 124

Focus Assessment and Treatment (continued)

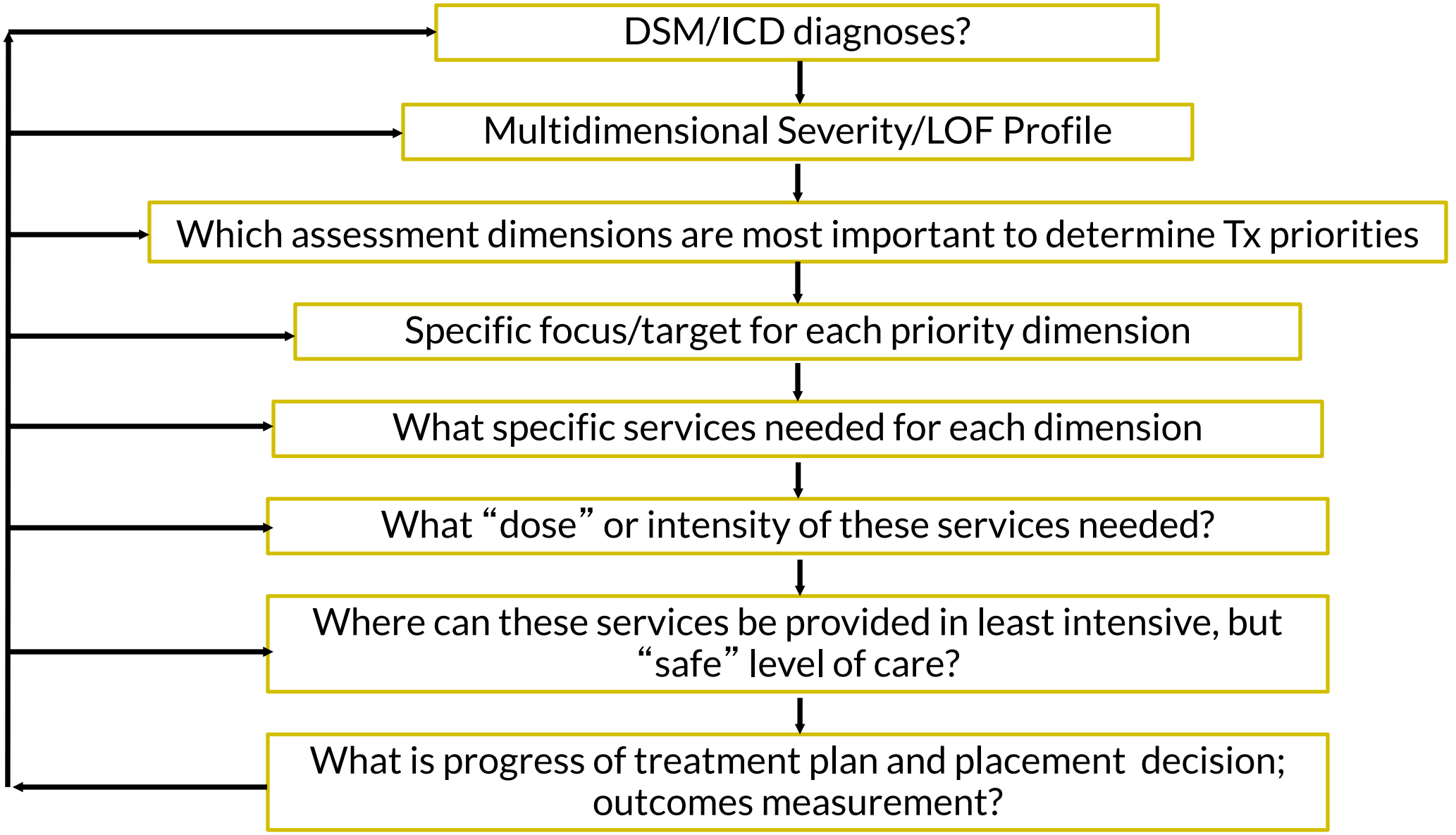


The ASAM Criteria, 2013, p. 124

Focus Assessment and Treatment (continued)



The ASAM Criteria, 2013, p. 124



The ASAM Criteria, 2013, p. 124

Procedures to assure treatment adherence

I. Multidisciplinary Team

Dedicated multidisciplinary team of professionals manages day-to-day operations of drug court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment, and supervision services.

A. Team Composition

Drug court team comprises representatives from all partner agencies involved in the creation ofthe program, including but not limited to judge or judicial officer, program coordinator, prosecutor, defense counsel representative, treatment representative (knowledgeable about participant's progress with MAT prescriber and treatment program), community supervision officer, and law enforcement officer.

National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II, 2014

Procedures to assure treatment adherence (cont.)

B. Pre-Court Staff Meetings

Team members consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court. Pre-court staff meetings are presumptively closed to participants and the public unless the court has good reason for the participant to attend discussions related to their case.

C. Sharing Information

Team members share information as necessary to appraise participants' progress in treatment and compliance with conditions of drug court. Partner agencies execute memoranda of understanding (MOUs) specifying what information will be shared among team members. Participants provide voluntary and informed consent permitting team members to share specified data elements relating to participants' progress in treatment and compliance with program requirements. Defense attorneys make it clear to participants and other team members whether they will share communications from participants with the drug court team.

National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II, 2014

Procedures to assure treatment adherence (cont.)

Information shared should focus on whether participant is changing his or her attitudes, thinking, and behavior in areas that previously threatened public safety, legal recidivism, and safety for children and families.

- Treatment providers share if and how the participant is doing treatment in good faith with personal effort and adherence; or whether the participant is passively engaged in treatment compliance—just "doing time".
- Clinician shares with the participant concerns about level of treatment engagement and effort and possible need to recommend graduated sanction to court team.
- Treatment reports should broaden information beyond mere attendance at all prescribed activities, participation in drug testing, and signed verifications of attendance at mutual/self help support groups.
- All members of the multidisciplinary team share observations on whether the participant is demonstrating improvement or not, to be proactive about public safety and the safety of children and families.
- Team members contribute relevant insights, observations, and recommendations based on their professional knowledge, training, and experience. The judge considers perspectives of all team members before making decisions that affect participants' welfare or liberty interests and explains the rationale for such decisions to team members and participants.

National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II, 2014, pages 38, 39, 43

Procedures to assure treatment adherence (cont.)

II. Team Communication and Decision Making

To increase team functioning, the following issues are best addressed:

1. Recognition that all team members have the same common purpose and mission: public safety, safety for children, decreased legal recidivism and crime.
2. All members could benefit from common language of assessment of stage of change – models of stages of change.
3. Develop consensus practice approach for addressing readiness to change: meeting participants where they are at, solution-focused, motivational enhancement that is affirming and respectful.
4. Develop consensus on how to combine resources and leverage to effect change, responsibility and accountability – coordinated efforts to create and provide incentives and supports for change.
5. Improve communication and conflict resolution - committed to common goals of public safety; responsibility, accountability, decreased legal recidivism and lasting change. Keep our collective eyes on the prize: “No one succeeds unless we all succeed!”

National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II, 2014

Procedures to assure treatment adherence (cont.)

III. Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the treatment court.

National Association of Drug Court Professionals (NADCP), Adult Drug Court Best Practice Standards Volume II, 2014

Criminal Justice's View of Presenting Problem and Solution

3 Cs

Consequences

Compliance

Control

From Punishment to Lasting Change – Implications for Sanctions and Incentives

1. Sanction for lack of good faith effort and adherence in treatment, not for signs and symptoms of addiction and/or mental illness.

2. The treatment provider is responsible for careful assessment, person-centered services, keeping the court informed about a participant's level of good faith effort in treatment, and whether participant is improving in function at pace consistent with their assessed needs, strengths, skills and resources.

3. If a participant is not changing their treatment plan in a positive direction, the participant is "doing time" not "doing treatment and change.

From Punishment to Lasting Change – Implications for Sanctions and Incentives (cont.)

4. Providers need to then inform the judge that the participant is out of compliance with the court order to do treatment. The participant consented to do treatment not just do time and should be held accountable for their individualized treatment plan. If the participant is substantively modifying their treatment plan in positive direction in response to poor outcomes and adhering to new direction in treatment plan, then he or she should continue in treatment and not be sanctioned for signs and symptoms of their illness(es).

5. Incentives for clients can be explored and matched to what is most meaningful to them.

Resources

ASAM has guidelines outlining best practices for drug testing in addiction settings:
“ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine.”
https://www.asam.org/resources/guidelines-and-consensus-documents/drug-testing

NADCP has developed a set of guidelines outlining how drug testing is applied in drug court settings:
National Association of Drug Court Professionals (NADCP), ADULT DRUG COURT BEST PRACTICE STANDARDS VOLUME II http://www.nadcp.org/sites/default/files/2014/Best%20Practice%20Standards%20Vol.%20II._0.pdf

Resources (cont.)

“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.

Critical Treatment Issues Webinar Series, Bureau of Justice (BJA) Drug Court Technical Assistance Project at American University Feb. 10, 2016 – May 3, 2016
https://www.youtube.com/watch?v=AuUEP52z1Xk

Resources (cont.)

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.

National Institute on Drug Abuse. "Principles of Drug Addiction Treatment for Criminal Justice Populations - A Research Based Guide" April 2014. https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles

"The Definition of Addiction" Adopted April 12, 2011. American Society of Addiction Medicine. http://www.asam.org/quality-practice/definition-of-addiction.

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

Resources (cont.)

RESOURCE FOR The ASAM Criteria book, 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

The ASAM Criteria Software Decision Engine - CONTINUUM™
The ASAM Criteria book and The ASAM Criteria Software now branded as Continuum™ are companion text and application.
The text delineates the dimensions, levels of care, and decision rules that comprise The ASAM Criteria.
The software provides an approved structured interview to guide adult assessment and calculate the complex decision tree to yield suggested levels of care, which are verified through the text.

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