

What to Do When Participants Aren't Really Participating: Doing the Minimum to Comply, Poor Attendance, Using Substances

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Drug Courts Past and Present

- 1989: Drug courts created to reduce crime by treating substance use problems of offenders and provide alternatives to incarceration for individuals involved with substance-related, nonviolent offenses.
- Central elements of most drug court programs were attendance at regularly scheduled group counseling sessions and frequent drug testing.
- Sanctions for noncompliance with drug court rules: verbal warnings from the judge, being put back a phase, more drug testing, or incarceration for several days or weeks.
- The nonadversarial approach meant participants typically removed from the program only after multiple and continuous failed drug tests
- Retention of participants has been problematic – approx. 60% of participants fail to complete the program, even up to 90%

(Lilley, DR (2013): "Drug Courts and Community Crime Rates: A Nationwide Analysis of Jurisdiction-Level Outcomes" <https://www.hindawi.com/journals/jcrim/2013/571760/>)



Drug Courts Past and Present (cont.)

- Individual studies & reviews conducted to assess recidivism outcomes associated with drug courts. Systematic reviews and meta-analyses have noted that most evaluations have been of poor quality, suffer from selection bias, and lack equivalent comparison.
- For example, many drug court evaluations have compared the outcomes of graduates to those of nongraduates. From a public policy perspective, however, this is an improper metric. **Drug court programs must be held accountable for the outcomes of those who drop out of the program as well as those who successfully complete.**
- Another common problem involves the “apples to oranges” comparison of participants who remained under drug court supervision with those who were not under any program restriction. One such study utilized random assignment of treatment and nontreatment groups but then compared the recidivism of individuals who were undergoing routine drug testing, meetings with judges, and other restrictions to those not under treatment, rather than assessing recidivism after program completion.
- Thus, potential for equivalent comparison was entirely negated with regard to post-program recidivism outcomes. This study also found that after 24 months of drug court involvement, only 19 percent of participants had completed the drug court program.

(Lilley, DR (2013): “Drug Courts and Community Crime Rates: A Nationwide Analysis of Jurisdiction-Level Outcomes”



Predicting Termination from Drug Court and Comparing Recidivism Patterns

Predicting Termination from Drug Court and Comparing Recidivism Patterns: Treating Substance Use Disorders in Criminal Justice Settings

John R. Gallagher, Anne Nordberg, Michael S. Deranek, Eric Ivory, Jesse Carlton & Jane Woodward Miller Pages 28-43 | Published online: 29 Jan 2015

Download citation <https://doi.org/10.1080/07347324.2015.982451>

Abstract

Study evaluates a drug court in Indiana, focusing on most predictive variables for being terminated & comparing recidivism patterns of drug court & probation participants.

Participants were most likely to be terminated from drug court if they:

- did not have a high school diploma or equivalent at admission,
- were not employed or a student at admission,
- identified cocaine as a drug of choice,
- had more positive drug tests,
- had a violation within the first 30 days of the program,
- had a criminal history.

Additional findings suggest that drug court is more effective than probation at reducing criminal recidivism rates for offenders with substance use disorders.



Predictors of drug court client graduation

Predictors of drug court client graduation

Marie E. Gill Pages 564-588 | Published online: 04 Oct 2016

Download citation <https://doi.org/10.1080/10509674.2016.1229710>

Abstract

Descriptive study examined differences between Shelby County Drug Court (DC) graduates and dropouts, and identified predictors of graduation.

- More graduates were employed,
- Caucasian females with a high school diploma and
- preferred alcohol as their primary drug choice.

Education, diluted urine drug screens, rearrests, and jail sentencing sanctions variables from the prediction model were tested for indirect effects with the mediating variable for number of program days on DC graduation.

- low education had the greatest effect on not graduating



Completion rates: An analysis of factors related to drug court program completion

Completion rates: An analysis of factors related to drug court program completion

Barbara Smith | John Martyn Chamberlain (Reviewing Editor)

Article: 1304500 | Received 11 Dec 2016, Accepted 07 Mar 2017, Published online: 23 Mar 2017

Abstract

Study evaluates 290 Felony Drug Court participants in large city in Texas to determine factors related to drug court completion. Population from which sample was drawn consists of adults in Felony Drug Court program from Jan. 2006 to September 2010.

Study reveals that associated with drug court completion are:

- employment
- marriage
- married participants (69.1%) who were employed (65.0%) when entering the program were more likely to graduate than:
 - Unemployed,
 - single and/or divorced.



Outcome Trajectories in Drug Court: Do All Participants Have Drug Problems?

Outcome Trajectories in Drug Court: Do All Participants Have Drug Problems?

David DeMatteo, JD, PhD, Douglas B. Marlowe, JD, PhD, David S. Festinger, PhD, and Patricia L. Arabia, MS

Crim Justice Behav. 2009 Apr; 36(4): 354–368. doi: 10.1177/0093854809331547

Abstract

Graduation rates in drug courts average 50% to 70%, but unclear what proportion of graduates responded to drug court services and what proportion might not have had serious drug problems upon entry.

Study cluster-analyzed urine drug screen results during the first 14 weeks of treatment on 284 participants from three misdemeanor drug courts. A four-cluster solution ($R^2 > .75$) produced distinct subgroups characterized by (1) consistently drug-negative urine specimens (34% of the sample), (2) consistently drug-positive specimens (21%), (3) consistently missed urine specimens (26%), and (4) urine specimens that began as drug-positive but became progressively drug-negative over time (19%).

These data suggest:

- Approximately one-third of the participants might not have had serious drug problems upon entry.
- Approximately one-fifth appeared to respond to drug court services, and
- Nearly one-half continued to exhibit problems after 14 weeks



Criminal Justice's View of Presenting Problem and Solution

3 Cs

Consequences

Compliance

Control

Coerced Clients and Working with Referral Sources

- Common purpose and mission
- Common language of assessment of stage of change
- Consensus philosophy of addressing readiness to change
- Consensus on how to combine resources and leverage to effect change, responsibility and accountability
- Communication and conflict resolution

A Word About Terminology

Treatment Compliance vs Adherence

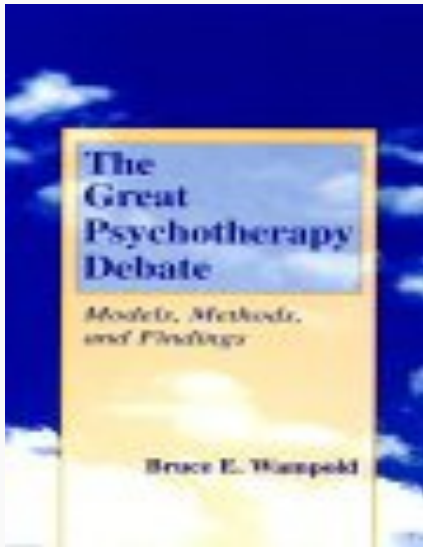
Webster's Dictionary defines:

“comply”: to act in accordance with another's wishes, or with rules and regulations

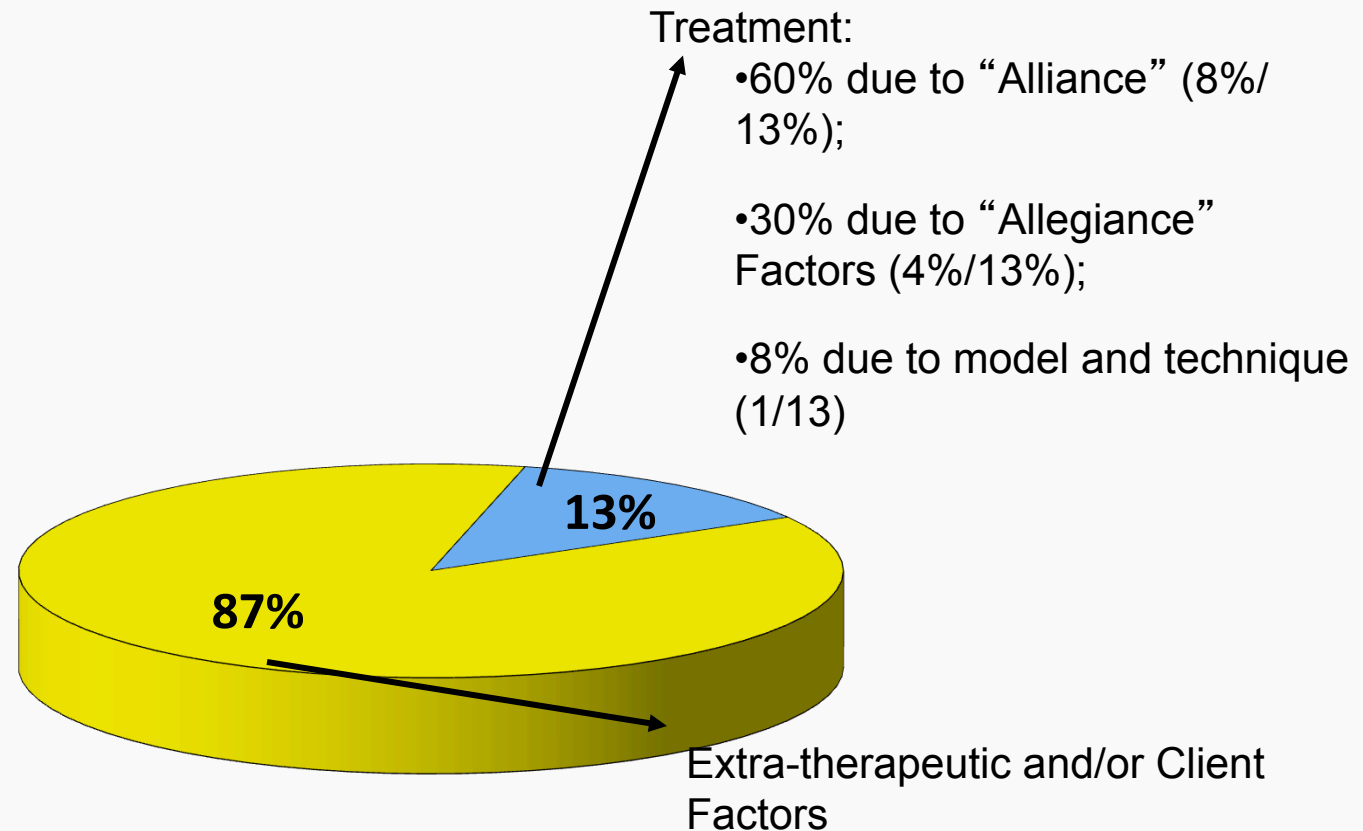
“adhere”: to cling, cleave (to be steadfast, hold fast), stick fast

What Works in Treatment

The Empirical Evidence



scottdmiller.com



Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.

Miller, S.D., Mee-Lee, D., & Plum, B. (2005). *Making Treatment Count*. In J. Lebow (ed.). *Handbook of Clinical Family Therapy*. New York: Wiley.

Ten Aspects of Successful Drug Courts

The NADCP Standards Committee identified ten key elements of successful drug courts:

- (1) drug courts integrate alcohol and other drug treatment services with the justice system case processing
- (2) drug courts use a non-adversarial approach in which prosecution and defense counsel promote public safety while protecting participants' due process rights
- (3) eligible participants are identified and placed in the drug court program
- (4) drug courts provide access to a continuum of treatment and rehabilitation services
- (5) abstinence is frequently monitored by drug testing
- (6) sanctions and incentives that participants receive from the court and the treatment programs are organized as personalized contingency contracts
- (7) drug court participants have an ongoing judicial interaction
- (8) program effectiveness and goals are monitored and evaluated
- (9) continuing interdisciplinary education of the drug court team promotes effective drug court planning
- (10) drug court effectiveness partnerships among drug courts, public agencies and community based organizations are established

(National Association of Drug Court Professionals, 1997)





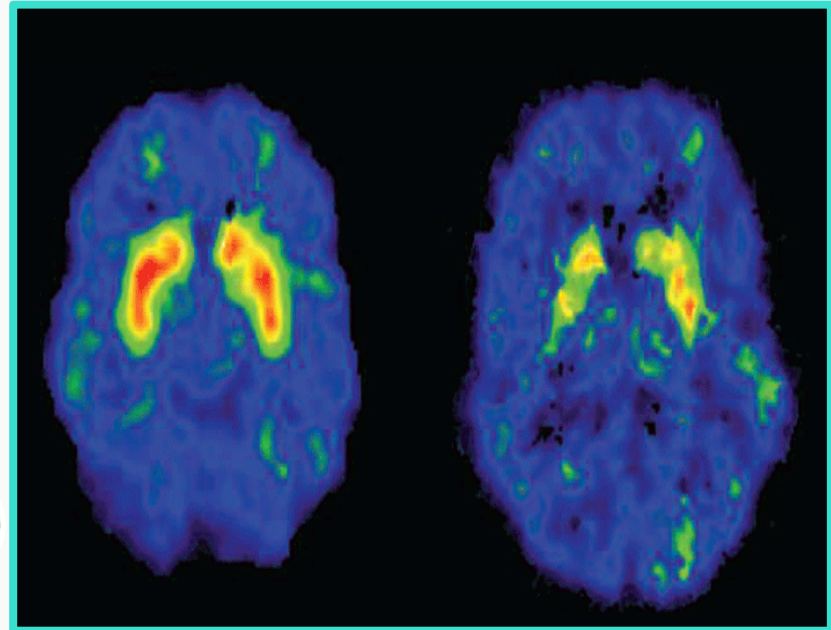
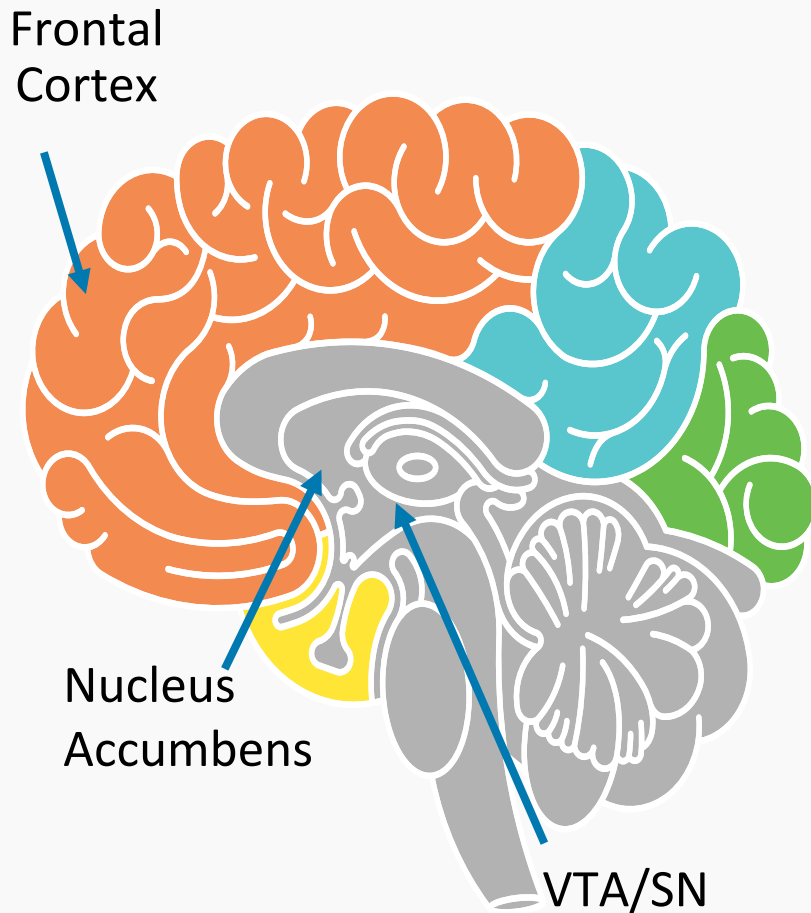
- “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry August 15, 2011
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- Pathologically pursuing reward and/or relief by substance use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

ASAM’s Revamped Definition of Addiction

<http://www.asam.org/quality-practice/definition-of-addiction>



Dopamine Levels



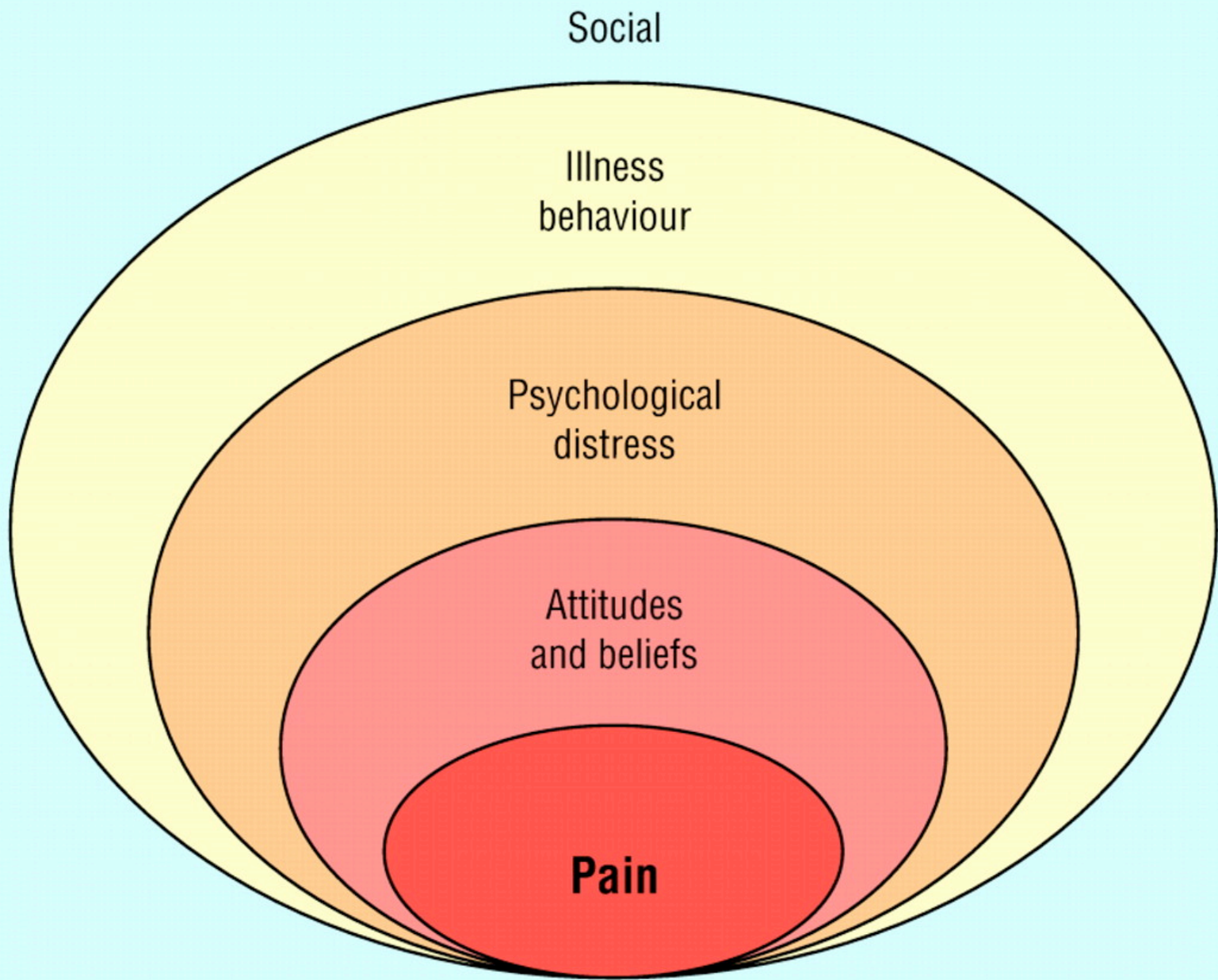
Addiction is a *Brain Disease*

- Prolonged Use Changes the Brain in Fundamental and Lasting Ways
- Addiction is about brains – not just about behaviors.

It isn't just a Brain Disease - Getting back to Biopsychosocial

George Engel Biopsychosocial Model

1977



Biopsychosocial

- Etiology – Causes
- Clinical Presentation
- Treatment

Genetic Factors

Genetic factors account for between **40 and 60%** of person's vulnerability to addiction (includes effects of environmental factors on function and expression of person's genes.)

(<https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction>)

Risk and Protective Factors

Risk Factors	Protective Factors
Aggressive behavior in childhood Lack of parental supervision Poor social skills Drug experimentation Availability of drugs at school Community poverty	Good self-control Parental monitoring and support Positive relationships Academic Competence School anti-drug policies Neighborhood pride

Behavioral Effects

- Enormous **cross-cultural variation** in way people behave when they drink. Some societies (UK, Scandinavia, US & Australia), alcohol associated with **violent and anti-social behavior**
- In others (Mediterranean & some South American cultures) drinking behavior **largely peaceful and harmonious**

Alcohol-related Problems

Cultural factors: beliefs, attitudes, norms and expectancies about drinking = problems or not

Positive beliefs and expectancies about

alcohol (variously defined as 'non-Temperance', 'wet',

'Mediterranean' or 'integrated' drinking-cultures = significantly **fewer** alcohol-related problems;

Negative or inconsistent beliefs and

expectancies (found mainly in 'Temperance', 'dry', 'Nordic' or

'ambivalent' drinking-cultures) = **higher levels** of alcohol-related problems

Transitional Rituals

- In everyday transitions, cultures (such as US and UK) **alcohol used to mark transition from work to play** – (drinking is associated with recreation & irresponsibility, and regarded as antithetical to working) – tend to have **higher levels of alcohol-related problems**
- Where drinking is **integral part of normal working day**, and alcohol may be used to mark transition to work (e.g. France, Spain, Peru), tend to have **lower levels of alcohol-related problems**

Drug, Set and Setting

- **Drug** – the pharmacological properties of the substance
- **Set** – the mindset with which a person approaches use
- **Setting** – the environment where the drug is used

Norman E. Zinberg, M.D. (<http://www.psychedelibrary.org/zinberg.htm>)



ASAMCriteria.org
asam.org
changecompanies.net

The ASAM Criteria

Multidimensional Assessment

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

The ASAM Criteria (2013) Pages 43-53



Criminogenic Factors and ASAM Criteria Dimensions

Criminogenic Factors

- Antisocial values, attitudes, behavior, personality
- Criminal/deviant peer association
- Substance Abuse
- Dysfunctional family relations

ASAM Criteria Dimensions

- Dimensions 3, 4, and 6
- Dimension 6
- Dimensions 1, 4, 5, 6
- Dimension 6

Biopsychosocial Treatment

Treatment Matching - Modalities

- **Motivate** - Dimension 4
- **Manage** – All Six Dimensions
- **Medication** – Dimensions 1, 2, 3, 5 - MAT
- **Meetings** – Dimensions 2, 3, 4, 5, 6
- **Monitor**- All Six Dimensions

Treatment Levels of Service

0.5 Early Intervention

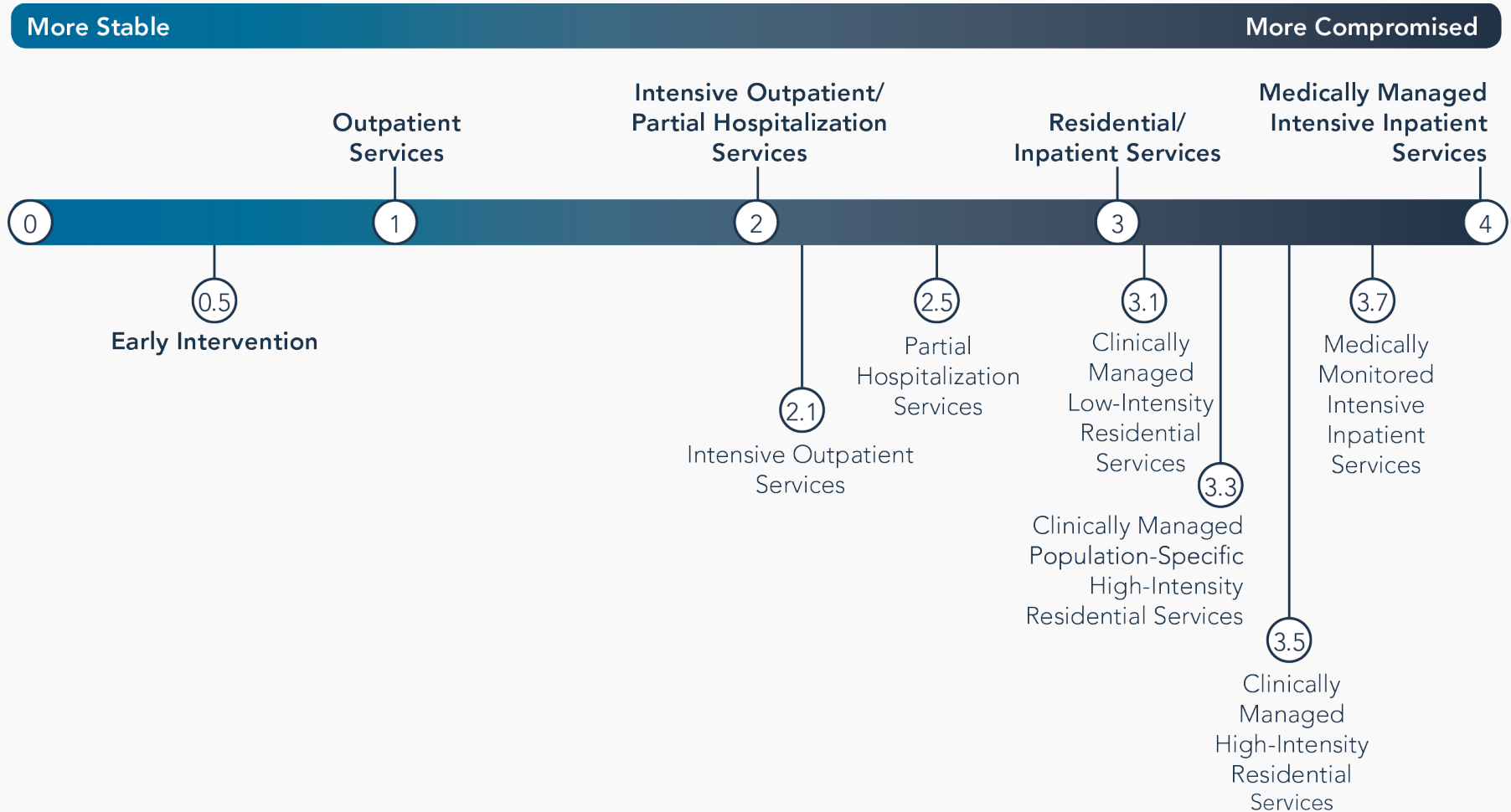
1 Outpatient Treatment

2 Intensive Outpatient and Partial Hospitalization

3 Residential/Inpatient Treatment

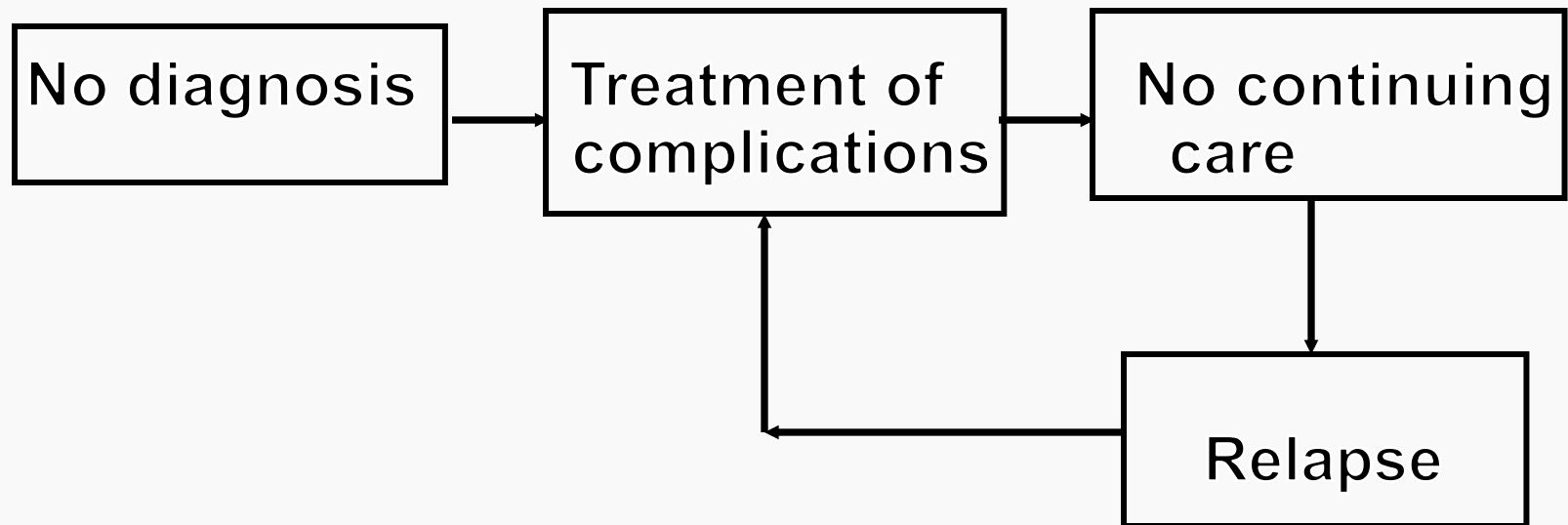
4 Medically-Managed Intensive Inpatient Treatment

ASAM Criteria Levels of Care



Generations of Clinical Care

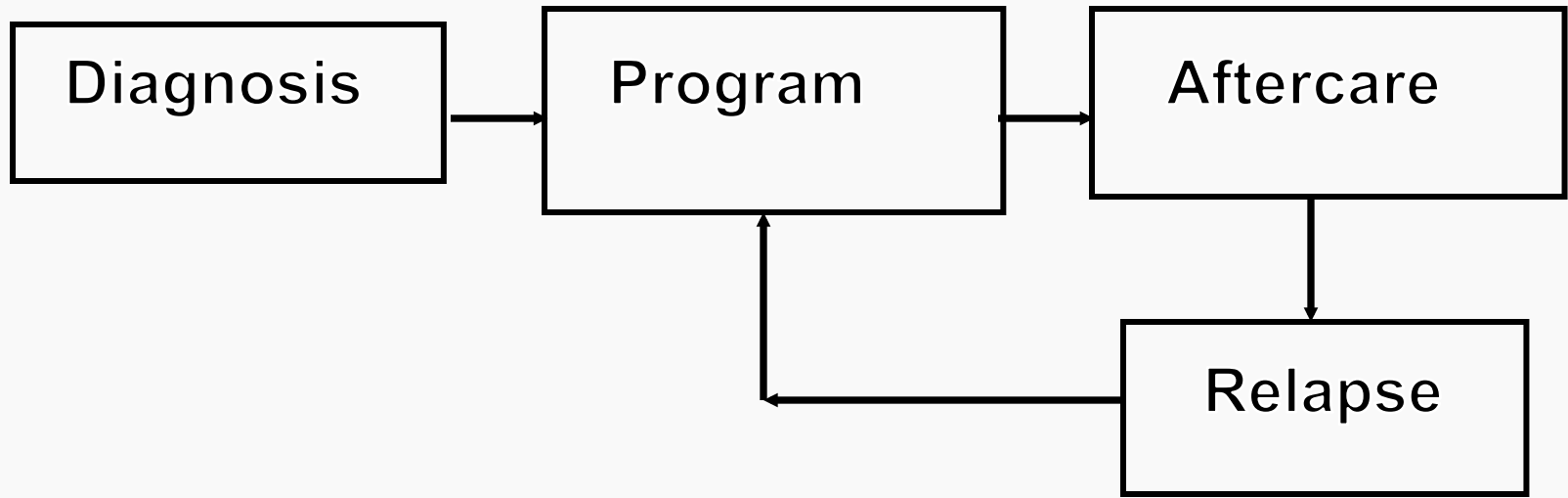
Complications-driven Treatment



Mee-Lee, David (2001): "Persons with Addictive Disorders, System Failures, and Managed Care"
Chapter 9, pp. 225-265 in "Managed Behavioral Health Care Handbook"

Generations of Clinical Care

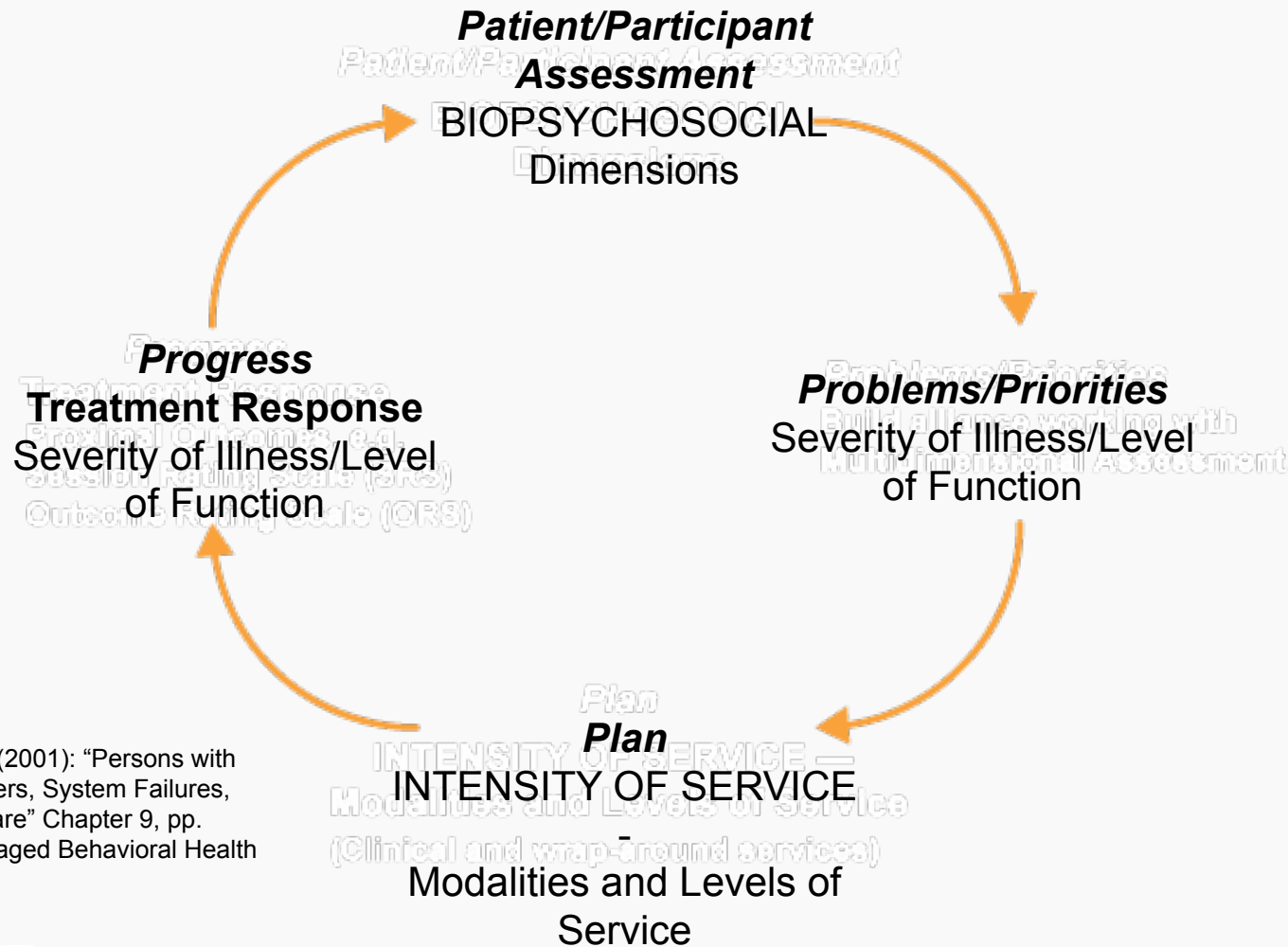
Diagnosis-driven Treatment



Mee-Lee, David (2001): "Persons with Addictive Disorders, System Failures, and Managed Care"
Chapter 9, pp. 225-265 in "Managed Behavioral Health Care Handbook"

Generations of Clinical Care

Individualized Clinically-driven Treatment



Mee-Lee, David (2001): "Persons with Addictive Disorders, System Failures, and Managed Care" Chapter 9, pp. 225-265 in "Managed Behavioral Health Care Handbook"



What to Do? - ACCEPT

Assess

Change treatment plan to improve the outcome

Check treatment contract if reluctant to modify the Tx. 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 not compliance

Engage the Client as Participant

Treatment Contract

What?

Why?

How?

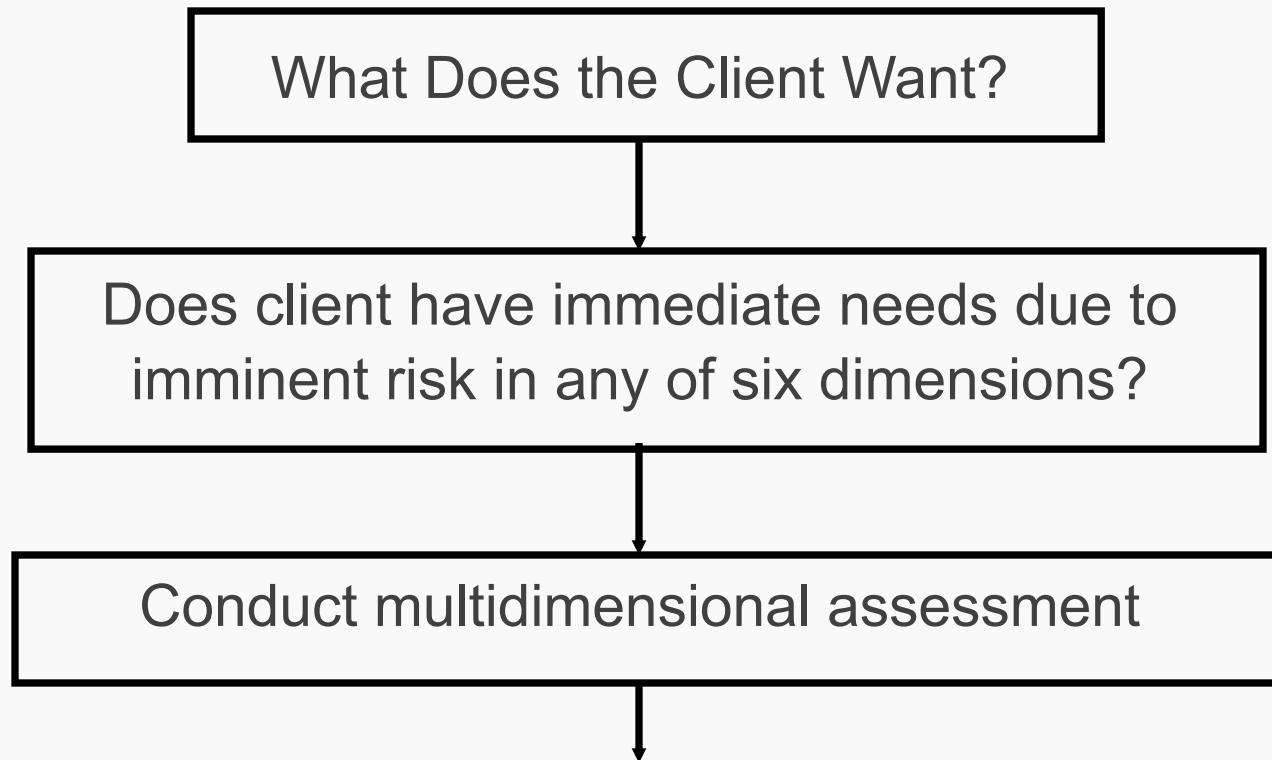
Where?

When?

Identifying the Assessment and Treatment Contract

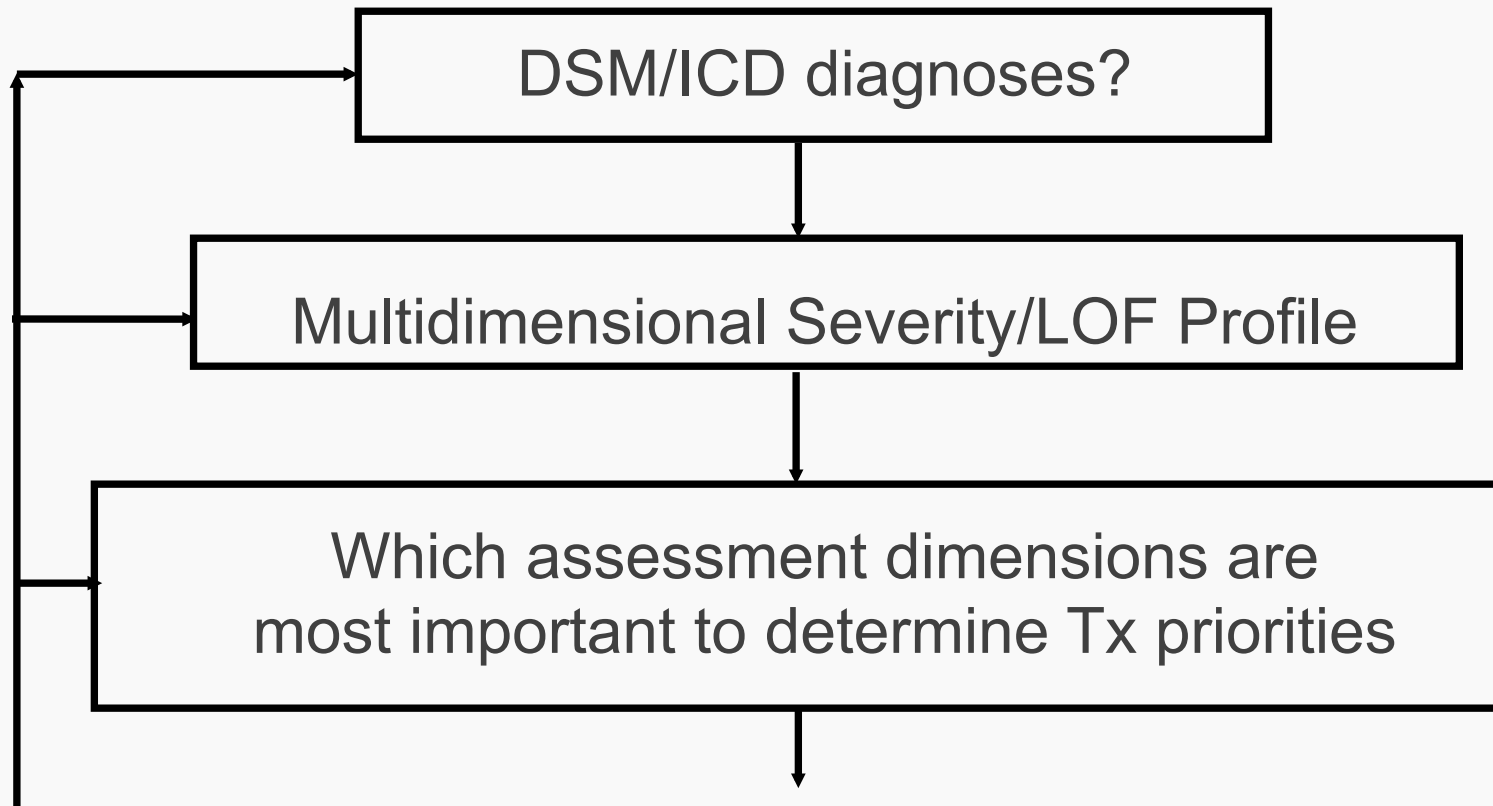
	<u>Client</u>	<u>Clinical Assessment</u>	<u>Treatment Plan</u>
<u>WHAT?</u>	What does client want?	What does client need?	What is the treatment contract?
<u>WHY?</u>	Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment date?	Is it linked to what client wants?
<u>HOW?</u>	How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
<u>WHERE?</u>	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
<u>WHEN?</u>	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?

Focus Assessment and Treatment



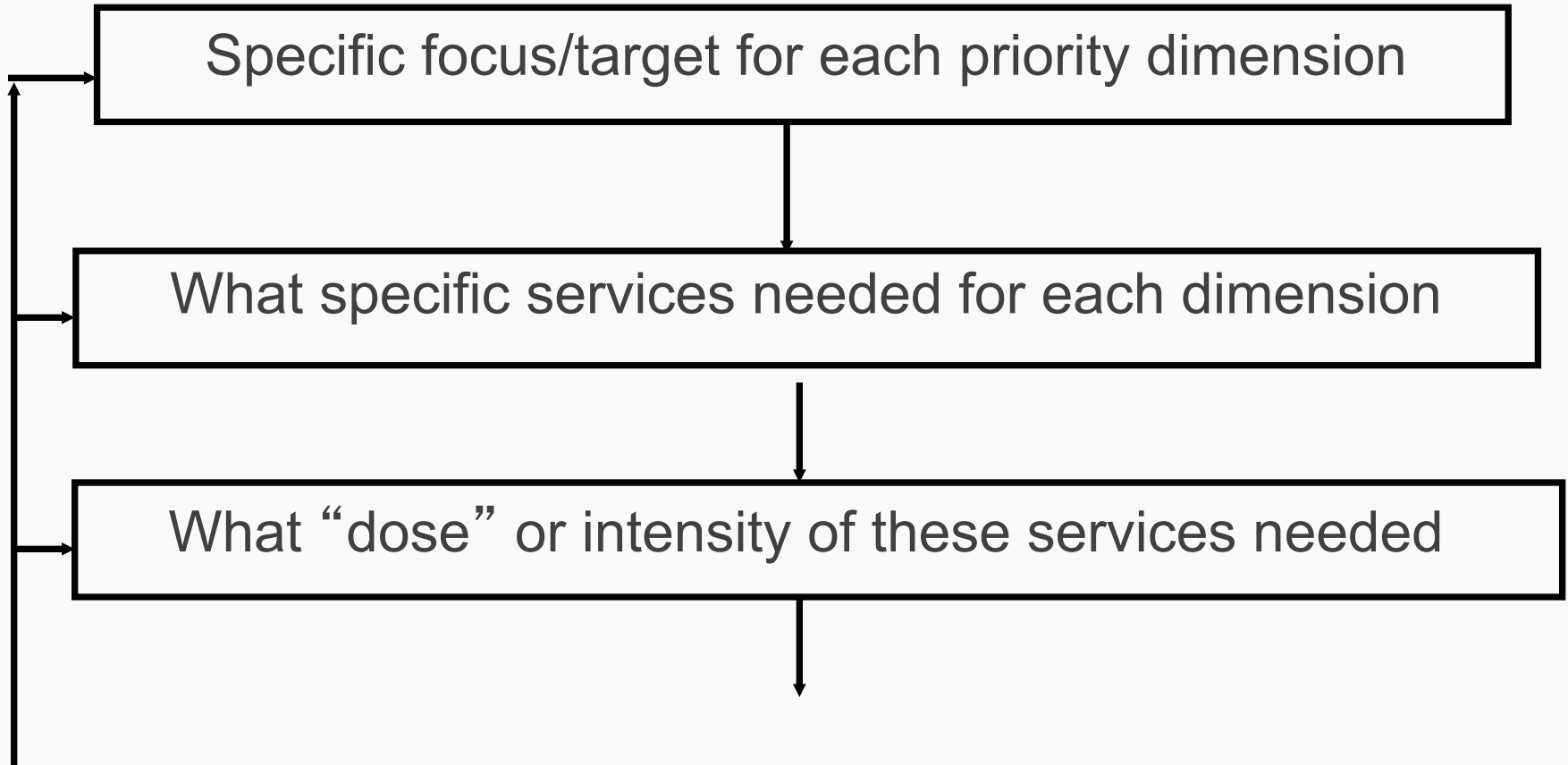
The ASAM Criteria p 124

Focus Assessment and Treatment (cont.)



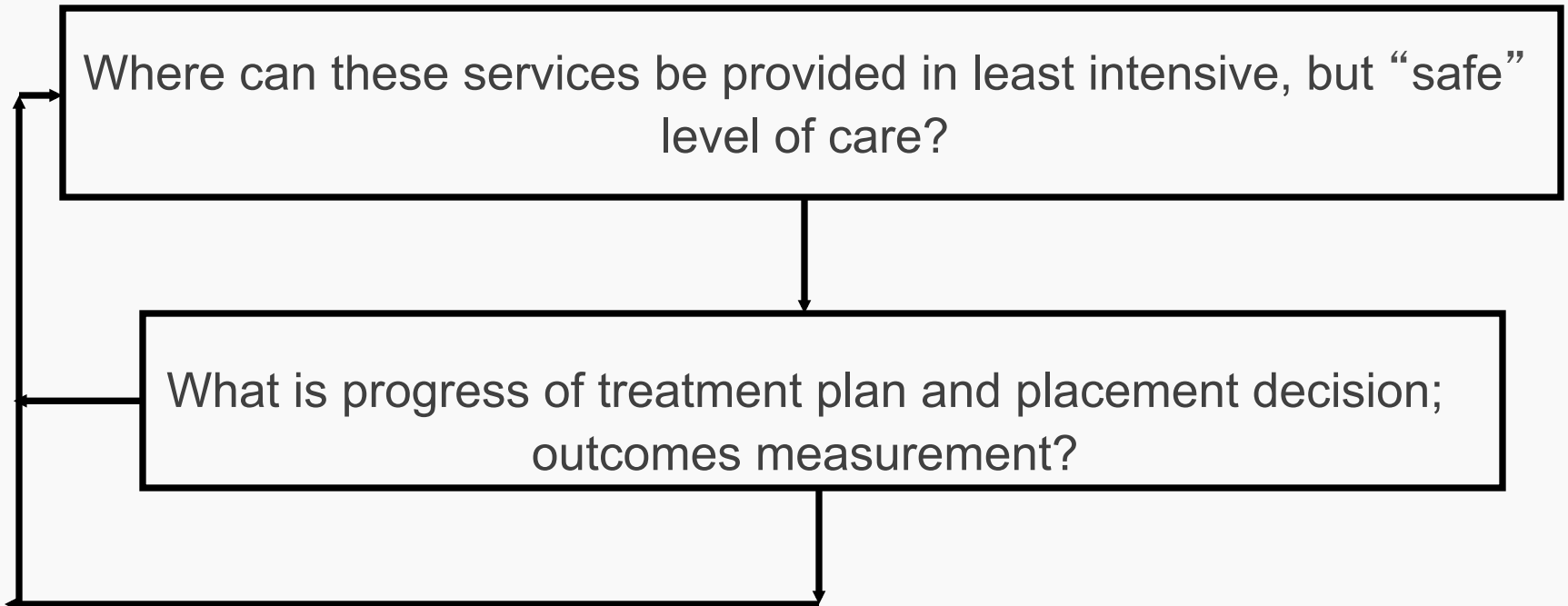
The ASAM Criteria p 124

Focus Assessment and Treatment (cont.)

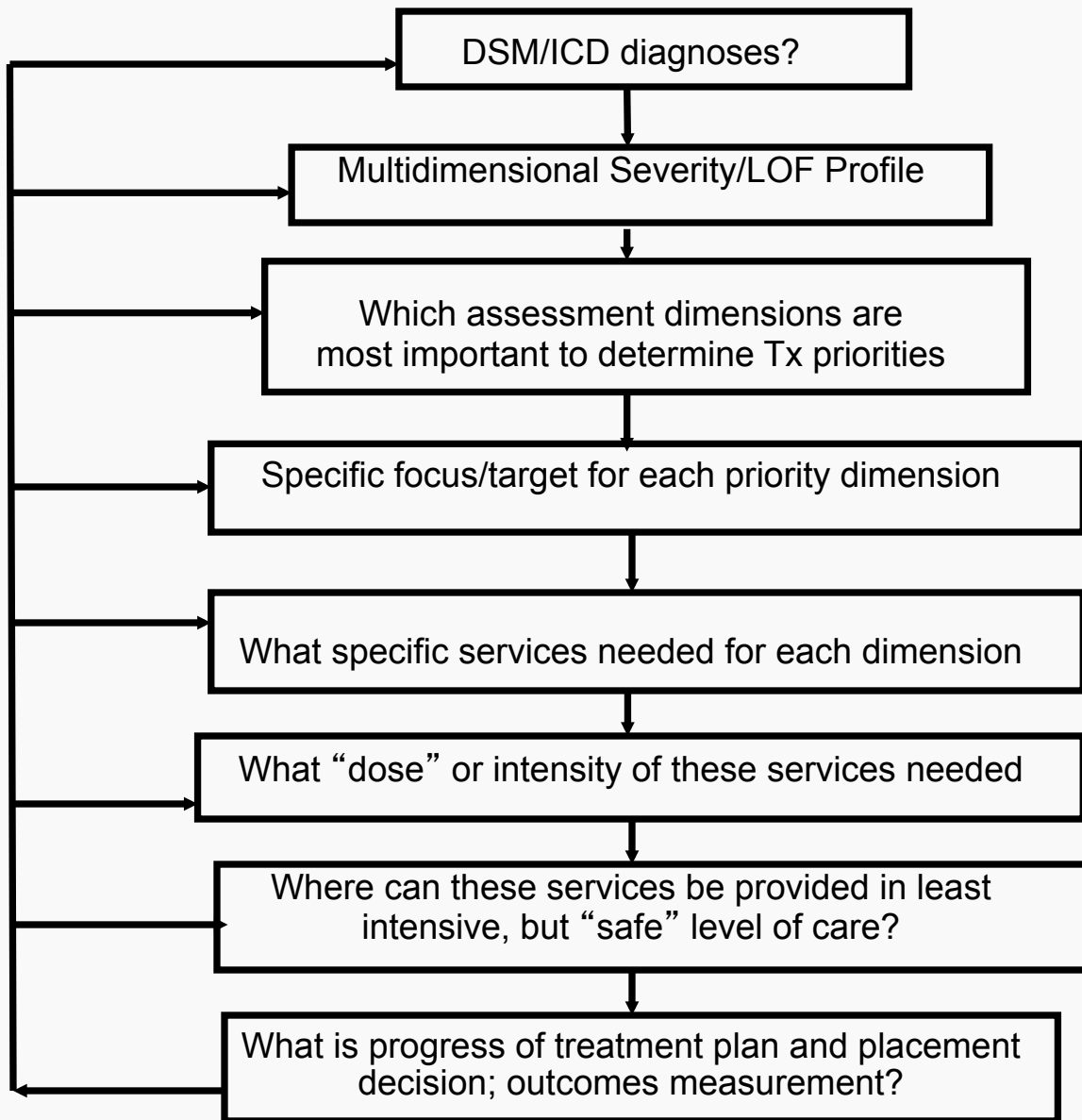


(The ASAM Criteria, 2013, p124)

Focus Assessment and Treatment (cont.)



The ASAM Criteria p 124



The ASAM Criteria p 124

Severity/LOF Assessment

The 3 H' s

HISTORY

HERE AND NOW

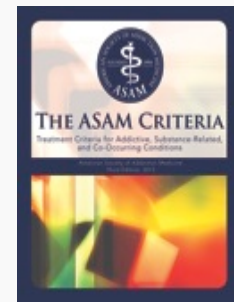
HOW WORRIED NOW

(The ASAM Criteria, 2013, p. 56)

Rating Risk

RISK RATING	4	This rating would indicate issues of utmost severity . The patient would present with critical impairments in coping and functioning, with signs and symptoms, indicating an “imminent danger” concern.	HIGH
	3	This rating would indicate a serious issue or difficulty coping within a given dimension. A patient presenting at this level of risk may be considered in or near “imminent danger.”	
	2	This rating would indicate moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills or support systems may be present.	MODERATE
	1	This rating would indicate a mildly difficult issue , or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.	
	0	This rating would indicate a non-issue or very low-risk issue . The patient would present no current risk and any chronic issues would be mostly or entirely stabilized.	LOW

ASAM Criteria Book pg. 74-89



Continued Service Criteria (ASAM Criteria)

Retain at the present level of care if:

1. Making progress, but not yet achieved goals articulated in individualized treatment plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals;

or

(The ASAM Criteria, 2013, p.300)

Continued Service Criteria (ASAM Criteria) (cont.)

2. Not yet making progress but has capacity to resolve his or her problems. Actively working on goals articulated in individualized treatment plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals;
and/or

(The ASAM Criteria, 2013, p.300)

Continued Service Criteria (ASAM Criteria) (cont.)

3. New problems identified that appropriately treated at present level of care. This level is least intensive at which patient's new problems can be addressed effectively.

(The ASAM Criteria, 2013, p.300)

Discharge/Transfer Service Criteria (ASAM Criteria)

Transfer or discharge from present level of care if he or she meets the following criteria:

1. Has achieved goals articulated in his or her individualized treatment plan, thus resolving problem(s) that justified admission to current level of care;

or

(The ASAM Criteria, 2013, p.303)

Discharge/Transfer Service Criteria (ASAM Criteria) (cont.)

2. Has been unable to resolve problem(s) that justified admission to present level of care, despite amendments to treatment plan. Treatment at another level of care or type of service therefore is indicated;
or

(The ASAM Criteria, 2013, p.303)

Discharge/Transfer Service Criteria (ASAM Criteria) (cont.)

3. Has demonstrated lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated; or

(The ASAM Criteria, 2013, p.303)

Discharge/Transfer Service Criteria (ASAM Criteria) (cont.)

4. Has experienced intensification of his or her problem(s), or has developed new problem(s), and can be treated effectively only at a more intensive level of care

(The ASAM Criteria, 2013, p.303)

Models of Stages of Change

- 12-Step model - surrender versus comply; accept versus admit; identify versus compare
- Transtheoretical Model of Change - Pre-contemplation; Contemplation; Preparation; Action; Maintenance; Relapse and Recycling; Termination
- Readiness to Change - not ready, unsure, ready, trying, doing what works

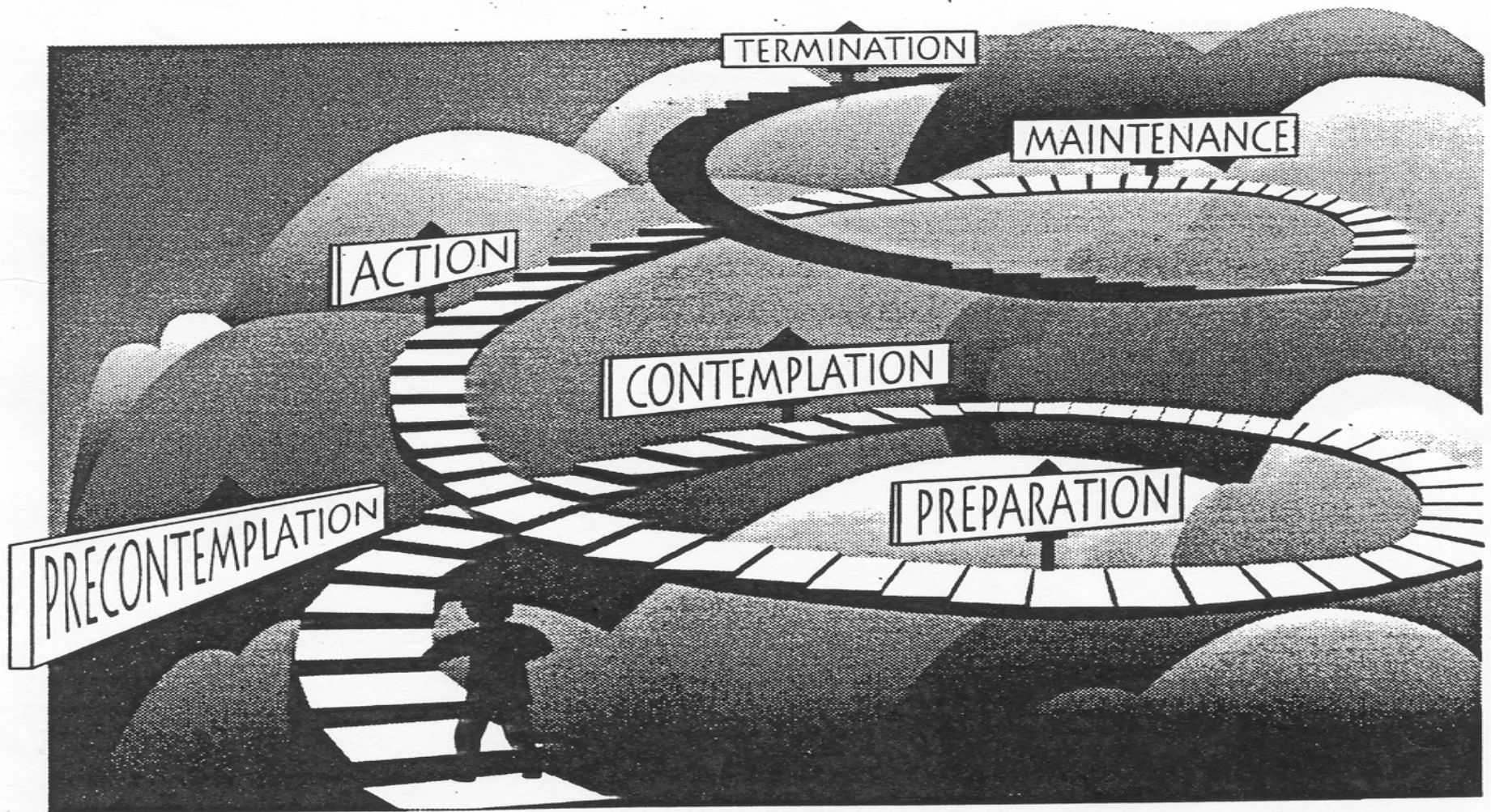


FIGURE 1. The Spiral of Change

Transtheoretical Model of Change – Spiral of Change figure from:
Prochaska, JO; Norcross, JC; DiClemente, CC (1994): “Changing For Good” Avon Books, New York

Revised Constructs for Dim. 5

- A. Historical Pattern of Use or Mental Health Problems
 - 1. Chronicity of Problem Use or MH problems
 - 2. Treatment or Change Response

- B. Pharmacologic Responsivity
 - 3. Positive Reinforcement (pleasure, euphoria)
 - 4. Negative Reinforcement (withdrawal discomfort, fear)

(The ASAM Criteria, 2013, pp..403 - 407)

Revised Constructs for Dim. 5 (cont.)

- 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

Revised Constructs for Dim. 5 (cont.)

- D. Cognitive and behavioral measures of strengths and weaknesses (cont.)
 - 8. Coping Skills (stimulus control, other cognitive strategies)
 - 9. Impulsivity (risk-taking, thrill-seeking)
 - 10. Passive and passive/aggressive behavior

Recovery and Psychosocial Crises

- Slips/using substances while in treatment
- Suicidal – impulsive or wanting to use
- Loss or death – cravings or impulsive
- Disagreements, anger, frustration with fellow clients or therapist

(The ASAM Criteria, 2013, pp.407 - 409)

Policy and Procedure

Implements principle of re-assessment and modification of treatment plan:

1. Face to face or telephone appointment ASAP.
2. Attitude of acceptance; listen for patient's point of view, rather than lecture, enforce "program rules"; or dismiss their perspective.
3. Assess safety and immediate needs in all six ASAM assessment dimensions.

(The ASAM Criteria, 2013, pp.407 - 409)

ASAM Six Assessment Dimensions

1. Acute Intoxication and/or Withdrawal Potential
2. Biomedical Conditions and Complications
3. Emotional, Behavioral or Cognitive Conditions and Complications
4. Readiness to Change
5. Relapse/Continued Use, Continued Problem Potential
6. Recovery Environment

The ASAM Criteria (2013) Pages 43-53



Policy and Procedure (cont.)

4. Discuss circumstances surrounding the crisis, develop a sequence of events/precipitants.
5. Modify participatory treatment plan to address new or updated problems.
6. Reassess treatment contract and what patient wants if any lack of interest in modifying Tx. Plan.
7. Determine if modified strategies need same level of care; or more or less intense level.

(The ASAM Criteria, 2013, pp.407 - 409)



Policy and Procedure (cont.)

8. If patient recognizes the problem/s; understands need to change, but still chooses no further treatment, then discharge.
9. If patient is invested in treatment, then Tx. Continues.
10. Document crisis and modified treatment plan or discharge in the medical record.

(The ASAM Criteria, 2013, pp.407 - 409)

Proximal and Distal Goals

- Traditionally: Abstinence is a “distal” goal for participants with addiction (dependence – they need treatment); but a “proximal” goal for those with Substance Abuse (assumes substance use is voluntary)
- Traditionally: Those with complex needs, “regimen compliance” is “proximal” goal. Better still “treatment adherence”
- Traditionally: Increase treatment for substance use early in treatment for participants with addiction; but punish with sanctions once engaged in treatment and some sustained sobriety
- Traditionally: For non-addicted participants, use escalating sanctions in initial phases to end voluntary use and not “reward” use

Proximal and Distal Goals (cont.)

This all based on a behavior modification approach when addiction is biopsychosocial-spiritual disease

- If participant has addiction, treatment is needed. If not, education, risk advice and escalating legal consequences (like speeding fines and DUI)
- Abstinence is a “proximal” or “distal” goal for participants with addiction depending on their stage of change regarding abstinence assessed in treatment
- Use escalating sanctions in initial and/or later phases of treatment for lack of good faith effort in treatment. Don't sanction for signs and symptoms of addiction flare-ups and poor outcomes.

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 their addiction and/or mental illness.
2. Treatment provider responsible to keep court apprised of level of active engagement, not just passive compliance with attendance and positive or negative drug screens.

From Punishment to Lasting Change – Implications for Sanctions and Incentives

3. If client is not changing their treatment plan in positive direction client is “doing time” not “doing treatment and change.
4. Incentives for clients can be explored/matched to what is most meaningful to them.
5. A close working relationship between client, judge, court team and treatment providers needed to actualize this approach.

Data to Identify Gaps

- Systems issues cannot change quickly. Each incident of inefficient or inadequate care can be a data point that promotes systems change
- Finding efficient ways to gather data as it happens in daily care of clients can provide hope, direction for change

(The ASAM Criteria, 2013, p. 126)

Data to Identify Gaps (cont.)

PLACEMENT SUMMARY

Level of Care/Service Indicated	
Level of Care/Service Received	

(The ASAM Criteria, 2013, p. 126)

Data to Identify Gaps (cont.)

PLACEMENT SUMMARY

Reason for Difference - Circle only one number -- **1.** Level of care or Service not available; **2.** Provider judgment; **3.** Client preference; **4.** Client is on waiting list for appropriate level/service; **5.** Level of care or Service available, but no payment source; **6.** Geographic inaccessibility etc.

(The ASAM Criteria, 2013, p. 126)

Data to Identify Gaps (cont.)

PLACEMENT SUMMARY

Anticipated Outcome If Service Cannot Be Provided-

Circle only one number -- 1. Admitted to acute care setting; 2. Discharged to street; 3. Continued stay in acute care facility; 4. Incarcerated; 5. Client will dropout until next crisis; 6. Not listed (Specify):

(The ASAM Criteria, 2013, p. 126)

Resources

“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>

DiClemente CC (2006): “Natural Change and the Troublesome Use of Substances – A Life-Course Perspective” in *Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It*. Ed. William R Miller and Kathleen M. Carroll. Guildford Press, New York, NY. pp 91; 95.



Resources (cont.)

Engel GL (1977): The need for a new medical model: a challenge for biomedicine. *Science* 196:129-136.

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.ht>

“Disease Model of Addiction versus – Biopsychosocial Model of Addiction” August 9, 2010

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