

Co-Occurring Disorders – Breakout Session

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Goals of this Presentation

Review:

- How to access relevant resources
- Challenges in addressing CODs
- Core components of COD treatment and supervision for offenders

Resources

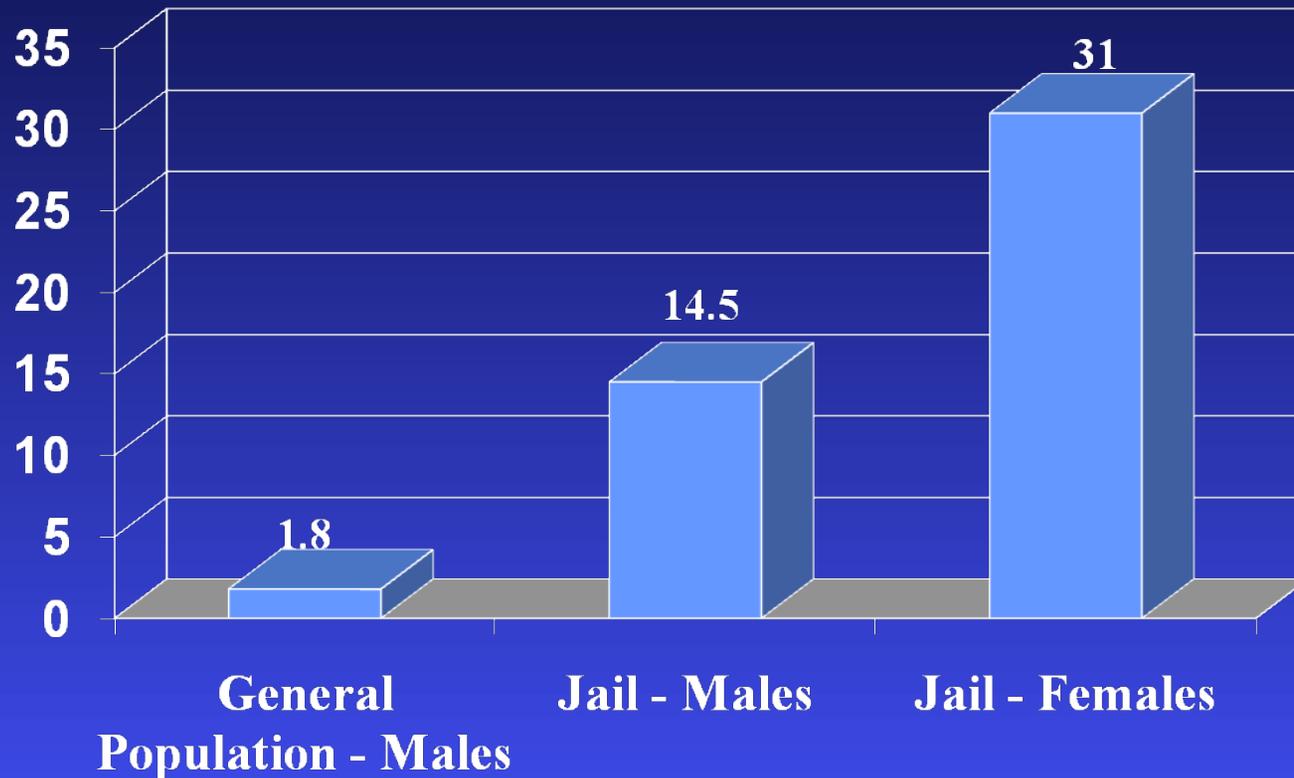
- CSAT TIP #42 and #44
- Co-Occurring Disorders Initiative (CODI)
- CMHS National GAINS Center
- CMHS Toolkit – CODs/IDDDT
- Council of State Governments
- NIDA

Defining “Co-Occurring Disorders”

The presence of at least two disorders:

- A substance abuse or dependence disorder
- A DSM-IV major mental disorder, usually Major Depression, Bipolar Disorder, or Schizophrenia

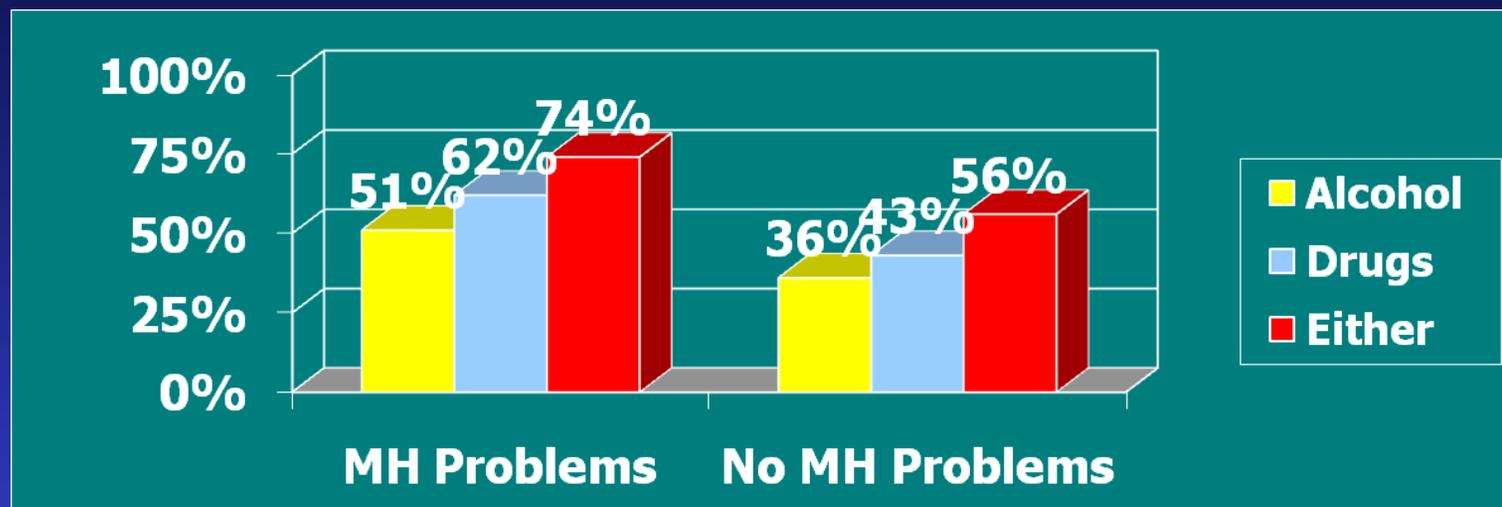
Mental Disorders in Jails (%)



□ Any Serious Mental Disorder

(GAINS Center, 2004;
Steadman et al., 2009)

Co-Occurring Substance Use Disorders



74% of state prisoners with mental problems also have substance abuse or dependence problems

(U.S. Department of Justice, 2006)

Juveniles and CODs

- Over half of juveniles have multiple disorders
 - 61% have co-occurring substance use disorders
- 27% have disorders requiring immediate treatment

Offenders with CODs

- Repeatedly cycle through the criminal justice and treatment systems
- Experience problems when not taking medications, not in treatment, experiencing mental health symptoms, using alcohol or drugs
- Small amounts of alcohol or drugs may trigger recurrence of mental health symptoms
- Antisocial beliefs similar to other offenders
- More criminal risk factors than other offenders

Relapse Factors and CODs

- The most common cause of mental illness relapse is substance abuse
- The most common cause of substance abuse relapse is untreated mental illness
- Criminal thinking triggers substance abuse relapse

Clinical Considerations

- Cognitive impairment
- Reduced motivation
- Impairment in social functioning

(Bellack, 2003)

Elements of Cognitive Impairment

- Difficulty comprehending or remembering important information (e.g., verbal memory)
- Not recognize consequences of behavior (e.g., planning abilities)
- Poor judgment
- Disorganization
- Limited attention span
- Not respond well to confrontation

Traditional MH Services are not Effective for Offenders with CODs

- **Unaddressed and ongoing SA interferes** with individuals' ability to follow MH treatment recommendations
- Active substance use **interferes with effectiveness** of MH treatment (i.e., medications, etc.)
- MH treatment may not focus on **changing substance use** and other maladaptive behaviors

Traditional SA Services are not Effective for Offenders with CODs

- **Absence of accurate MH diagnosis** prevents effective treatment
- **Cognitive impairment** detracts from understanding and processing information
- **Confrontational approaches** used in SA treatment are not well tolerated
- **Frustration and dropout** may result from requirements of abstinence

Traditional Supervision Approach is Ineffective for Offenders with CODs

- **Large caseloads** discourage responsive and individualized approach to CODS
- **Authoritarian and confrontational approach** less effective with CODs
- **Focus on sanctions** vs. problem-solving, use of low revocation thresholds
- Inconsistent engagement and monitoring in **SA and MH treatment**
- Absence of **specialized COD training**

Screening for CODs

- Routine screening for both sets of disorders
- Criminal risk level
- Acute MH and SA symptoms:
 - Suicidal thoughts and behavior
 - Depression, hallucinations, delusions
 - Potential for drug/alcohol withdrawal
 - History of MH treatment including use of meds
- Determine need/urgency for referral

Challenges in Selecting Screening Instruments

- **Proliferation** of screening instruments
- Use of **non-standardized instruments**
- Instruments **not validated in CJ settings**
- Absence of **comparative data**
- **Direct to consumer marketing** of instruments with poor psychometric properties (e.g., SASSI)

Screening - Mental Health

- Brief Jail Mental Health Screen
- Mental Health Screening Form – III
- MINI – M
- CODSI (Sacks et al, 2007)
- GAIN - SS

Screening - Substance Abuse

- Simple Screening Instrument
- TCU Drug Screen – II
- ASI – Alcohol and Drug Abuse sections
- GAIN - SS

Screening - Trauma and PTSD

- Clinician-Administered PTSD Scale for DSM-IV
- Impact of Events Scale
- Primary Care PTSD Screen
- PTSD Checklist – Civilian Version
- Trauma Symptom Inventory

Specialized Screens

- **BASIS-24**
- **Centre for Addiction and Mental Health
Concurrent Disorders Screener (CAMH-CDS)**
- **Psychiatric Diagnostic Screening Questionnaire
(PDSQ)**

Instruments for Adolescents

- **CAFAS**
- **GAIN**
- **MAYSI-2**
- **PESQ**
- **POSIT**

Assessment Considerations

- Substance abuse can **mimic** all major mental health disorders
- Several strategies will help to gauge the potential effects of SA on MH disorders
 - Use **drug testing** to verify abstinence
 - Take a longitudinal history of MH and SA **symptom interaction**
 - Compile **diagnostic impressions** over a period of time
 - **Repeat assessment** over time

Placement Issues and CODs

- Excluding persons with CODs is NOT a viable option
- How to determine eligibility for services?
- Triage to specialized COD services
- Target moderate to high criminal risk levels

Factors Affecting Eligibility and Triage to Services

- Severity of mental disorder
- Criminogenic needs (e.g., antisocial beliefs, peers)
- Functional abilities
- Motivation for recovery and “stage of change”
- Available program resources

Treatment Targets

- Mental disorders
- Substance use disorders
- Criminal thinking
- Prosocial peer supports
- Educational/vocational skills
- Family stabilization
- Reentry

Evidence-Based Interventions

- Integrated treatment for CODs (IDDT)
- Cognitive-behavioral treatment
- Trauma-focused treatment
- Illness self-management
- Motivational enhancement
- Contingency management

Evidence-Based Interventions

- Family psychoeducation
- Assertive Community Treatment
- Medications
- Supported employment
- Specialized community supervision

Key Features of COD Treatment Programs

- Highly structured therapeutic approach
- Destigmatize mental illness
- Focus on symptom management vs. cure
- Education regarding individual diagnoses and interactive effects of CODs
- “Criminal thinking” groups
- Basic life management and problem-solving skills

Structural Features of Offender Treatment Programs

- Therapeutic communities
- Isolated treatment units
- Program phases
- Blending of MH and SA services
- Assessment
- Specialized mental health services
- Transition and reentry services

Stage-Specific Treatment

- People with CODs who have had contact with the CJ system come to treatment with varying degrees of **readiness and motivation**
- Assessment of individuals' stages of change is valuable in treatment planning
- Allows development of **stage-specific treatment** for co-occurring disorders
- Interventions are more likely to address goals that are valued by the individual

COD Program Phases

- Orientation
- Intensive treatment
- Relapse prevention/transition

Trauma and Victimization

- Over 90% of female offenders have experienced physical or sexual violence
- One third will develop PTSD symptoms
- Impact of violence is widespread, can impair recovery from MH and SA disorders

Treatments for Trauma and Substance Abuse

- Seeking Safety (Najavits, 2002)
- Trauma Recovery and Empowerment (TREM) (Harris, 1998)
- Treating concurrent PTSD and cocaine dependence (Brady et al., 2001)
- Substance Dependence Posttraumatic Stress Disorder Therapy (Triffleman, et al., 1999)

Pharmacological Interventions

- Medications are routinely and effectively prescribed for individuals with CODs
- Medications serve to successfully:
 - Decrease drug **cravings**
 - Reduce **reinforcing effects** of drugs
 - Assist in **acute withdrawal**

Pharmacological Interventions

- Abuse of illicit drugs and alcohol can **impair the action of medications**
- **Toxic effects** can occur if alcohol or illicit drugs are used while taking certain medications (e.g., lithium, tricyclic antidepressants, MOI inhibitors)
- Medications with **addictive potential** should be avoided, or used with caution

Peer Support Interventions

- Traditional 12-step programs have **not always meshed well** with the needs of individuals with co-occurring disorders
- 12-step models such as AA and NA have been **adapted for co-occurring disorders**
- **“Double Trouble”** and similar groups have been developed throughout the U.S.

Key Transition Services

- Development of **re-entry or transition plan**
- Assistance to engage in **community-based SA and MH treatment**
- Engagement in **peer support and self-help networks** to assist in recovery
- Stable **housing**
- **Vocational training** and employment support
- **Case management** and community supervision

The APIC Model

- Assess clinical and social needs and risk level
- Plan for treatment and services
- Identify required community programs
- Coordinate the transition plan services

(Osher, Steadman, & Barr, 2002)

APIC Reentry Checklist: Primary Domains

- ◆ Mental health services
- ◆ Psychotropic medications
- ◆ Housing
- ◆ Substance abuse services
- ◆ Health care/benefits
- ◆ Income/benefits
- ◆ Food/clothing
- ◆ Transportation
- ◆ Other

Community Supervision

- **Specialized caseloads** (MH/COD)
- **Smaller caseloads** (e.g., < 45)
- Active engagement in **SA and MH treatment**
- **Dual focus** on treatment and surveillance

Community Supervision

- **Problem-solving approach**

- Higher revocation threshold
- Wide range of incentives and sanctions
- Flexibly apply sanctions
- Avoid sanctions that remove participants from treatment
- Relationship quality important (trust, caring-fairness, avoid punitive stance) – “firm but fair”

Community Supervision

- Sustained and specialized **officer training**
- **Improved outcomes** – lower rates of revocation, arrest, and incarceration (Skeem et al., 2009)