

Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders

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SAMHSA'S GAINS Center EBP Webinar Series
April 8, 2014

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Introduction to Discussion

- ▶ High prevalence of Co-occurring Disorders (COD) in criminal justice system
 - ▶ High rates of co-occurring dx in MI and SA populations
 - ▶ Poor outcomes associated with COD
 - ▶ Increased criminal activity associated with addiction and poverty (i.e. crimes of survival amongst homeless persons)
 - ▶ Increased arrests associated with COD
 - ▶ Poor services upon re-entry
- ▶ History of non-integrated responses to COD
- ▶ Increased interest in “integrated treatment” as an EBP



Case Example: Steve

- ▶ 28 years old
- ▶ Bipolar Disorder
- ▶ Crack/Heroin Use Disorders - severe
- ▶ Felony charge/ on parole
- ▶ Hepatitis C with elevated liver function tests
- ▶ Unemployed
- ▶ Living in shelter



Definition: Co-occurring Disorders

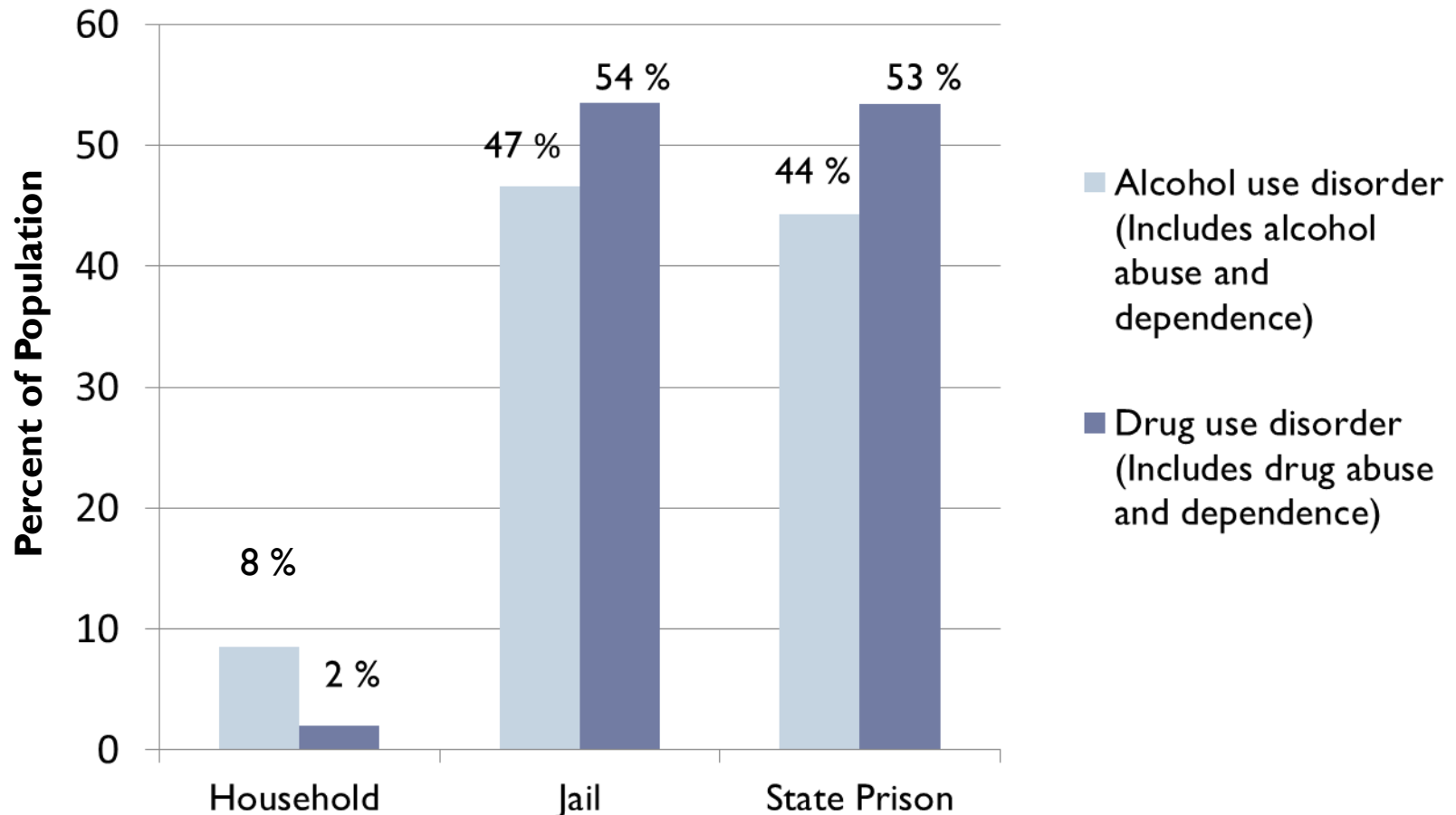
- ▶ The term refers to co-occurring substance use (abuse or dependence) and mental disorders.
- ▶ Clients said to have co-occurring disorders when at least one disorder of each type can be established independently of the other and is not simply a cluster of symptoms resulting from a single disorder.

COCE, 2007

Consequences of Co-occurring Disorders

- ▶ Increased vulnerability to relapse and re-hospitalization
- ▶ Housing instability and homelessness
- ▶ Non-adherence with medications and treatment
- ▶ Difficulty in managing finances
- ▶ Increased rates of physical illnesses
- ▶ Higher service utilization and costs
- ▶ Increased recidivism rates

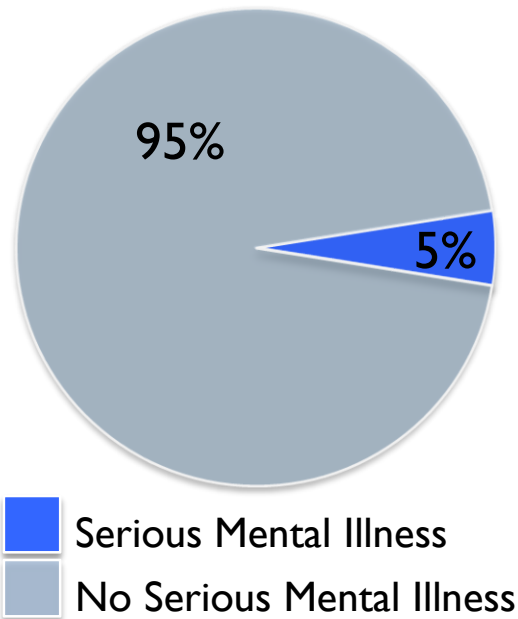
Substance Use Disorders in Criminal Justice Settings



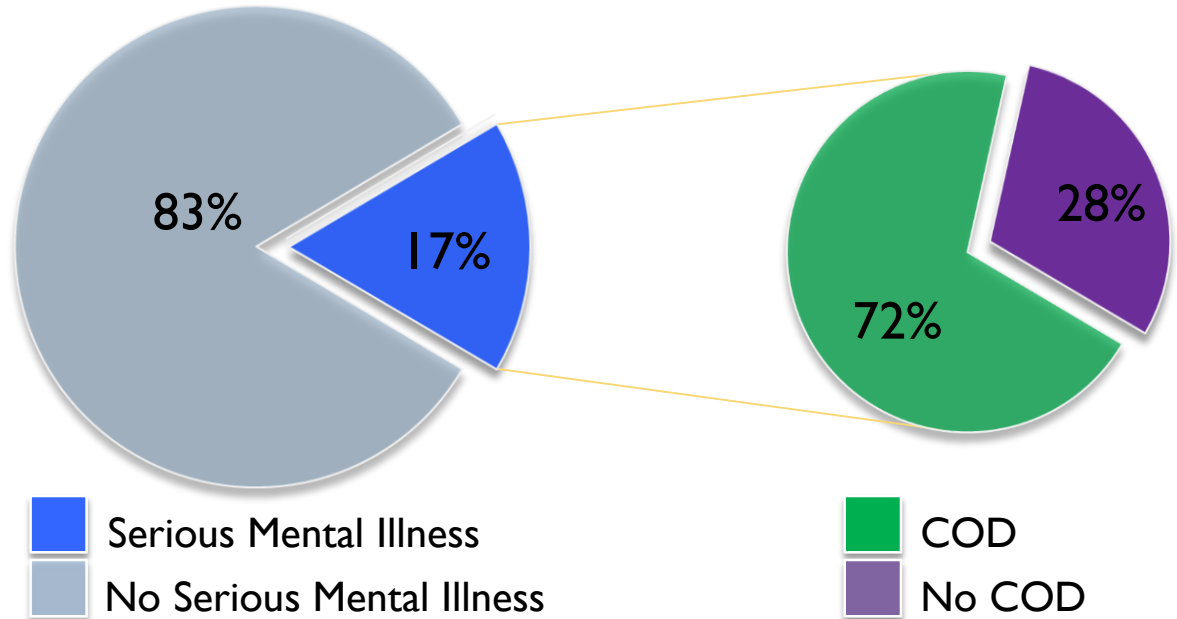
SMI and Co-Occurring Substance Use Disorders (CODs)

Prevalence of SMI and CODs in Jail Populations

General Population

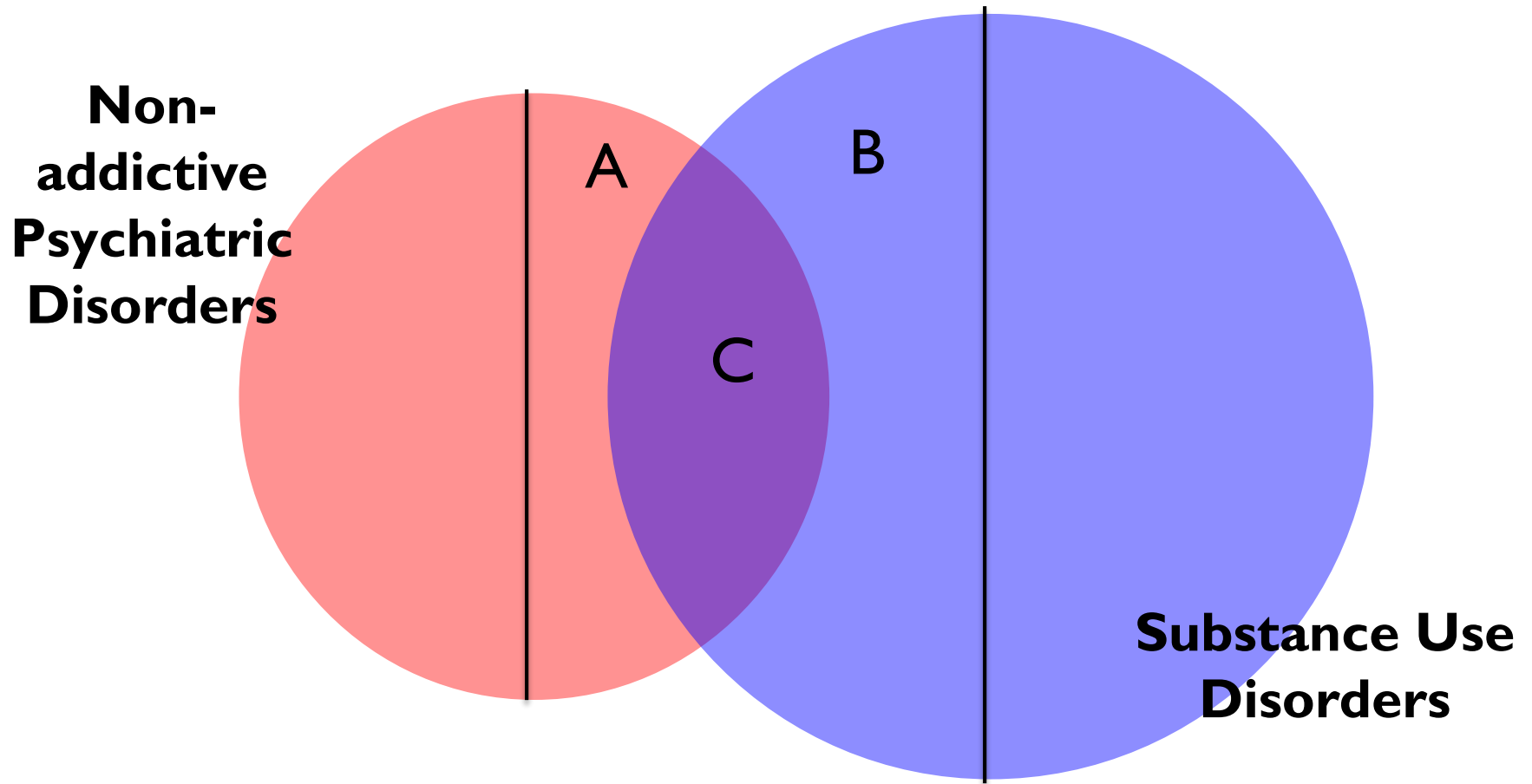


Jail Population

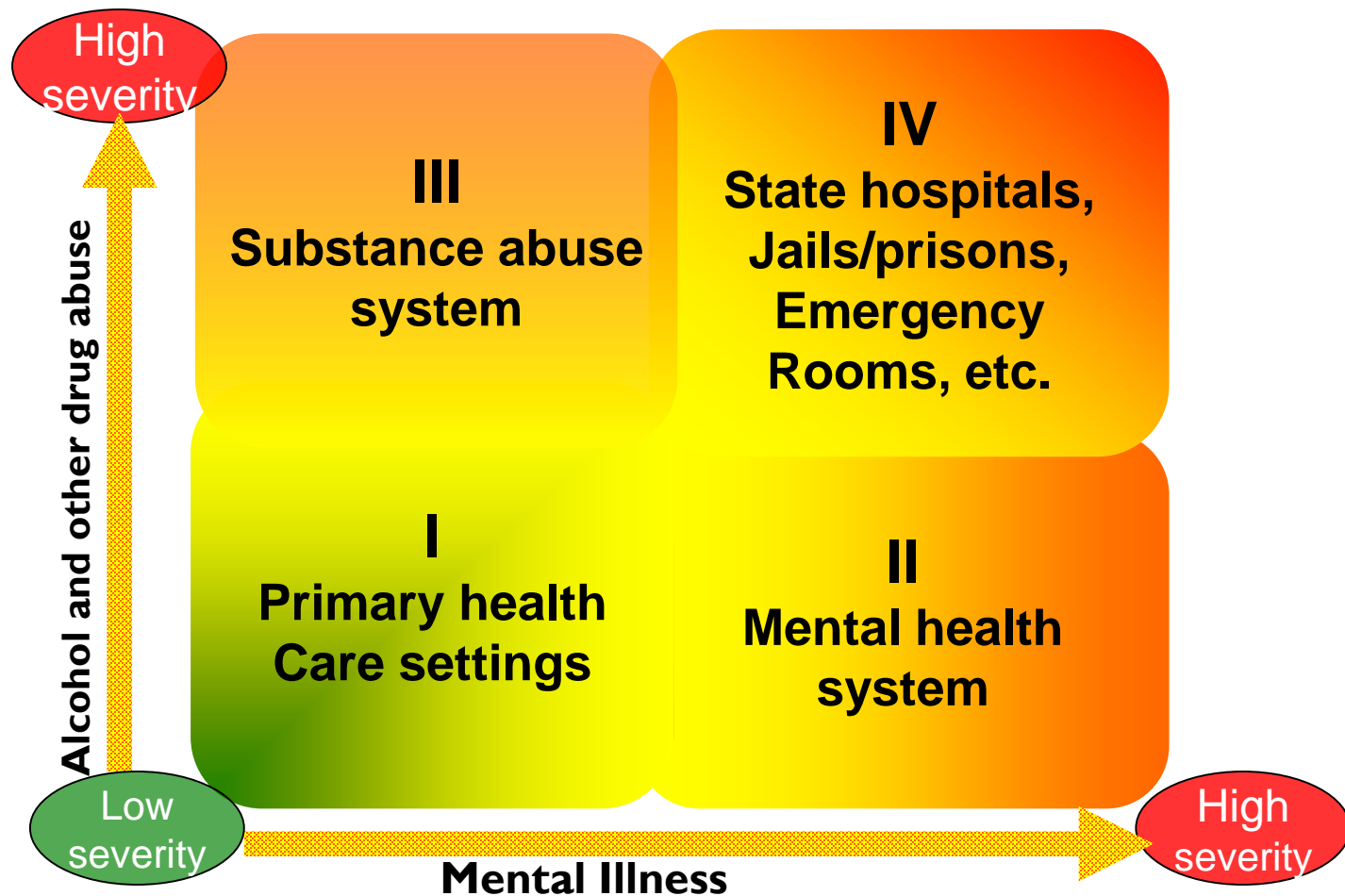


Sources: Kessler RC, Chiu WT, Demler O, Walters EE. "Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication" (NCS-R). *Archives of General Psychiatry*, 2005 Jun; 62 (6): 617-27; Henry Steadman, Fred C. Osher, Pamela C. Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services*, 60 (2009): 761-65; Abram, K. M., Teplin, L.A. (1991). "Co-occurring disorders among mentally ill jail detainees," *American Psychologist*, 46 (10), 1036-1045.

Co-occurring Mental and Addictive Disorders

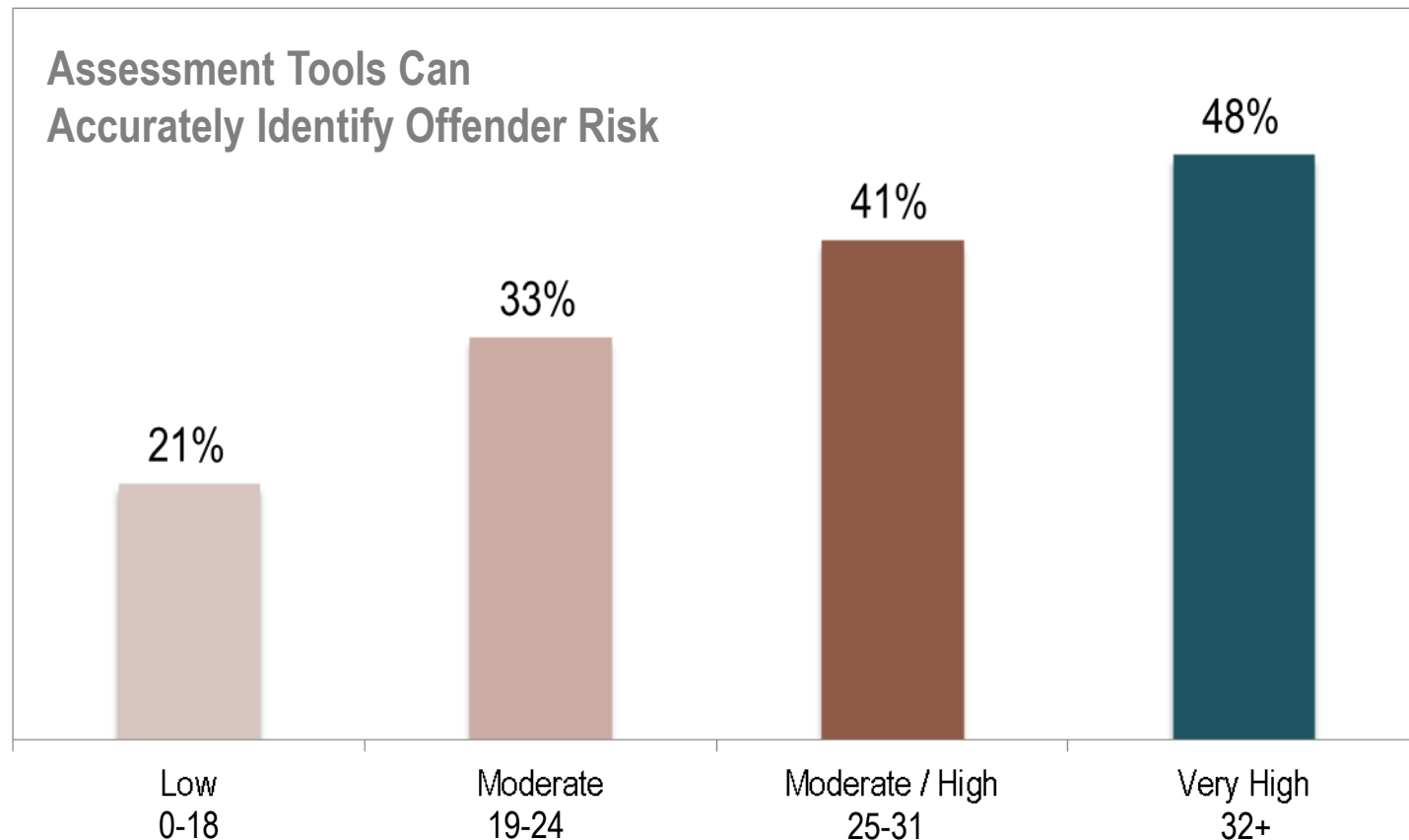


Heterogeneity of the Population with Co-occurring Disorders



Criminal Justice Risk on a Continuum

Rates of Failure Across LSI-R Categorization: Kansas Department of Corrections



ADULTS WITH **BEHAVIORAL HEALTH NEEDS** UNDER CORRECTIONAL SUPERVISION:

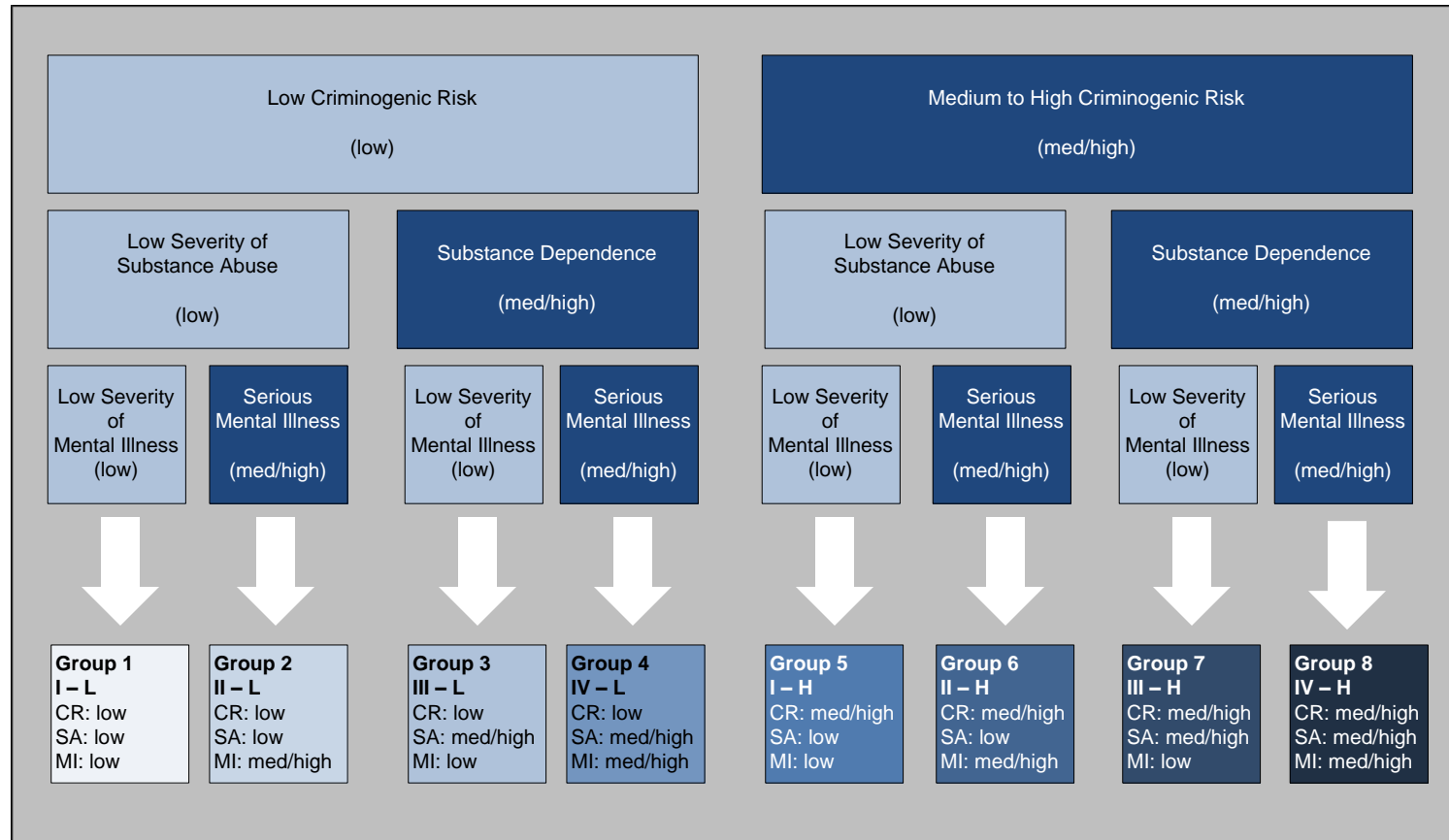
A Shared Framework for Reducing Recidivism and Promoting Recovery



Bureau of Justice Assistance
U.S. Department of Justice



A Framework for Prioritizing Target Population



The Goal: Universal Screening

- ▶ All individuals presenting for treatment of a substance use disorder should be routinely screened for any co-occurring mental disorders.
- ▶ All individuals presenting for treatment of a mental disorder should be screened routinely for any co-occurring substance use disorders.
- ▶ All individuals booked into jails should be screened for both mental and substance use disorders AND criminogenic risk.

Features of Screening Instruments

- ▶ High sensitivity (but not high specificity)
- ▶ Brief
- ▶ Low cost
- ▶ Minimal staff training required
- ▶ Consumer friendly

Some Recommended Screening Instruments for COD

- ▶ Mental Health Screening Form – III
- ▶ Simple Screening Instrument for Substance Abuse (SSI-SA)
- ▶ Global Appraisal of Individual Needs - Short Screener

Corrections Specific Instruments

- ▶ Brief Jail Mental Health Screen
- ▶ Texas Christian University Drug Screen - II
- ▶ Co-Occurring Disorder Screening Instrument (CODSI)

Assessment for Co-occurring Disorders

- ▶ Goals of a Basic Behavioral Health Assessment
 - ▶ Gathering key information
 - ▶ Enable the counselor/therapist to understand the client
 - ▶ Determine readiness for change
 - ▶ Discover problem areas
 - ▶ Determine COD diagnoses
 - ▶ Identify disabilities, and strengths.

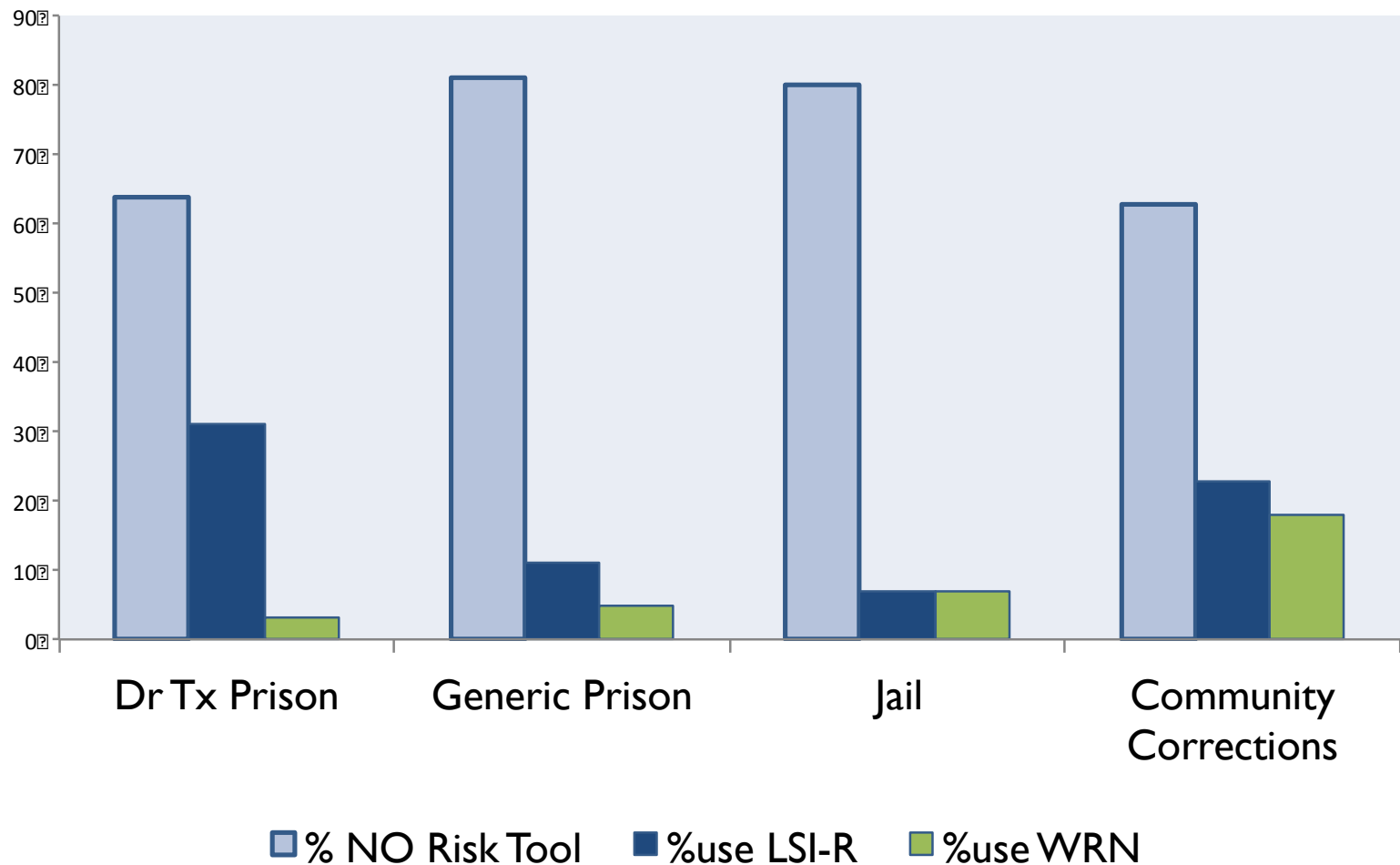
The “Best” Assessment Tool

Assessment for Criminogenic Risk

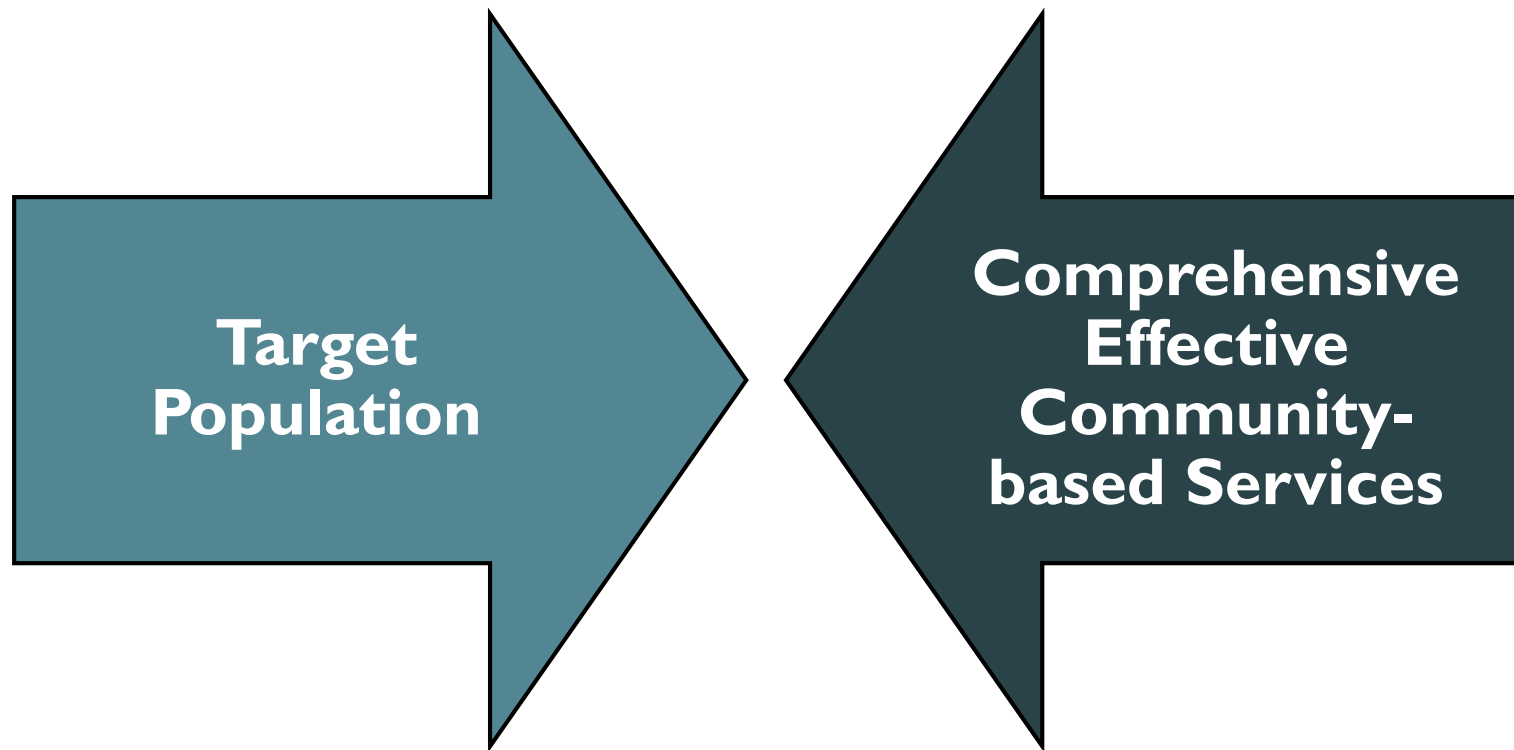
..... the goal of risk assessment is not simply to predict the likelihood of recidivism, but, ultimately, to reduce the risk of recidivism. To do so, the information derived during the risk assessment process must be used to guide risk management and rehabilitation efforts.

Desmarais et al, 2013

Risk Assessment Tools: Few In Practice



Two Critical Components



Hypothesis for Justice Involved Persons with COD

Interventions (at the program or provider level) that reduce substance use (licit and illicit), mitigate criminogenic risks, and improve levels of functioning in persons with COD ...

will reduce both their frequency of involvement with the justice system and their time spent in justice settings or under correctional supervision.

Principles

1. Integrated treatment
2. Individualized treatment planning
3. Assertiveness
4. Close monitoring
5. Longitudinal perspective/Stages of Change
6. Harm Reduction Strategies
7. Employ Evidence Based Practices
8. Stable living situation
9. Cultural competency and consumer centeredness
10. Optimism



1. Integrated treatment

- ▶ Traditional models of treatment for homeless persons with dual disorders results in poor outcomes
- ▶ Integrated treatment associated with better outcomes
- ▶ Supported by integrated systems of care
- ▶ Need to bring in housing, health, and other service arenas
- ▶ Integrated Dual Disorders Treatment to be discussed as an evidence based practice

Components of Integrated Treatment

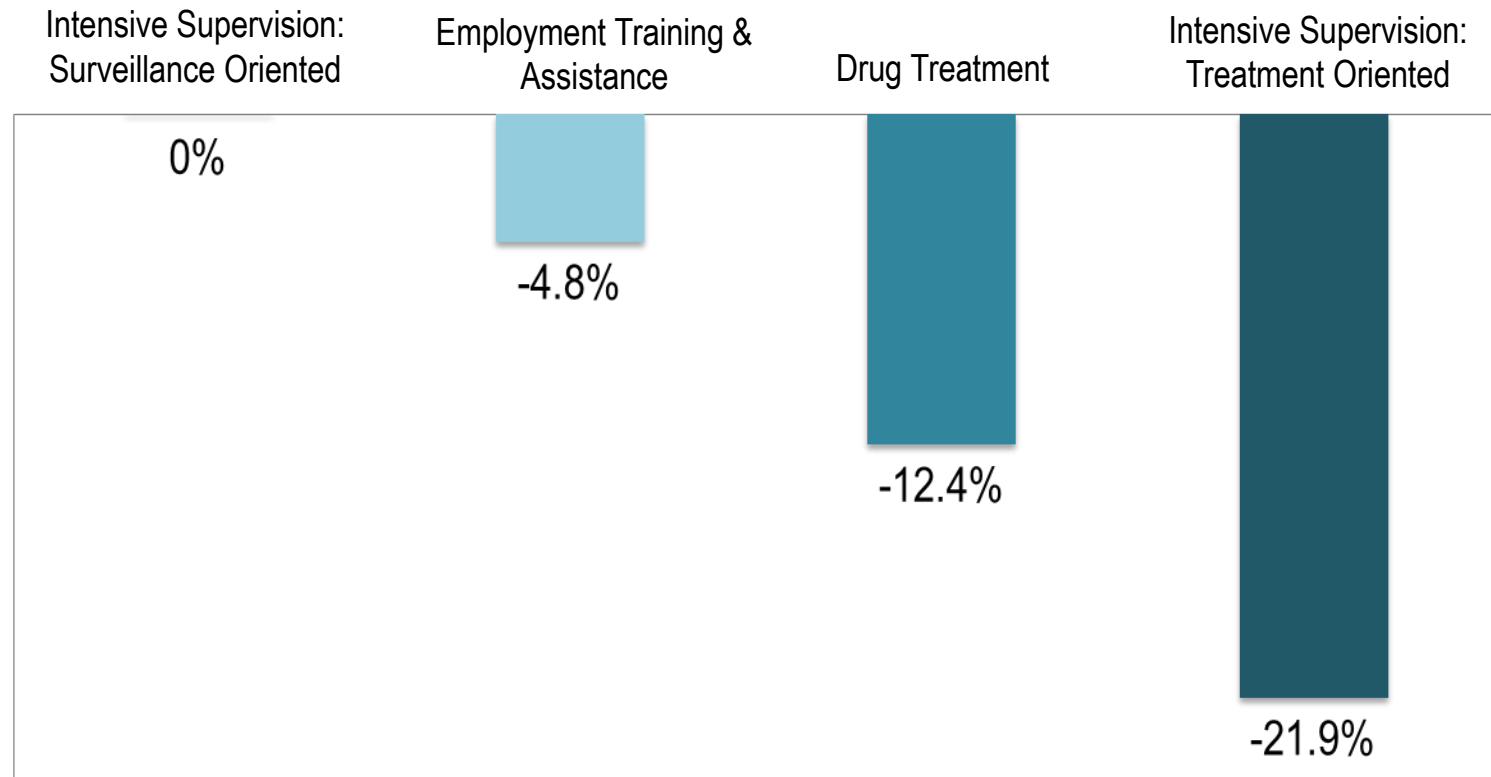
(IDDT Toolkit)

- ▶ Multidisciplinary Team
- ▶ Integrated Specialists
- ▶ Access to Comprehensive Services
- ▶ Time-Unlimited Services
- ▶ Outreach
- ▶ Pharmacologic Treatment
- ▶ Stage-Wise Interventions



Combining Treatment and Supervision Improves Outcomes

Changes in Recidivism Rates for Adult Offenders



2. Individualized treatment planning

- ▶ Treatment planning is derived from a comprehensive assessment
- ▶ Accurate assessment is difficult to do:
 - ▶ poor clinician assessment skills
 - ▶ lack of standardized instruments
 - ▶ inaccuracy of self-report
- ▶ Use of several approaches concurrently
- ▶ Assess for SA, MH, and Criminogenic Risk
- ▶ Longitudinal nature of assessments

3. Assertiveness

- ▶ Responsibility of systems to support outreach and engagement services
- ▶ Successful interventions:
 - ▶ “go wherever the client is”
 - ▶ work with family, landlords and employers
- ▶ Assertive Community Treatment (ACT) and FACT discussed as an evidence based practice
- ▶ Inherent in integrated supervision and treatment models

4. Close monitoring

- ▶ Intensive supervision needed until stable
- ▶ Sometimes coercive, always persuasive
 - ▶ representative payeeship
 - ▶ mandatory substance abuse treatment
 - ▶ urine testing
- ▶ Often used as an extension of court sanctions and conditions of release

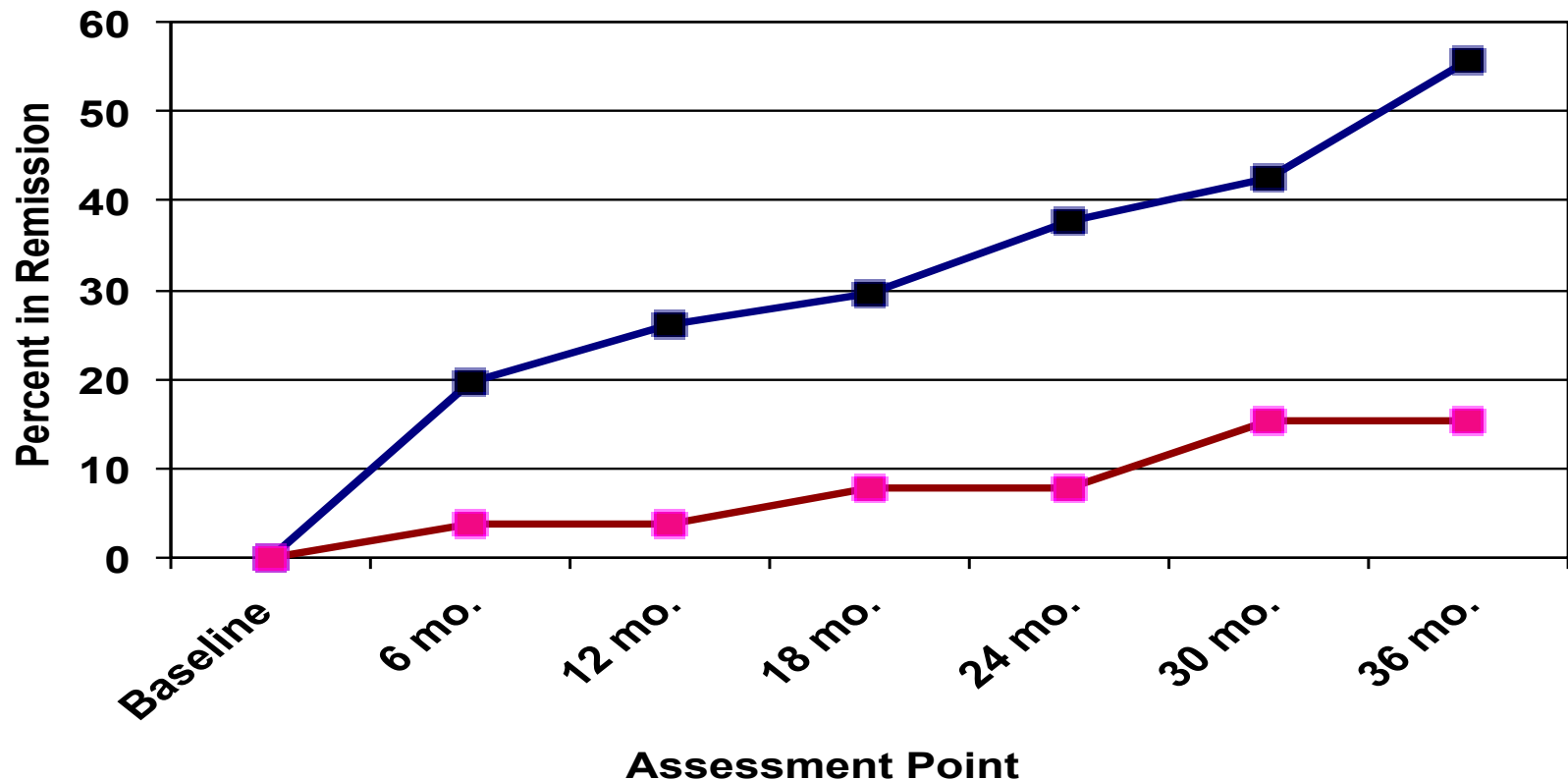
5. Longitudinal perspective

- ▶ Mental health, substance use disorders, and disease are chronic, relapsing conditions
- ▶ Treatment occurs continuously over years
- ▶ Period of supervision is a discrete period within the recovery process
- ▶ Handoffs between providers over time is critical to ensure continuity of care

Fidelity to Dual Diagnosis Principles

(McHugo et al, 1999)

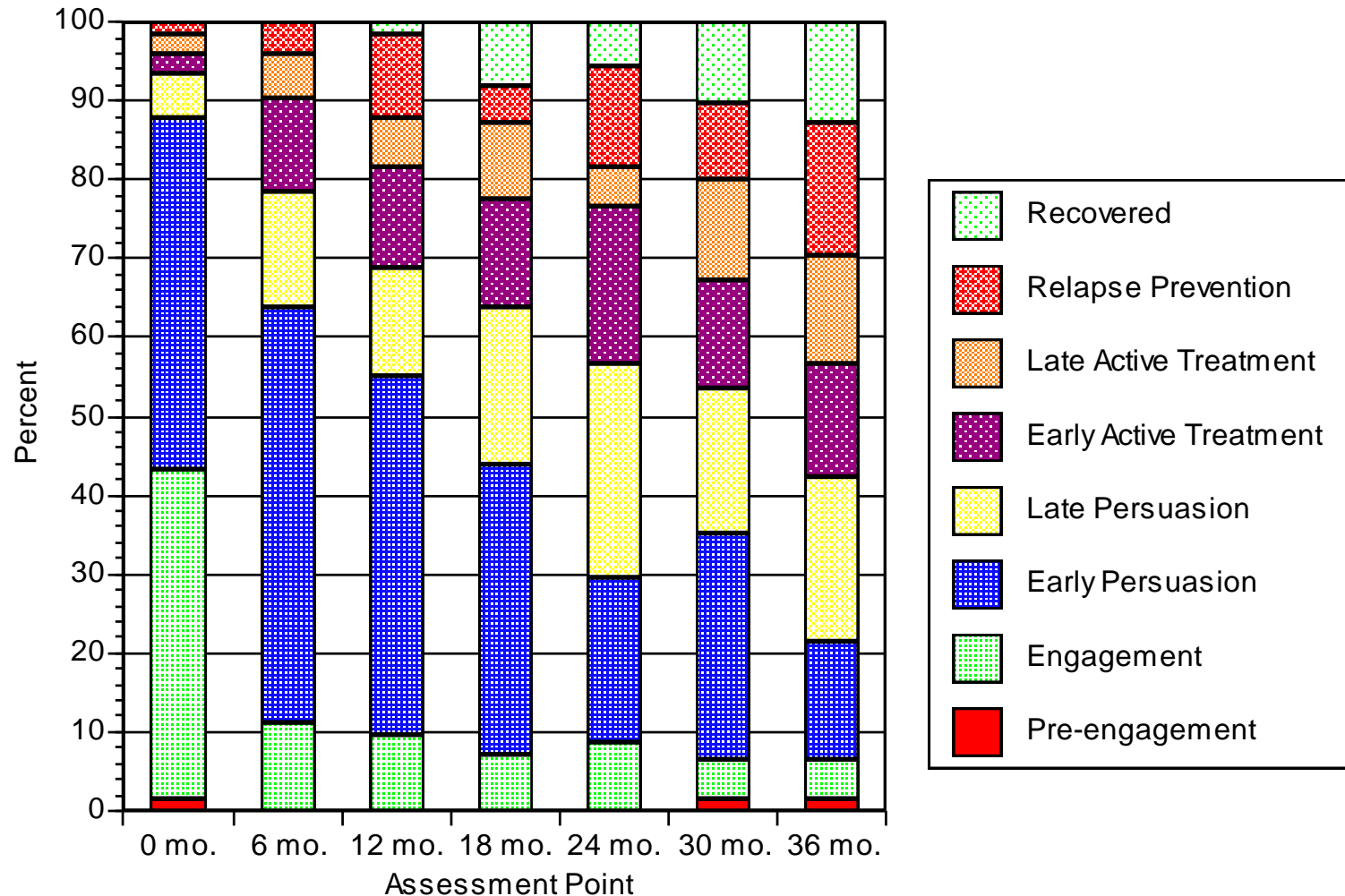
Percent of Participants in Stable Remission for High-fidelity ACT Programs (E:n=61) vs. Low-fidelity ACT Programs (G: n=26)



5. Stages of change

- ▶ Engagement - connecting people to treatment
- ▶ Persuasion - convincing engaged clients to accept treatment
- ▶ Active treatment - range of behavioral, psychoeducational and medical interventions
- ▶ Relapse prevention - prevention and management of relapses

Course of Attaining Stable Remission



6. Harm reduction strategies

- ▶ Continuum from abstinence ➡ problematic use
➡ abuse/dependence
- ▶ Reducing quantity/frequency of use decreases likelihood of negative consequences
- ▶ Provide alternatives to traditional abstinence-only philosophies
- ▶ More likely to engage those who don't yet have treatment and/or abstinence as goals
- ▶ Controversial in treatment and criminal justice communities

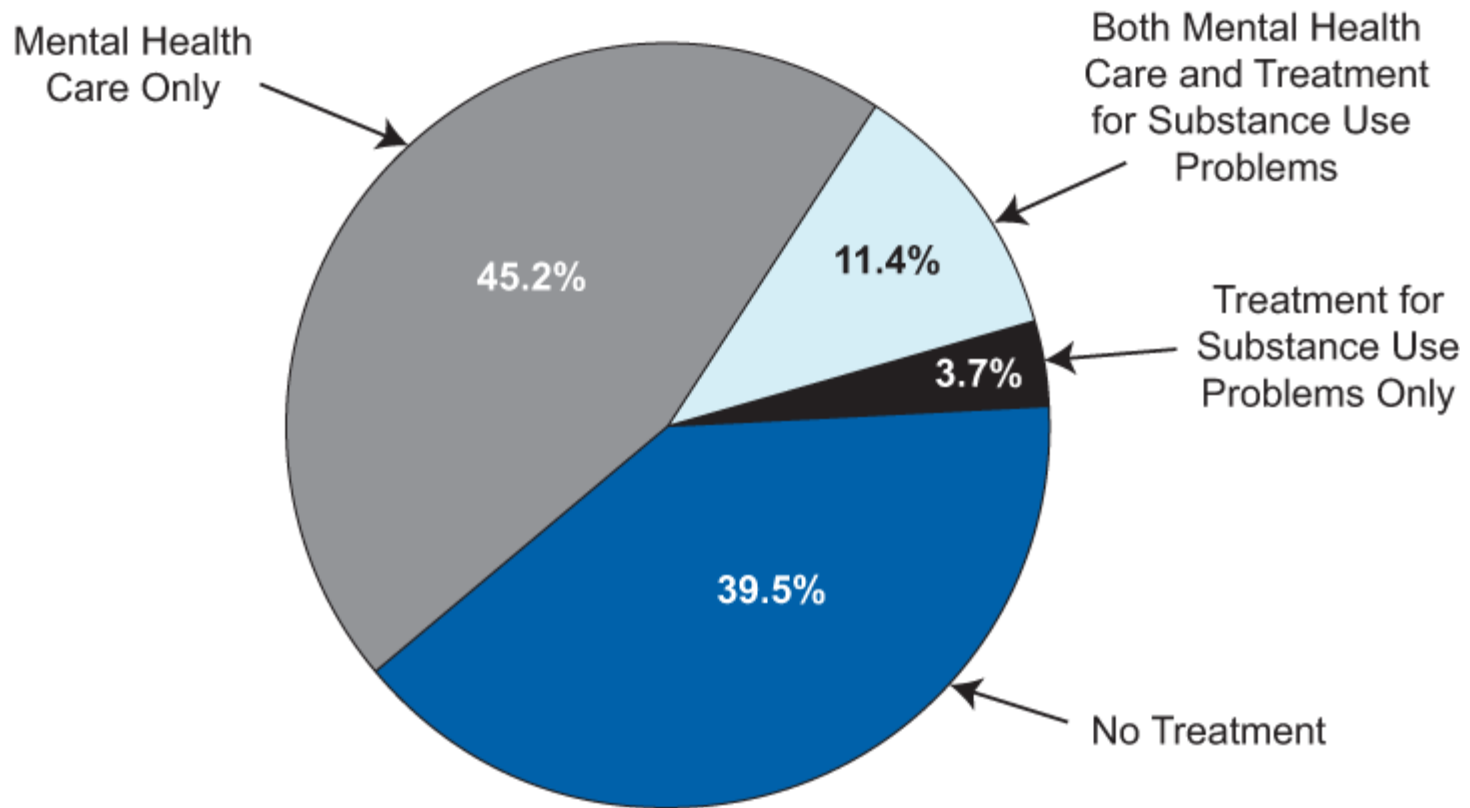
7. Employ Evidence-Based Practices

Evidence-Based Practices are:

“the integration of the best
research evidence with
clinical expertise and
patient values.”

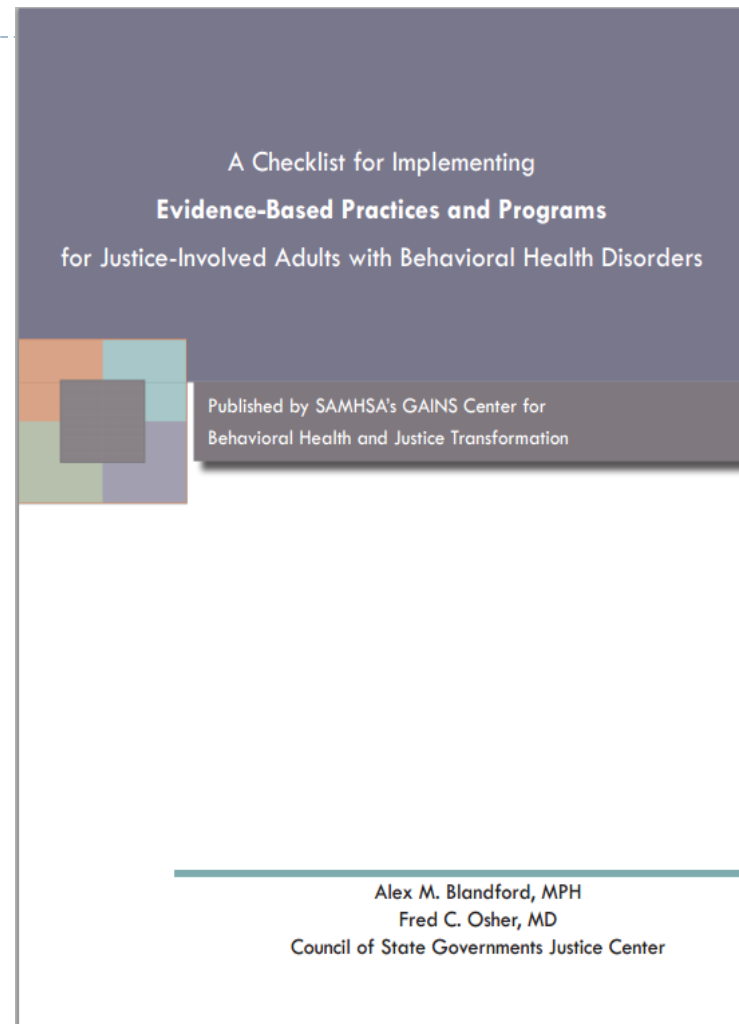
Institute of Medicine, 2000

Past Year Mental Health Care and Treatment for Adults Aged 18 or Older with Both Serious Mental Illness and a Substance Use Disorder (NSDUH, 2008)



2.5 Million Adults with Co-Occurring SMI and Substance Use Disorder

Resource:
***A Checklist for
Implementing
EBP's for
Justice-involved
with Behavioral
Health Disorders***



<http://gainscenter.samhsa.gov/cms-assets/documents/73659-994452.ebpchecklistfinal.pdf>

8. Stable living situation

- ▶ Not having a home makes assessment difficult and protracted
- ▶ Range of safe, affordable housing options are necessary
 - ▶ safe havens or low demand residences for engagement and persuasion
 - ▶ alcohol and drug free housing during active treatment and relapse prevention
- ▶ Separate assessment and treatment from housing

9. Cultural competency and consumer centeredness

- ▶ Seek to understand - don't assume a shared set of values or impose one's own
- ▶ Respect cultural differences
- ▶ Value the consumer's point of view

10. Optimism

- ▶ Critical ingredient for recovery
- ▶ Hope as an antidote to despair
- ▶ Peer supervision and training needed to bolster staff optimism

CASES – New York City

Adult Behavioral Health Programs

Manhattan START

Misdemeanor Alternative to Incarceration (ATI)

Manhattan CIRT

Felony & Misdemeanor ATI & Alternative to Detention

Nathaniel Assertive Community Treatment (ACT) Felony ATI

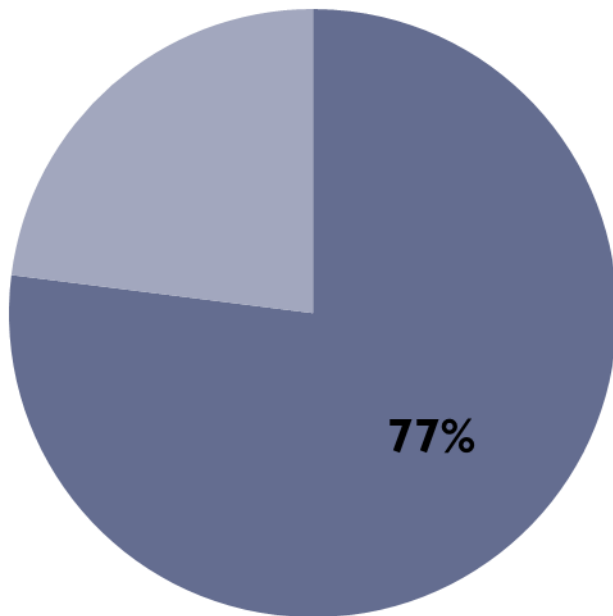
Manhattan ACT Team

Nathaniel Clinic

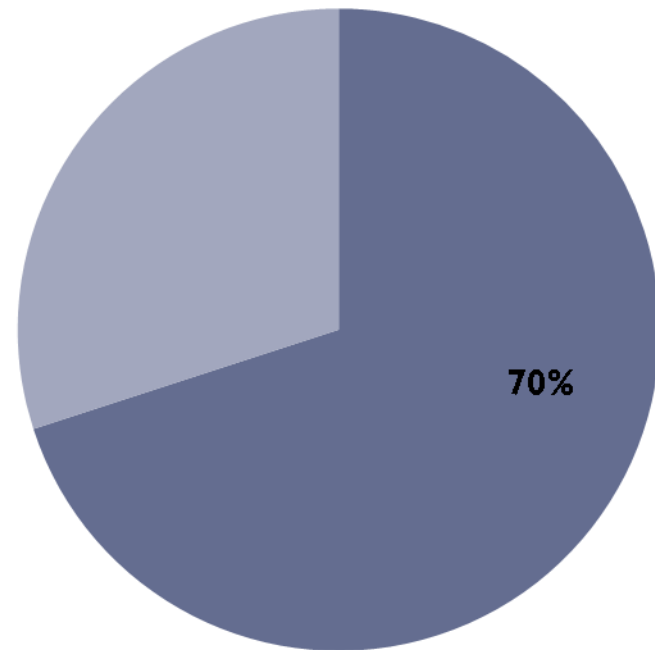
Outpatient MH Justice Involved Youth & Adults

Co-occurring Disorders

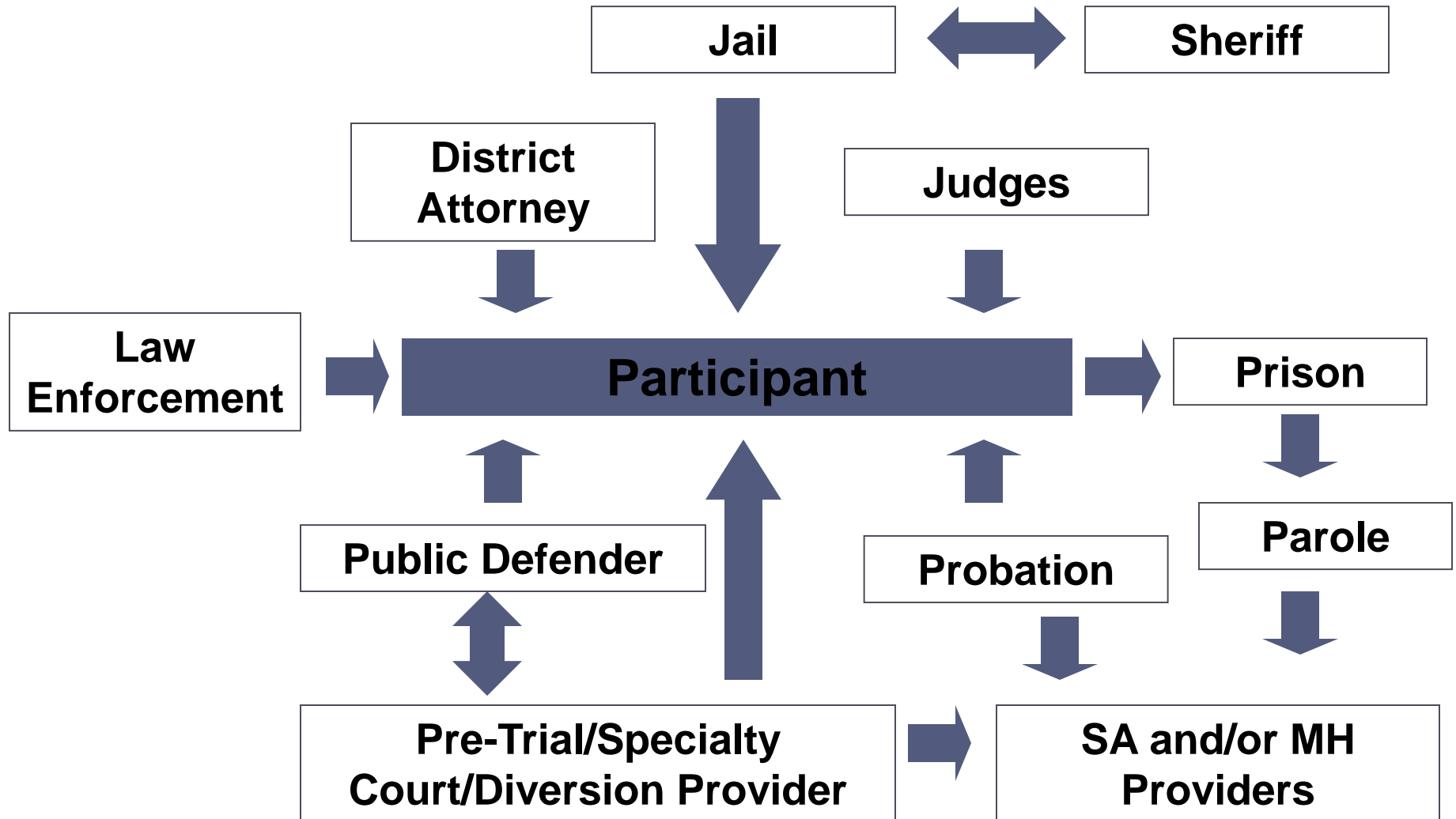
**Justice Specific
Programs**



Non-Justice Involved



Criminal Justice & Integrated Treatment



Integrated Screening & Assessment

- ▶ Brief Jail Mental Health Screen
- ▶ Mental Health Screening Form III
- ▶ Patient Health Questionnaire - 9
- ▶ Texas Christian University Drug Screen II
- ▶ Post Traumatic Stress Disorder Checklist
- ▶ Comprehensive Assessment (developmental, psychosocial, interpersonal, skills deficits, culture, strengths)
Cognitive and functional impairments
- ▶ Health Assessment
- ▶ Psychiatric Evaluation
- ▶ Fagerstrom Test for Nicotine Dependence (FYND)

Treatment Planning

“I want to find housing”

“I want to get my GED”

- ▶ Focus on participants’ goals and functioning (not on adhering to treatment)
- ▶ Participant choice
- ▶ Shared decision-making

Medications

- ▶ Appropriate and are needed
- ▶ Participants should receive the most most clinically effective psychopharmacologic strategy available
- ▶ Injectable medications may be used because of adherence issues
- ▶ Evidence participants that adhere to medications substance abuse is lessened
- ▶ When possible, prescribing physician will avoid use of: opioids and muscle relaxants for chronic pain; stimulants for ADD; benzodiazepines, and barbiturates
- ▶ If outside physician insists on prescribing dependency-producing drugs consultation with an addiction specialist may be needed



Co-occurring Services & Treatment

- ▶ Stagewise Individual Services and Treatment
 - Case Management/Care Coordination
 - Individual counseling and/or psychotherapy
- ▶ Stagewise Group Treatment
 - Early engagement
 - Relapse prevention – cognitive behavioral skills
 - Substance Use & Trauma (present focused therapy)
 - Psychoeducational instruction
 - Family work
- ▶ Self-Help Support Group (NA, AA, Double Trouble)

Integrated

Substance Relapse	Attitude & Thinking Changes	Mental Health Relapse
	Thinking counseling and/ medication not needed anymore	
Substance Relapse	Mood and Emotion Changes	Mental Health Relapse
	Feeling bored, empty, or lonely	
Substance Relapse	Behavior Changes	Mental Health Relapse
	Putting yourself in high risk situations where there is pressure to use	
Substance Relapse	Changes Daily Living or Physical Changes	Mental Health Relapse
	Trouble falling asleep/staying asleep	

Staff & Training

- ▶ Clinicians have competency in mental health and substance use
- ▶ Clinicians have competency in substance use and mental health
- ▶ Focus on Integrated Treatment (FIT)
- ▶ Motivational Interviewing
- ▶ Trauma Informed and Trauma Specific
- ▶ One consistent message about treatment and recovery

Outcomes



Integrated from first point of contact
with participant
Assessment is continuous
Protocols and responses with criminal
justice individualized and structured
All staff are competent in mental health
and substance use



Thank you

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IDDT Discussion Group

“Ask the Experts” discussion session

- **Fred Osher, MD**, Council of State Governments Justice Center
- **Ann-Marie Louison**, CASES (NYC)

- **Monday, April 21, 2014 from 1:00 – 2:00 pm ET**

Register: <http://prainc.adobeconnect.com/iddtreg/event/registration.html>

- Webinar and discussion group will be archived on the GAINS Center website at: http://gainscenter.samhsa.gov/topical_resources/ebps.asp





SAMHSA's GAINS Center *for* **Behavioral Health and Justice Transformation**

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