Recognizing and Addressing Hybrid Needs: Co-Occurring Issues in Treatment Courts

John Collins
To be addressed during this session

- Defining Co-Occurring Issues
- Prevalence and Other Data
- Why Address Co-Occurring Disorders in Drug Court?
- Best Practice Standards
- Adaptations – A Six Step Approach
Co-Occurring Disorders (CODs)

✓ Previously referred to as dual diagnoses

The coexistence of both a mental health and a substance use disorder

Each diagnosis is independent of the other and is not a cluster of symptoms resulting from the one disorder
Mental Health Disorders

- Bipolar Disorders
- Depressive Disorders
- Anxiety Disorders
- Trauma- & Stress-Related Disorders
- Psychotic Disorders
- Personality Disorders
Prevalence and other Data

Source: Kessler et al. 1994. Table 2 and unpublished data from the survey.

(SAMHSA, 2013)
Prevalence and other Data

(SAMHSA, 2015)
Prevalence and other Data

- 10% of male offenders have co-occurring disorders
- 24% of female offenders have co-occurring disorders
- 63% of Drug Court participants report serious mental health symptoms
- 30%–40% of current drug court participants have diagnosable mental illnesses
- 75%–80% of mental health court enrollees have substance use disorders
### Prevalence and other Data

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Mental Health Courts</th>
<th>Drug Courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar</td>
<td>35%</td>
<td>8%</td>
</tr>
<tr>
<td>Psychotic disorder</td>
<td>24%</td>
<td>2%</td>
</tr>
<tr>
<td>Major depression</td>
<td>22%</td>
<td>16%</td>
</tr>
<tr>
<td>PTSD</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Antisocial personality</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Borderline personality</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>

(Peters, Kremling, Bekman, & Caudy, 2012)
Admitting Clients with CODs

- Clients with CODs are already in our program
- DC can achieve positive outcomes
- Meet HR/HN Criteria
- Only a small number suffer profound impairments
Untreated mental health concerns lead to:

- Difficulty in adjusting to group treatment
- Increased episodes of decompensation and hospitalization
- Higher dropout rates
- Struggles engaging employment/education programs
- Increased recidivism
- When a mental health problem goes untreated, the substance abuse problem usually gets worse
Addressing MH needs

Best Practice Standard VI:

“Addiction and mental illness are reciprocally aggravating conditions. For this reason, best practice standards for Drug Courts and other treatment programs require mental illness and addiction to be treated concurrently as opposed to consecutively.”
Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders


One of the biggest challenges for drug courts is effectively working with participants with co-occurring disorders. By definition, persons with the dual diagnosis of both substance use disorders and mental illnesses have co-occurring disorders. All mental disorders, such as schizophrenia, bipolar disorder, posttraumatic stress disorder (PTSD), or severe depression, increase the chances of having a drug-or alcohol-use disorder, leading to a co-occurring disorder (Kessler et al., 2005; Grant et al., 2004). While some people with profound impairments related to their mental illnesses will be inappropriately referred to adult drug courts and need other options, these participants will be a small minority of persons with mental illness (Kessler et al., 1996). The National Drug Court Institute and Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) GAINs Center believe that every adult drug court can achieve positive outcomes for persons with co-occurring disorders—if the court is committed to doing so. With some creativity and thoughtful planning, most persons with co-occurring disorders can successfully participate in drug courts.

Treatment Court Models

Adult treatment courts generally comprise three main types: drug courts, mental health courts, and co-occurring courts. Drug courts are the most abundant and standardized because of federal funding and regulations. Mental health courts and co-occurring courts are alternatives to incarceration and are more varied as a result of evolving independence in their jurisdictions. Table 1 on page 2 highlights some major differences between these treatment courts.

Flexibility

No matter which type of court you have, the key to treating participants with co-occurring disorders is flexibility. People with difficulty thinking, concentrating, or controlling emotions are not able to successfully participate in standard therapeutic groups or 12-step programs (Mueller et al., 2003). However, remaining flexible and using individualized criteria does not mean the participants lack rules or expectations for change. Courts might need to apply a different paradigm to
Adapting your Drug Court

**Step 1:** Know Who Your Participants Are and What They Need
- Key Components 3 & 4

**Step 2:** Adapt Your Court Structure
- Key Components 1, 2, 5, 6, & 7

**Step 3:** Expand Your Treatment Options
- Key Component 4
Adapting your Drug Court

- **Step 4:** Target Your Case Management and Community Supervision
  - Key Components 1, 2, 5, 6, & 7

- **Step 5:** Expand Mechanisms for Collaboration
  - Key Components 3, 6, 9, & 10

- **Step 6:** Educate Your Team
  - Key Component 9
Step 1: Identifying Appropriate Clients

✓ the best outcomes are achieved when drug courts target participants who are at a greater risk for criminal recidivism and have greater criminogenic needs.

Quadrant Model: Participants in Adult Drug Courts with Co-Occurring Disorders

<table>
<thead>
<tr>
<th>Quadrant III</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Severity</td>
<td>High Severity</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>SU* Disorder</td>
</tr>
<tr>
<td>High Severity</td>
<td>High Severity</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>SU Disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Severity</td>
<td>Low Severity</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>SU Disorder</td>
</tr>
<tr>
<td>High Severity</td>
<td>High Severity</td>
</tr>
<tr>
<td>Mental Disorder</td>
<td>Low Severity</td>
</tr>
<tr>
<td>SU Disorder</td>
<td></td>
</tr>
</tbody>
</table>

* Substance Use Adapted from a figure developed by the NASADAD & NASMHPD Council of State Government Justice Center, 2012
Step 1: Assessment

The assessment of MH needs is complicated by:

- Type of Mental Health Disorder
- Presence of Multiple Disorders
- Severity
- CJ history
- Treatment history
- Interaction of Substance Use Disorders and Mental Health Disorders
Step 1: Interaction between SUD and MH

- Anhedonia
- Anxiety
- Motivational deficits
- Concentration problems
- Fatigue/Insomnia
- Depressed mood
- Social withdrawal
- Suicidal thoughts
Step 1: Interaction between SUD and MH

- In cases of pre-existing mental illness, the individual may abuse alcohol or drugs as a form of self-medication.
- Drug and alcohol abuse can also bring about mental illness, due to the effects of the substances on brain chemistry and how it is manifested in thoughts, emotions, and behavior.
Step 1: Interaction between SUD and MH

- Biological factors
- "Self-medication"
- Facilitation of relationships
- Lack of structure/boredom
Step 1: Screening

- determine if a person is eligible for drug court and identify any special needs
- look for symptoms of mental disorders
- brief sets of questions, which do not typically require staff with advanced degrees
- standardized, validated screening instruments that have proven psychometric properties
- Interview and observation to assess ability to interact with drug court staff without excessive anxiety, agitation, or aggressive behavior
# Step 1: Mental Health Screening

<table>
<thead>
<tr>
<th></th>
<th>Brief Jail Mental Health Screen</th>
<th>GAIN-SS</th>
<th>MHSF-III</th>
<th>Modified MINI Screen1 (MMS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td>8 questions (5 minutes)</td>
<td>23 questions (5-10 Minutes)</td>
<td>18 questions (15 minutes)</td>
<td>22 questions (5-10 minutes)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>FREE</td>
<td>$100 for 5 years (paper version)</td>
<td>FREE</td>
<td>FREE</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>One page instruction sheet</td>
<td>60 minute online training</td>
<td>Minimal Training Required</td>
<td>Training is brief, a manual is available</td>
</tr>
</tbody>
</table>
### Step 1: Trauma & PTSD Screening

<table>
<thead>
<tr>
<th></th>
<th>Primary Care PTSD Screen (PC-PTSD -5)</th>
<th>PTSD Checklist—Civilian Version (PCL-C)</th>
<th>Stressful Life Events Screening Questionnaire—Revised (SLESQ-R)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td>5 items (5 minutes)</td>
<td>17 items (5-10 minutes)</td>
<td>13 items</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>FREE (Developed by VA)</td>
<td>FREE (Developed by VA)</td>
<td>FREE</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>One page instruction sheet</td>
<td>5 page manual - Interpretation should be made by a clinician</td>
<td>Minimal Training Required</td>
</tr>
</tbody>
</table>
# Step 1: Other Screening Tools

<table>
<thead>
<tr>
<th></th>
<th>PHQ-9 Quick Depression Assessment</th>
<th>COLUMBIA-SUICIDE SEVERITY RATING SCALE</th>
<th>Anxiety Disorders (GAD-7) scale</th>
<th>Mini Mental State Examination (MMSE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
<td>10 items (5 minutes)</td>
<td>6 items (10 minutes)</td>
<td>7 items</td>
<td>11 items (5-10 minutes)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>FREE</td>
<td>FREE</td>
<td>FREE</td>
<td>FREE</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>One page scoring sheet</td>
<td>Mental health training is not required to administer</td>
<td>Instruction sheet</td>
<td>2-page administration and scoring sheet</td>
</tr>
</tbody>
</table>
Step 2: Adapt Your Court Structure

Team Members

Progress ↔ Process
Step 2: Team Members

- Community treatment agencies and individual practitioners
- Psychiatrist or Psychologist
- Caseworkers
- Staff to Participant Ratios
Step 2: Process

- Court Attendance
- Support Groups
- Working with the Family
- Developing Tracks
Step 2: Progress & Completion of Goals

Equality doesn't mean Equity
Step 2: Progress & Completion of Goals

- Reconsider Proximal Goals
- Phase Structure
- Rethinking time to Commencement
- Specific rather than Universal Goals
Step 2: Progress & Completion of Goals

- Sobriety & medication compliance
- Reduction in MH symptoms
- Treatment
- Stable home plan
- Support network
- Fees and/or community service
Step 3: Expand Your Treatment Options

- Engage and motivate
- Reach out to family and support
- Reduce symptoms
- Reduce relapses
- Improve functioning at work/school/parenting
- Improve socialization
- Increase independent living skills
Step 3: Define Recovery

“Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities”

(President’s New Freedom Commission on Mental Health, 2003)
Step 3: Recovery Orientated Approach

- Be optimistic and future-oriented
- Concentrate on the person rather than the illness
- Actively-involve the person in their own treatment and treatment planning
- Focus on real-world functioning including work, school, and social relationships
Step 3: Addressing the Underlying Issues

Step 1: Interaction between SUD and MH

- Biological factors
- "Self-medication"
- Facilitation of relationships
- Lack of structure/boredom
Step 3: Addressing the Underlying Reasons

- Educate people about their mental illness including its biological nature and their increased sensitivity to substances
- Teach more effective strategies for coping with symptoms and distress
- Improve social skills and identify alternative social outlets to meet social needs
- Help people develop purpose
Step 3: Evidence-Based Treatment

- Integrated Treatment
- Medications
- CBT
- Illness Management & Recovery
- Family Psychoeducation
- Social Skills Training
Step 3: Integrated Treatment

- Mental health and substance abuse are treated concurrently by clinician or treatment team.
- Treatment of both disorders is integrated.
- Treatment is low-stress and motivation-based.
- Outreach and close monitoring are provided as needed.
Step 3: Medications

Symptom reduction

Prevention of relapses and hospitalizations
Step 3: Anti-Psychotic Medications

- Treat hallucinations and delusions
- Schizophrenia and Bipolar Disorder
- Block dopamine
- Typical (first generation) and atypical (second generation) antipsychotics
Step 3: Anti-Psychotic Medications

Typical
- Haldol
- Thorazine (chlorpromazine)

Atypical
- Risperdal
- Seroquel
- Zyprexa
- Invega
- Abilify
- Clozaril
Step 3: Antidepressant Medications

- Treat mood/distress
- Depressive and Anxiety Disorders
- Five Subtypes
- Two thirds of all mental health-related prescriptions
## Step 3: Antidepressant Medications

<table>
<thead>
<tr>
<th>Class</th>
<th>Function</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selective serotonin reuptake inhibitors (SSRIs)</td>
<td>Block the reuptake, or absorption, of serotonin in the brain</td>
<td>Celexa, Lexapro, Prozac, Paxil, and Zoloft.</td>
</tr>
<tr>
<td>Serotonin and noradrenaline reuptake inhibitors (SNRIs)</td>
<td>Raise levels of serotonin and norepinephrine</td>
<td>Cymbalta and Effexor</td>
</tr>
<tr>
<td>Tricyclic antidepressants (TCAs)</td>
<td>Block the reuptake, or absorption, of serotonin and norepinephrine</td>
<td>Norpramin</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors (MAOIs)</td>
<td>Inhibits the action of monoamine oxidase</td>
<td>Nardil and Parnate</td>
</tr>
<tr>
<td>Noradrenaline and specific serotonergic antidepressants (NASSAs)</td>
<td>Enhances the action of noradrenaline and serotonin</td>
<td>Remeron</td>
</tr>
</tbody>
</table>
Step 3: Anti-Anxiety Medications

✓ Benzodiazepines have largely replaced barbiturates
  ✓ Xanax
  ✓ Klonopin
  ✓ Valium
  ✓ Ativan

✓ Buspirone (Buspar)
✓ Antidepressants are frequently used
## Step 3: Most Prescribed Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Class</th>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xanax (alprazolam), 48.5 million</td>
<td>Benzodiazepine¹</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Zoloft (sertraline), 41.4 million</td>
<td>SSRI¹</td>
<td>Depression</td>
</tr>
<tr>
<td>Celexa (citalopram), 39.4 million</td>
<td>SSRI</td>
<td>Depression</td>
</tr>
<tr>
<td>Prozac (fluoxetine), 28.3 million</td>
<td>SSRI²</td>
<td>Depression</td>
</tr>
<tr>
<td>Ativan (lorazepam), 27.9 million</td>
<td>Benzodiazepine¹</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Desyrel (trazodone HCL), 26.2 million</td>
<td>Non-narcotic²</td>
<td>Depression</td>
</tr>
<tr>
<td>Lexapro (escitalopram), 24.9 million</td>
<td>SSRI</td>
<td>Depression</td>
</tr>
<tr>
<td>Cymbalta (duloxetine), 18.6 million</td>
<td>SNRI</td>
<td>Depression</td>
</tr>
<tr>
<td>Wellbutrin XL (bupropion HCL XL), 16.1 million</td>
<td>Aminoketone²</td>
<td>Depression</td>
</tr>
<tr>
<td>Effexor XR (venlafaxine HCL ER), 15.8 million</td>
<td>SNRI</td>
<td>Depression</td>
</tr>
</tbody>
</table>
## Step 3: False Positive Drug Tests

<table>
<thead>
<tr>
<th>Positive for Benzodiazepine</th>
<th>Positive for Amphetamines</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Xanax</td>
<td>• Wellbutrin</td>
</tr>
<tr>
<td>• Ativan</td>
<td>• Prozac</td>
</tr>
<tr>
<td>• Zoloft</td>
<td>• Desyrel</td>
</tr>
<tr>
<td>• Klonopin</td>
<td></td>
</tr>
</tbody>
</table>
Step 3: Cognitive Behavioral Therapy

Reduction of symptom severity or distress related to the following:

- Hallucinations or delusions
- Depression or suicidal thinking
- Anxiety, including PTSD
- Urges to use substances
- Criminogenic thinking
Step 3: CBT Interventions

- Inaccurate thoughts and beliefs that lead to negative feelings and maladaptive behaviors
- Help change self-defeating thinking
- Teach how to evaluate the accuracy of upsetting thoughts and beliefs
- Problem solve challenging situations
Step 3: Illness Management & Recovery

- Provide psychoeducation about mental illness and its treatment.
- Teach medication adherence strategies.
- Build social support.
- Improve self-management of stress and persistent symptoms.
- Develop a relapse prevention plan.
Step 3: Family Psychoeducation

- Group psychoeducation sessions
- Relapse prevention plan
- Collaborative relationship
- Communication and problem solving skills
Step 3: Social Skills Training

- Role playing social situations
- Break down complex skills into smaller steps
- Assign homework for the practice of skills
- Elicit natural supports (such as family)
Step 4: Case Management

Case management is a means for achieving participant wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.

Case Management Society of America
Step 4: Case Management

- Meet regularly with the participant
- Evaluate needs
- Referrals to treatment
- Coordinate services
- Set up more intensive community approaches
- Assist with applying for benefits

☑️ Individual case manager or team

Set up more intensive community approaches
Evaluate needs
Referrals to treatment
Coordinate services
Assist with applying for benefits
Step 4: Case Management

Medication
- Appointments
- Prescriptions
- Side-effects
- Costs

Housing
- Initial placement
- Supported housing
- Monitoring

Finances
- Budgeting
- Benefits
- SOAR trained
Step 4: Case Management

<table>
<thead>
<tr>
<th>Vocational</th>
<th>Health Care</th>
<th>Supervision</th>
</tr>
</thead>
</table>
| • Assessment  
  • Supported employment  
  • Advocacy | • Effective referral  
  • Community health care resources  
  • Dental  
  • Education | • Helping relationship  
  • Understanding functional limitations  
  • Ongoing contact with treatment |
Step 5: Expand Mechanisms for Collaboration

- Developing a Common Understanding
  - Interdisciplinary training

- Maintaining Collaborative Partnerships
  - MOUs

- Mapping the Relevant Resources
  - Emergency and crisis intervention
  - Behavioral health residential treatment programs
  - Specialized mental-health-supportive housing agencies
  - Local chapter of the National Alliance on Mental Illness
  - Psychosocial clubhouses, peer support programs,
Step 6: Educate Your Team

- Nature of Co-occurring Disorders
- Treatment
- Trauma
- Supports
- Response
- Cultural Issues
- Working with an Extended Team
- Finding Educational Resources
Local Support

✓ National Association of State Mental Health Program Directors Web site at www.nasmhpd.org
✓ The local chapter of the National Alliance on Mental Illness at https://www.nami.org/Find-Your-Local-NAMI
✓ Behavioral Health Evolution, Double Trouble in Recovery at http://www.bhevolution.org/public/doubletroubleinrecovery.page
Information on Co-Occurring Disorders

✓ SAMHSA Co-Occurring Disorders:  
  http://www.samhsa.gov/co-occurring/

✓ Mental Health America, Co-Occurring Disorders:  
  http://www.mentalhealthamerica.net/go/co-occurring-disorders

✓ • Policy Research Associates, Publications:  

• SAMHSA’s GAINS Center:  
Information on Co-Occurring Disorders

- Screening tools: https://www.integration.samhsa.gov/clinical-practice/screening-tools