Co-Occurring Disorder Treatment in Mental Health Courts

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Course Description

• How do you determine treatment needs for your participants with co-occurring psychiatric and substance use disorders (COD)?

• What are evidenced-based treatment approaches that can be used with the COD population?
Course Objectives

• #1: Identify co-occurring disorders (COD) and their prevalence in the general population.
• #2: Identify the prevalence of COD in mental health court and criminal justice settings.
• #3: Identify levels of care for individuals using the 4-Quadrant Model.
• #4: Identify and describe evidenced-based practices utilized in various levels of care.
Prevalence of COD in the US

Learning Objective #1

• A 2002 Report to Congress showed that 14.8 million adults in the US have a Serious Mental Illness (SMI)
  – That is 7.3% of all adults
  – 3 million (20.3%) of those adults with SMI, have a co-occurring substance use disorder

• A 2014 report showed that 7.9 million Americans aged 18+ have a COD
Prevalence of COD in Criminal Justice and Mental Health Court

Learning Objective #2
COD Prevalence in Criminal Justice

• 60-70% of offenders in the US criminal justice system have a COD.
• Individuals with COD have higher rates of arrest than the general population.
COD Prevalence in Criminal Justice

• Offenders with COD had more immediate service needs upon release from correctional facilities than those with mental illness alone.
  – More likely to be serving misdemeanor sentences related to their substance use.
  – Substance abuse among offenders with mental illness increases the likelihood of problems such as homelessness and escalating involvement with the criminal justice system.
COD Prevalence in Criminal Justice

• Social Justice opportunity for treatment based courts – an alternative to the ‘New Institutions’

• Literature highlights the need for an integrated approach to treatment
COD Prevalence in Mental Health Court

• There is a high percentage of participants in Mental Health/Behavioral Health Courts that have COD.

• 29th District Court’s Western Wayne County Regional Behavioral Treatment Court
  – As of February 2016, 83% of all participants screened (whether or not they entered the program) have a COD
  – 88% of current active participants have a COD
COD Prevalence in Mental Health Court

• Research is showing that there is rapid and substantial growth of treatment based courts that serve offenders with COD.

• A treatment based court study found that Mental Health Courts more frequently provided specialized COD services than Drug Courts for their COD participants.
Assessing for COD

Learning Objective #1
Start with Screenings & an Integrated Assessment

• A qualified treatment professional should conduct the assessment.

• The assessment should include:
  – Background information: family, trauma hx, hx of domestic violence, marital status, legal involvement, financial situation, health status, education, housing status, strengths, resources, and employment
Screening & Integrated Assessment

– Mental health problems: family hx, diagnosis hx, hospitalization hx, other treatment episodes, symptoms (especially during periods of abstinence or symptoms lasting 30 days or more), mental status, medications, etc. Mental health symptoms that resolve themselves in less than 30 days with abstinence from substances then they may be substance induced.
Screening & Integrated Assessment

- Substance use: age of first use, primary drugs used, family history of SUD, including any treatment history and patterns of abuse

- Objective screening measures include: DAST, AUDIT, URICA, MSSI, PHQ-9, GAD-7, MDQ

- In an integrated COD assessment, both disorders are considered primary

- Screening can be complicated due to some individuals minimizing symptoms experienced
Cultural Competence During the Assessment

• Use the LEARN model for intake interviews:
  – L: Listen to the client from his/her cultural perspective
  – E: Explain the purpose of the intake and interview process
  – A: Acknowledge client concerns and any differences between you
  – R: Recommend a course of action through collaboration
  – N: Negotiate a plan of action that uses the clients culture throughout treatment goals, objectives, and interventions.
Levels of Care Using the 4-Quadrant Model.

Learning Objective #3
Utilization Management

• What is UM?
• Based on Medical Necessity
• HPI’s UM Criteria
• American Society of Addiction Medicine (ASAM)
  – utilized in primary SUD
• Level of Care Utilization System (LOCUS)
  – can be used in both MI and SUD settings
• Use the information from the integrated assessment to determine level of care using a UM tool
What is the 4-Quadrant Model?

The Four Quadrant Framework for Co-Occurring Disorders Classifies Patients Into 4 Quadrants of Care Based on Symptom Severity, Not Diagnosis.

This framework is suggested to guide systems integration and resource allocation in treating individuals with co-occurring disorders (NASMHPD, NASADAD, 1998; NY State; Ries, 1993; SAMHSA Report to Congress, 2002).
What Are Different Levels of Care for Individuals with COD?

**Quadrant 1:** Individuals are often seen in primary health care (doctor’s office) or outpatient settings.

Low MH – anxiety, mood, personality, and behavioral disorders

**Quadrant 1:** Individuals are often seen in primary health care (doctor’s office) or outpatient settings.
What Are Different Levels of Care for Individuals with COD?

Quadrant 2: Individuals are often seen in the mental health system. Most often outpatient settings.

High MH – Schizophrenia, Bipolar, Schizoaffective, Major Affective disorders
What Are Different Levels of Care for Individuals with COD?

Quadrant 3: Individuals are often seen in addiction settings. Adult residential settings and/or IOP. Detox settings may be necessary initially.

Low SUD- mild substance use disorder/substance abuse
What Are Different Levels of Care for Individuals with COD?

Quadrant 4: Individuals are often seen in the mental health system. Outpatient settings are common. Acute care settings may be needed, depending on severity of symptoms.

High SUD-moderate and high substance use disorder/substance dependence
How Do You Know What Level of Care is Appropriate for your Participants?

• All people with COD are not the same. Services need to be individually matched to need.

• Use the 4-Quadrant Model to Determine the most effective treatment approaches.

• Utilization Management is key
What Evidenced-Based Treatment Models Are Being Used?

Learning Objective #4
Being Evidenced-Based Minded When Working with COD Population

• Critical components of integrated programs can be considered evidenced-based because they are present in studies with positive outcomes.

• These include 8 evidenced-based program components
Evidenced-Based Program Components

• 1) Staged Intervention
• 2) Assertive Outreach
• 3) Motivational Interventions
• 4) Counseling
• 5) Social Support
• 6) Long-term Perspective
• 7) Comprehensive
• 8) Culturally Sensitive and Culturally Competent
Evidence-Based

- All programs targeting COD individuals should strive to at least be dual diagnosis capable.
- There is no “one best” approach.
- Interventions are diagnosis specific and phase of recovery/stage of change specific.
- Intervention should also be individualized by quadrant, level of functioning, and supports.
Phases of Recovery

• Acute Stabilization
• Motivational Enhancement
• Active Treatment
• Relapse Prevention
• Rehabilitation/Recovery
Stages of Change

• Pre-Contemplation
• Contemplation
• Preparation
• Action
• Maintenance
Evidence-Based

• Clinical outcomes for levels of care should be individualized and may include:
  – Abstinence and Full Mental Illness Recovery
  – Reduction in symptoms
  – Reduction in use of substances
  – Increase in level of functioning
  – Increase in disease management skills
  – Movement through stages of change
  – Reduction in harm
  – Reduction in service utilization
  – Movement to a lower level of care
Evidence-Based

• Primary clinicians in every setting should develop and implement integrated treatment plans with diagnosis specific and stage specific recommendations/goals for each disorder.
• They should both be simultaneously treated.
• Treatment success is based on the treatment provider’s ability to combine diagnosis specific treatment into a patient-centered approach.
Residential SUD Setting

• Quadrant: 3

• Living in Balance
  – EBP for SUD, Modify as needed for COD

• Model Components Include:
  – Psycho educational and experiential training sessions
  – 12 core sessions, 21 supplemental sessions
  – Group or Individual Format
Intensive Outpatient (IOP)

- Quadrant: 3
- Matrix Model
  - EBP for SUD, Modify for COD
- Model Components Include:
  - Relapse prevention groups
  - Education groups
  - Social support groups
  - Individual counseling
Outpatient

• Quadrant 2:
  – DBT (can be modified for Quadrant 3 also)
  – TREM

• Quadrant 4:
  – IDDT
Integrated Dual Disorder Treatment - IDDT

- Multidisciplinary team
- Stage-wise interventions
- Time unlimited service
- Outreach programming
- Motivational enhancement interventions
- SUD counseling
- Group & family treatment
- Self-help groups
- Health interventions
Dialectical Behavior Treatment - DBT

• Cognitive behavioral approach
• Emphasis on:
  – Behavioral change
  – Problem solving
  – Emotional regulation
  – Mindfulness and acceptance
DBT

- Components include: skills training, homework, individual treatment, skills coaching
- Research has shown effective for:
  - Suicide attempts and parasuicidal behavior
  - Borderline Personality Disorder
  - SUD
  - Eating Disorders
Trauma Recovery and Empowerment Model - TREM

• Group format of 24-29 sessions
• For Women
• Focus is on developing coping skills and social support
• Research has shown effective for:
  – Trauma
  – SUD
  – Mental health
Compliance Monitoring – A Treatment Perspective

• UDS
• Breathalyzer
• Self-Report
• Keeping it Real
Contact Information

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Questions?
References


References

References
