

Addressing Co-Occurring Disorders in Court-Based Programs

Roger H. Peters, Ph.D.

Professor; Department of Mental Health Law and Policy
at the Louis de la Parte Florida Mental Health Institute
(FMHI), University of South Florida

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Poll Question

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Today's Presentation

- ▶ Importance of targeting co-occurring disorders (CODs) in problem-solving courts
- ▶ Screening and assessment of CODs
- ▶ Evidence-based COD interventions
- ▶ Modifying and enhancing problem-solving courts for CODs

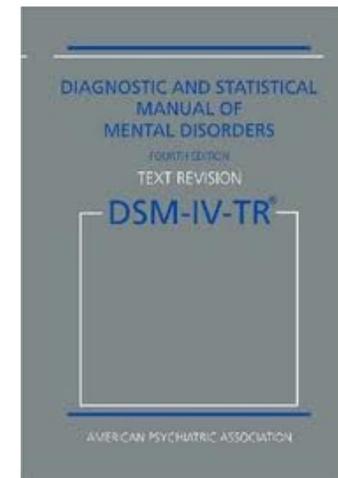


What are co-occurring disorders?

Defining “Co-Occurring Disorders”

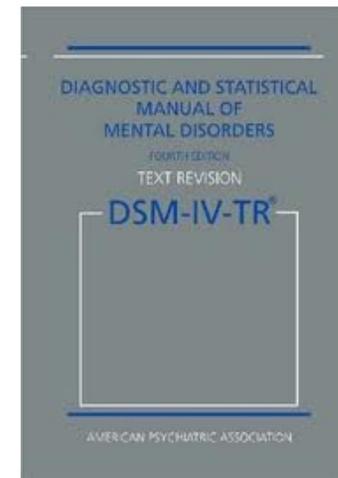
The presence of at least two disorders:

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



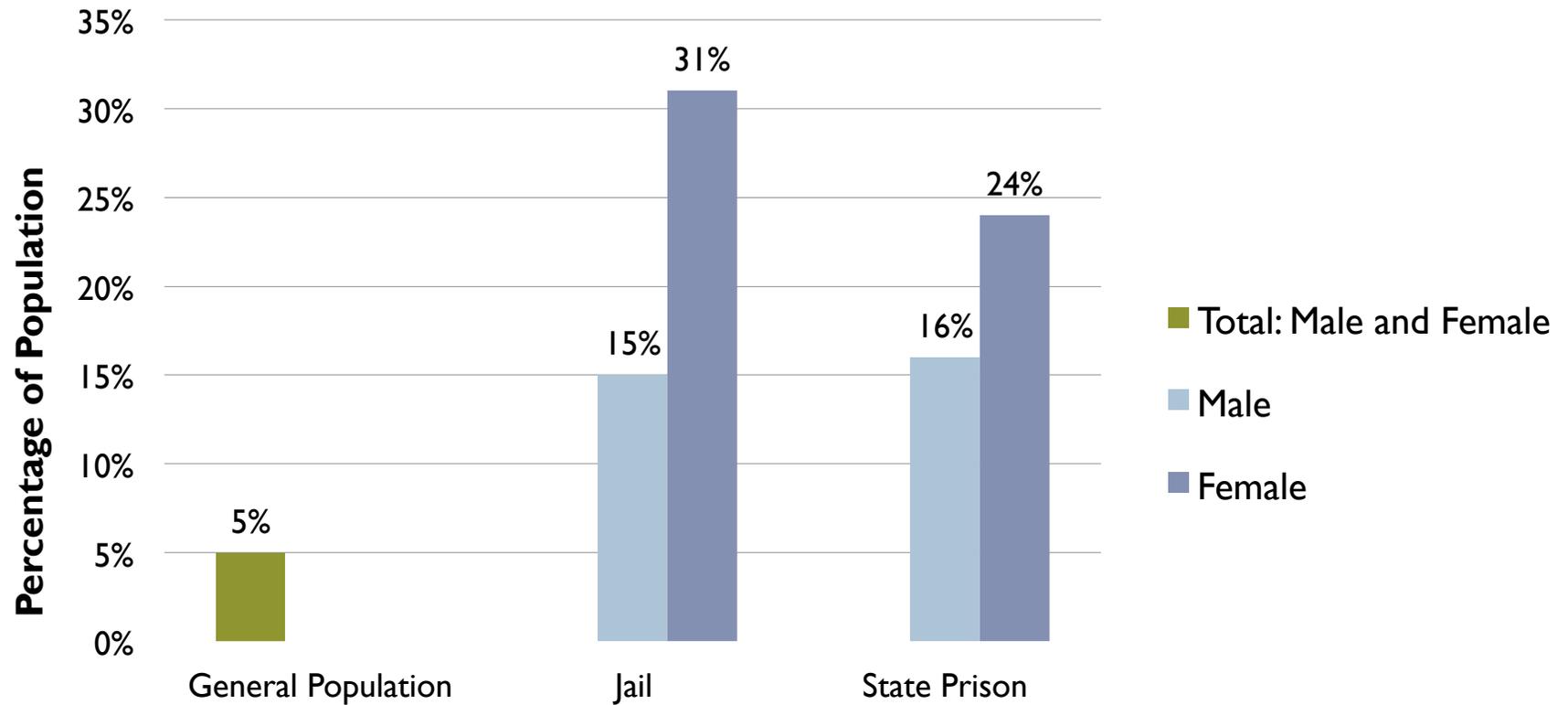
Serious Mental Disorders

- ▶ **Axis I Disorders:**
 - ▶ Major Depressive Disorder
 - ▶ Bipolar Disorder
 - ▶ Schizophrenia
- ▶ **Often Accompanied by Axis II (Personality) Disorders:**
 - ▶ Borderline Personality Disorder
 - ▶ Antisocial Personality Disorder



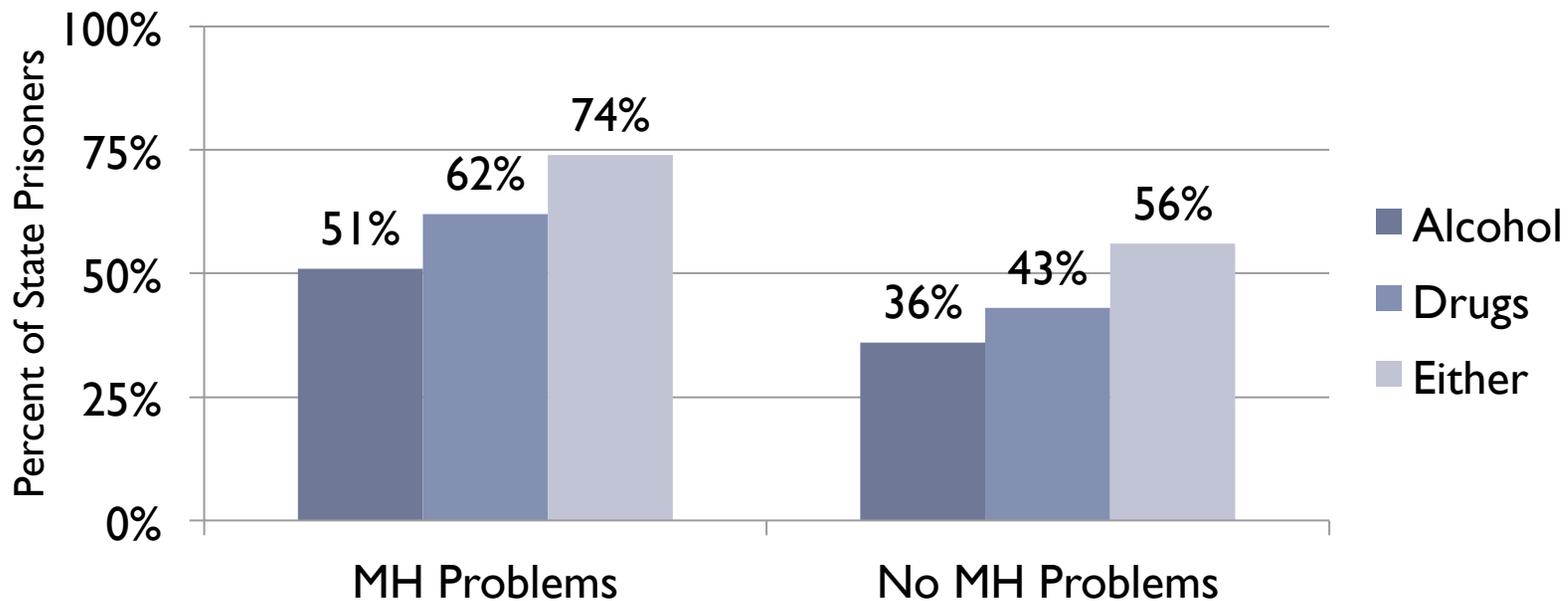
Prevalence of Mental Illness in Jails and Prisons

Serious Mental Disorders among Offenders and the General Population



Sources: General Population (Kessler et al., 1996), Jail (Steadman et al., 2009), Prison (Ditton 1999)

Co-Occurring Substance Use Disorders

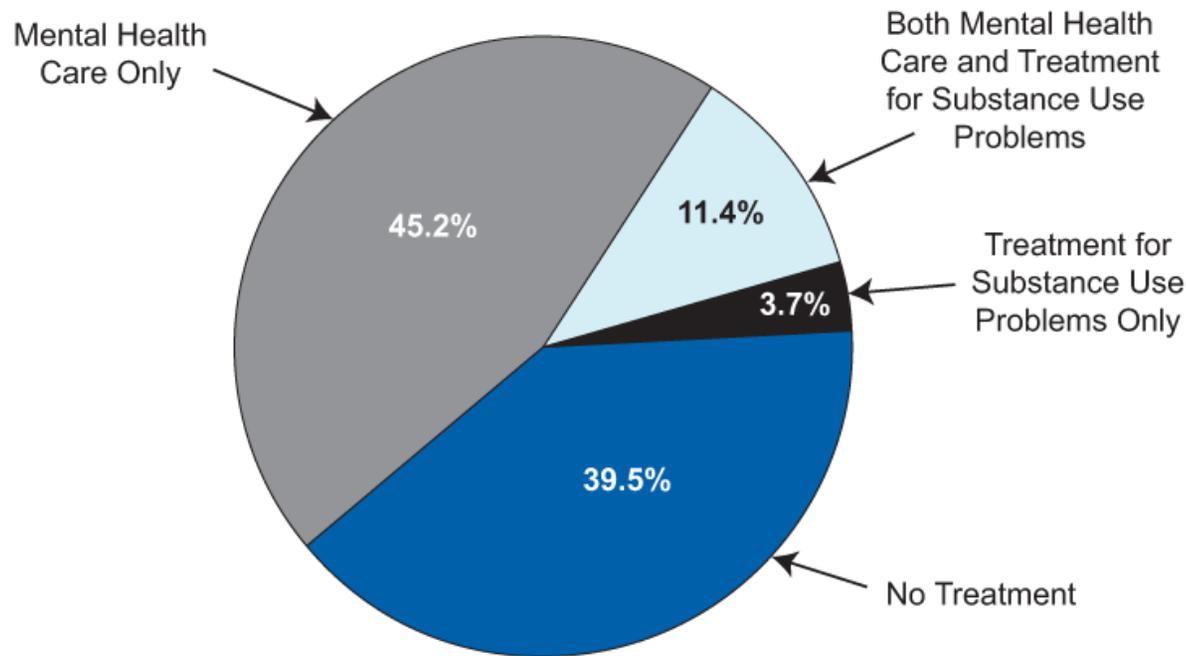


74% of state prisoners with mental problems also have substance abuse or dependence problems

Source: U.S. Department of Justice, 2006

What Treatment is Received by People with CODs?

▶ Treatment Received in Past Year by Adults with CODs



Source: NSDUH (2008)

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

Clinical Considerations

- ▶ Cognitive impairment
- ▶ Reduced motivation
- ▶ Impairment in social functioning

Source: Bellack, 2003



Cognitive Features of CODs

- ▶ Limited attention span
- ▶ Difficulty understanding and remembering information
- ▶ Not recognize consequences of behavior
- ▶ Poor judgment
- ▶ Disorganization
- ▶ Not respond well to confrontation



Persons with CODs in the Justice System

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

What's the Connection between Mental Illness and Criminal Behavior?

Mental illness is not an independent risk factor for arrest and recidivism

For 92% of individuals with mental illnesses, arrest is mediated by factors other than mental illness



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For 92% of individuals with mental illnesses, arrest is mediated by factors other than

So if mental illness isn't a risk factor, why treat the mental illness?



What's the Connection between Mental Illness and Criminal Behavior?

Mental illness is not an independent risk factor for arrest and recidivism

For 92% of individuals with mental illnesses, arrest is mediated by factors other than mental illness

- ▶ Individuals with mental illness have elevated criminogenic risk factors
- ▶ Greater likelihood of arrest, technical violations, and incarceration
- ▶ For participants with CODs, treating mental disorders is insufficient to reduce recidivism
- ▶ However, mental health services enhance participants' **responsivity** to evidence-based treatments that address key criminogenic risk areas (substance abuse, criminal beliefs/attitudes, criminal peers, education, employment, family discord, leisure skills)



Focusing on people with high criminal risk and significant behavioral health needs

Risk-Need-Responsivity Model as a Guide to Best Practices

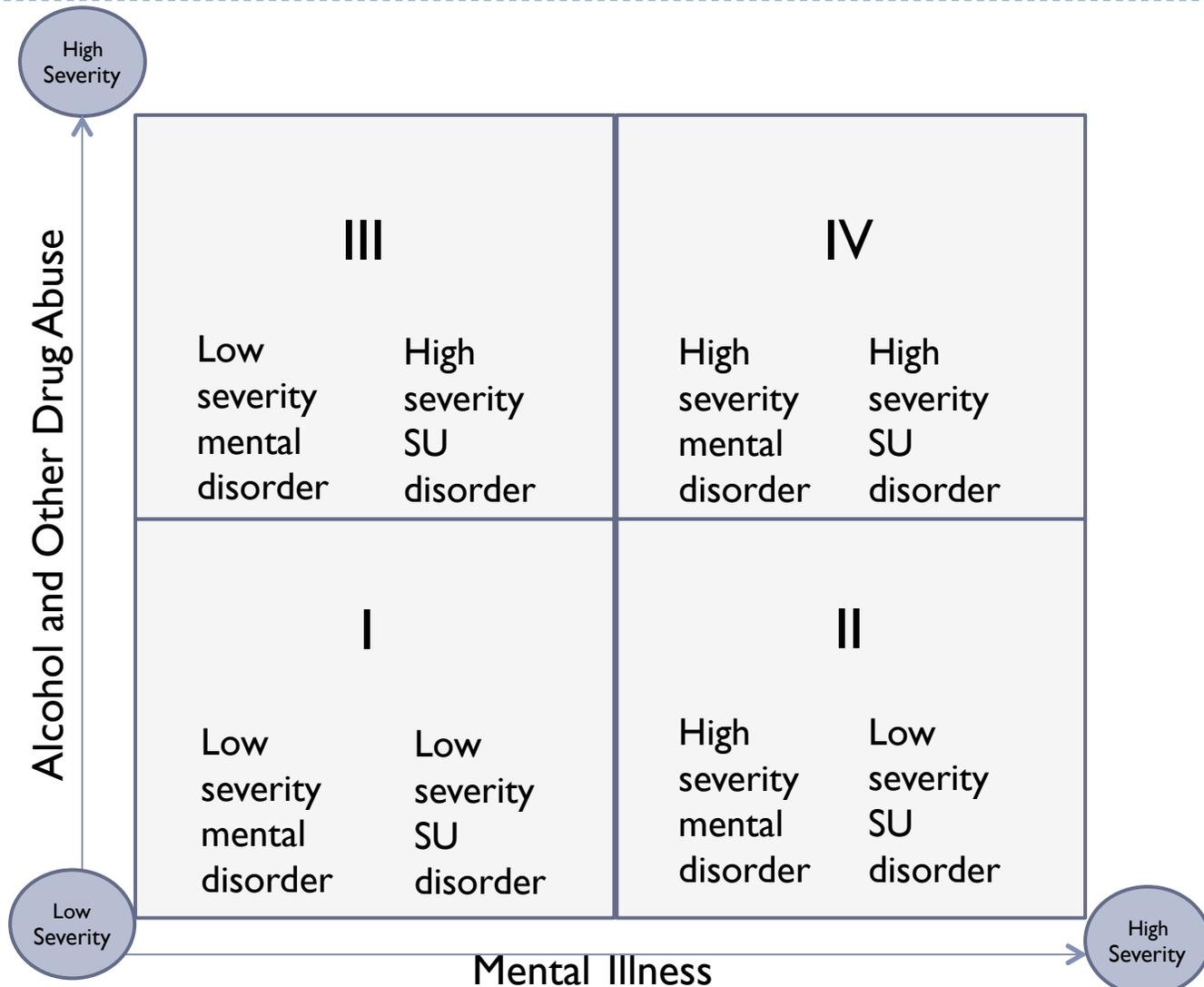
- ▶ Focus resources on high **RISK** cases
- ▶ Target criminogenic **NEEDS**, such as antisocial behavior, substance abuse, antisocial attitudes, and criminogenic peers
- ▶ **RESPONSIVITY** – Tailor the intervention to the learning style, motivation, culture, demographics, and abilities of the offender. Address the issues that affect responsivity (e.g., mental illnesses)

Determining Risk: Dynamic Risk Factors

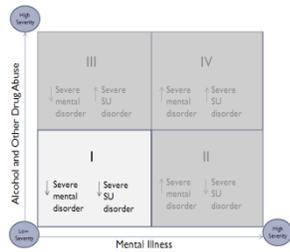
1. Antisocial attitudes
2. Antisocial personality pattern
3. Antisocial friends and peers
4. Substance abuse
5. Family and/or marital factors
6. Lack of education
7. Poor employment history
8. Lack of pro-social leisure activities



Putting It All Together: Implications for Problem-Solving Courts

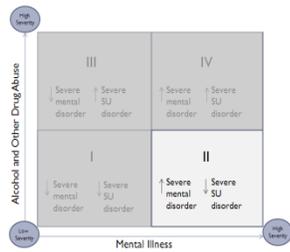


Source: Adapted from a figure developed by the NASADAD and NASMHPD, 1999



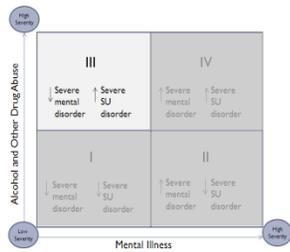
Quadrant I: For High Risk People With Low MH Needs and Low SA Needs

- ▶ **What type of programming would be most appropriate?**
 - ▶ Not appropriate for diversion programs focusing on BH needs
 - ▶ Traditional court processing taking into account the need to change antisocial thinking and behaviors
 - ▶ Intensive monitoring and supervision
- ▶ **Behavioral health treatment needs**
 - ▶ Referral to community service providers as needed to address low level MH/SA treatment needs
- ▶ **High criminogenic needs**
 - Emphasis on addressing non-behavioral health criminogenic needs
 - Significant criminal history, antisocial beliefs, and peers
 - Educational and employment deficits
- ▶ **Screening/eligibility concerns**
 - ▶ Violent or aggressive behavior



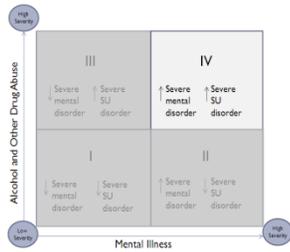
Quadrant II: For High Risk People With High MH Needs and Low SA Needs

- ▶ **What type of programming would be most appropriate?**
 - ▶ Mental health courts or similar diversion programs
- ▶ **Behavioral health treatment needs**
 - ▶ Mental health treatment to improve responsiveness to other recidivism-reduction practices
 - ▶ Emphasis on integrated service models
- ▶ **High criminogenic needs**
 - Significant criminal history, antisocial beliefs, and peers
 - Educational and employment deficits
 - Family and social supports
- ▶ **Screening/eligibility concerns**
 - Functional impairment that would prevent effective participation
 - Active substance abuse that requires detoxification
 - Persons who have chronic medication adherence issues
 - Suicidal, violent, or aggressive behavior



Quadrant III: For High Risk People With Low MH Needs and High SA Needs

- ▶ **What type of programming would be most appropriate?**
 - ▶ Drug court programs
- ▶ **Behavioral health treatment needs**
 - ▶ Substance abuse treatment and EBPs to improve responsiveness to other recidivism-reduction practices
 - ▶ Emphasis on integrated service models
- ▶ **High criminogenic needs**
 - Substance dependence
 - Significant criminal history, antisocial beliefs, and peers
 - Educational and employment deficits
- ▶ **Screening/eligibility concerns**
 - Historical inability to sustain abstinence, even with treatment supports and monitoring
 - Violent or aggressive behavior



Quadrant IV: For High Risk People With High MH Needs and High SA Needs

- ▶ **What type of programming would be most appropriate?**
 - ▶ Specialized court-supervised co-occurring disorder treatment programs
 - ▶ Enhancement of existing problem-solving court programs to create unique “tracks” or components that include coordination between intensive supervision and monitoring, and integrated treatment
- ▶ **Behavioral health treatment needs**
 - ▶ Application of EBPs for CODs
 - ▶ Emphasis on integrated service models
- ▶ **High criminogenic needs**
 - Substance dependence
 - Significant criminal history, antisocial beliefs, and peers
 - Educational and employment deficits
- ▶ **Screening/eligibility concerns**
 - Suicidal, violent, or aggressive behavior
 - Functional impairment that would prevent effective participation

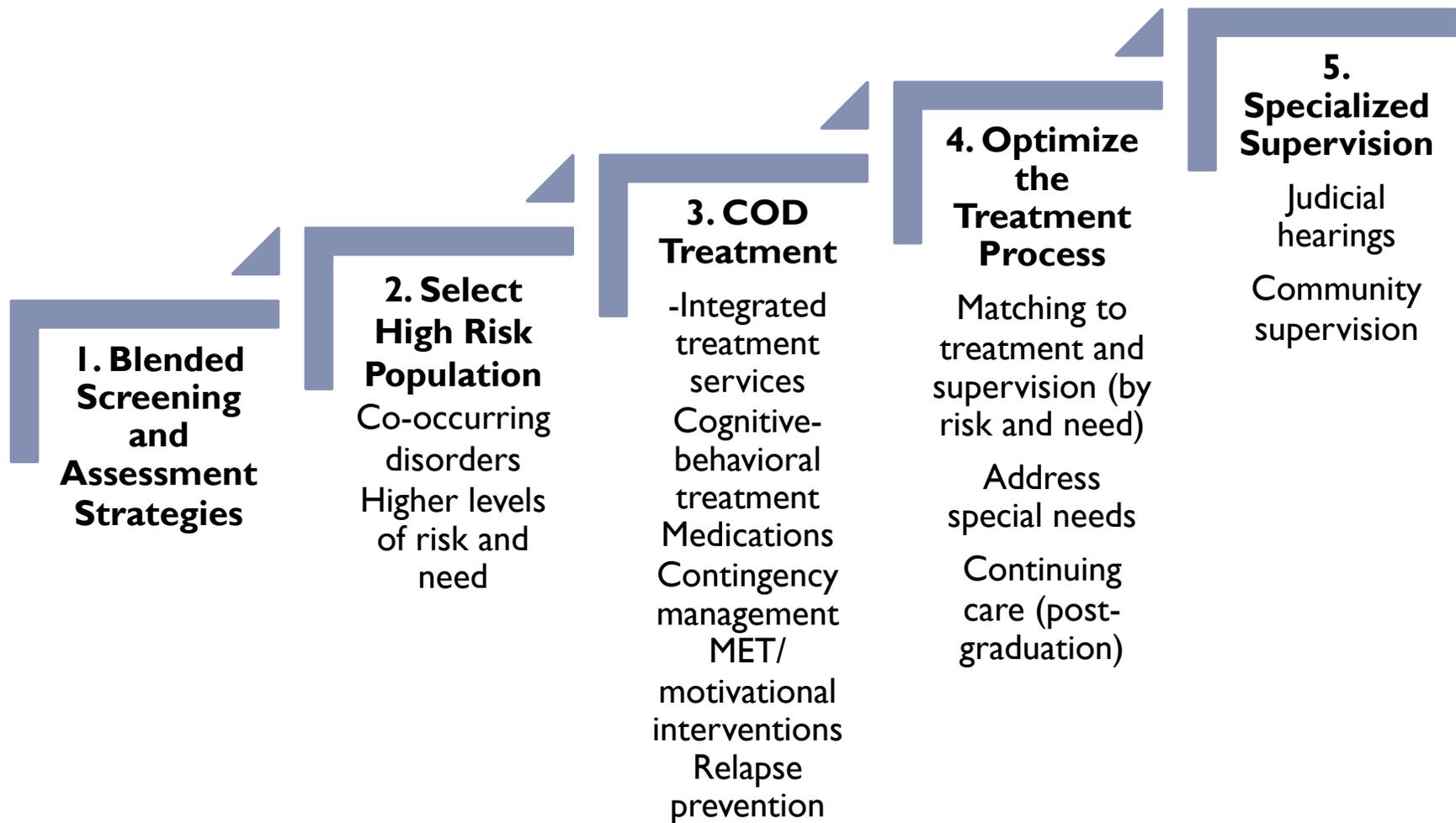
Putting It All Together: Implications for Problem-Solving Courts

Behavioral Health Disorders & Criminal Behavior

- ▶ Target CODs in problem-solving courts – you have the resources to address ‘high risk’ and ‘high need’ participants
- ▶ Therefore, court-based treatment and supervision should address both CODs and other areas of criminogenic risk
- ▶ The design of your program will be contingent on resources, prosecutorial requirements, community linkages, available SA treatment resources



Conceptual Model of COD Treatment Services in Problem-Solving Courts



Screening and Assessment

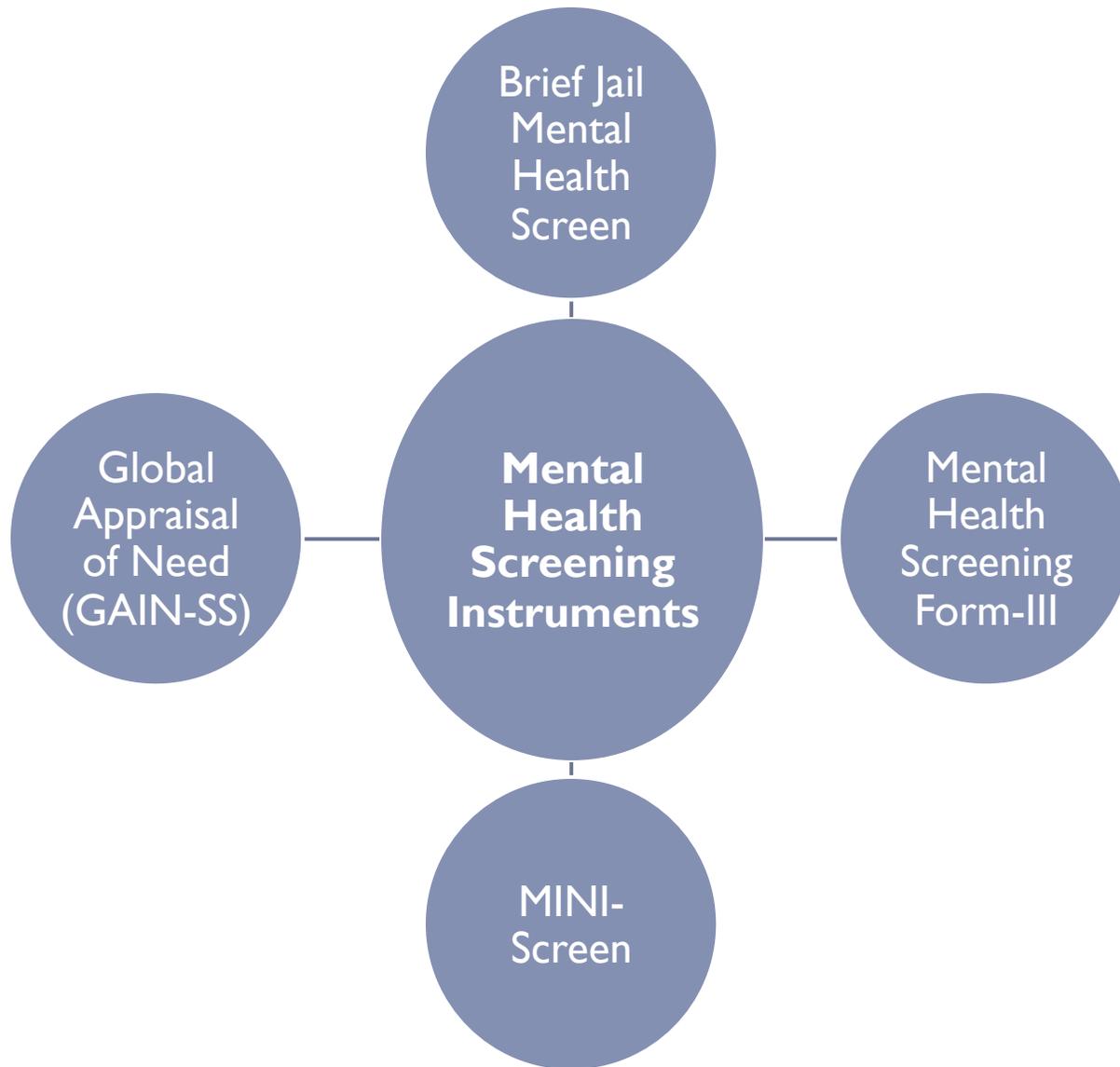
Don't exclude persons based on serious mental illness, substance dependence, or active substance use

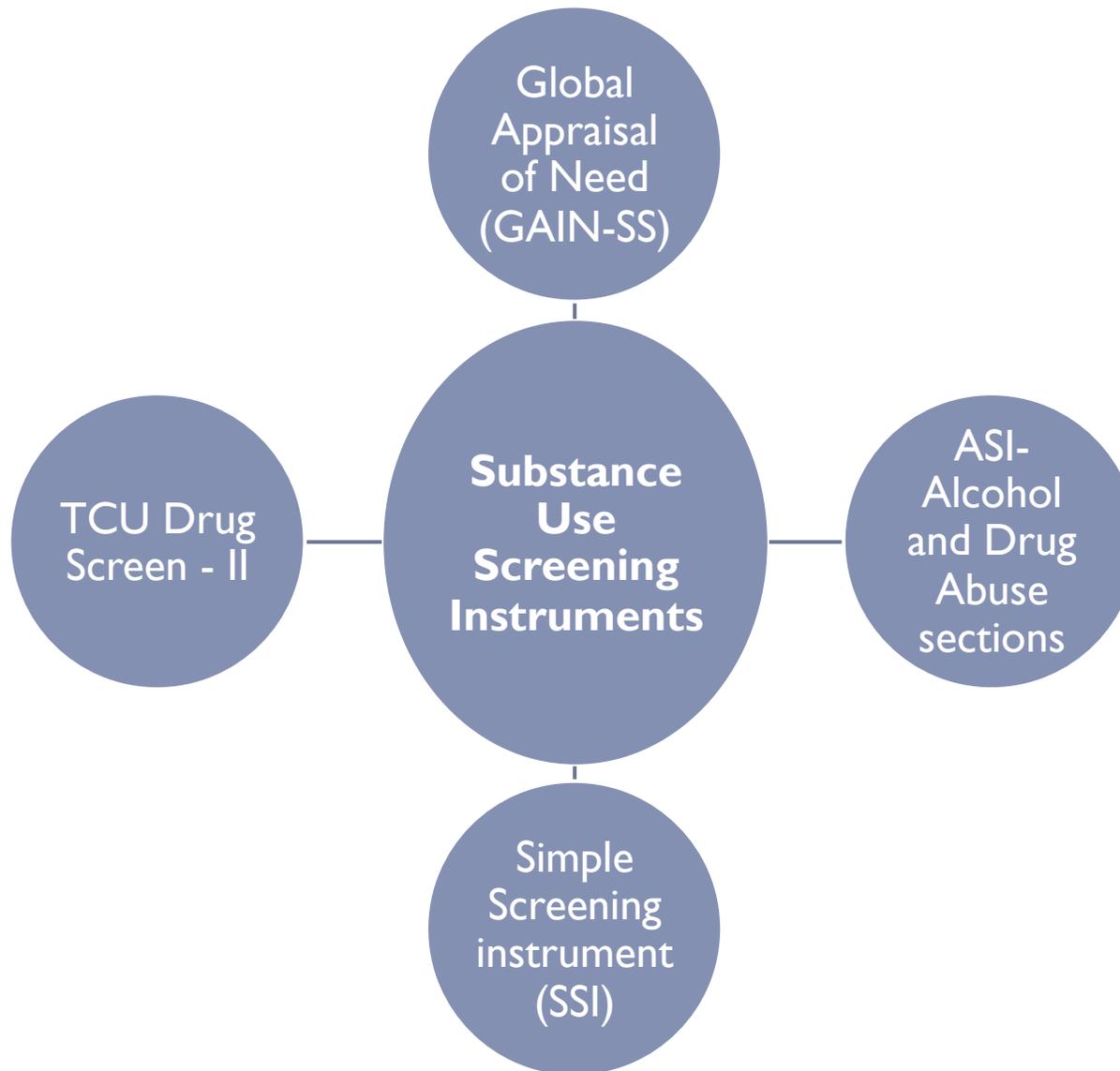
Screening

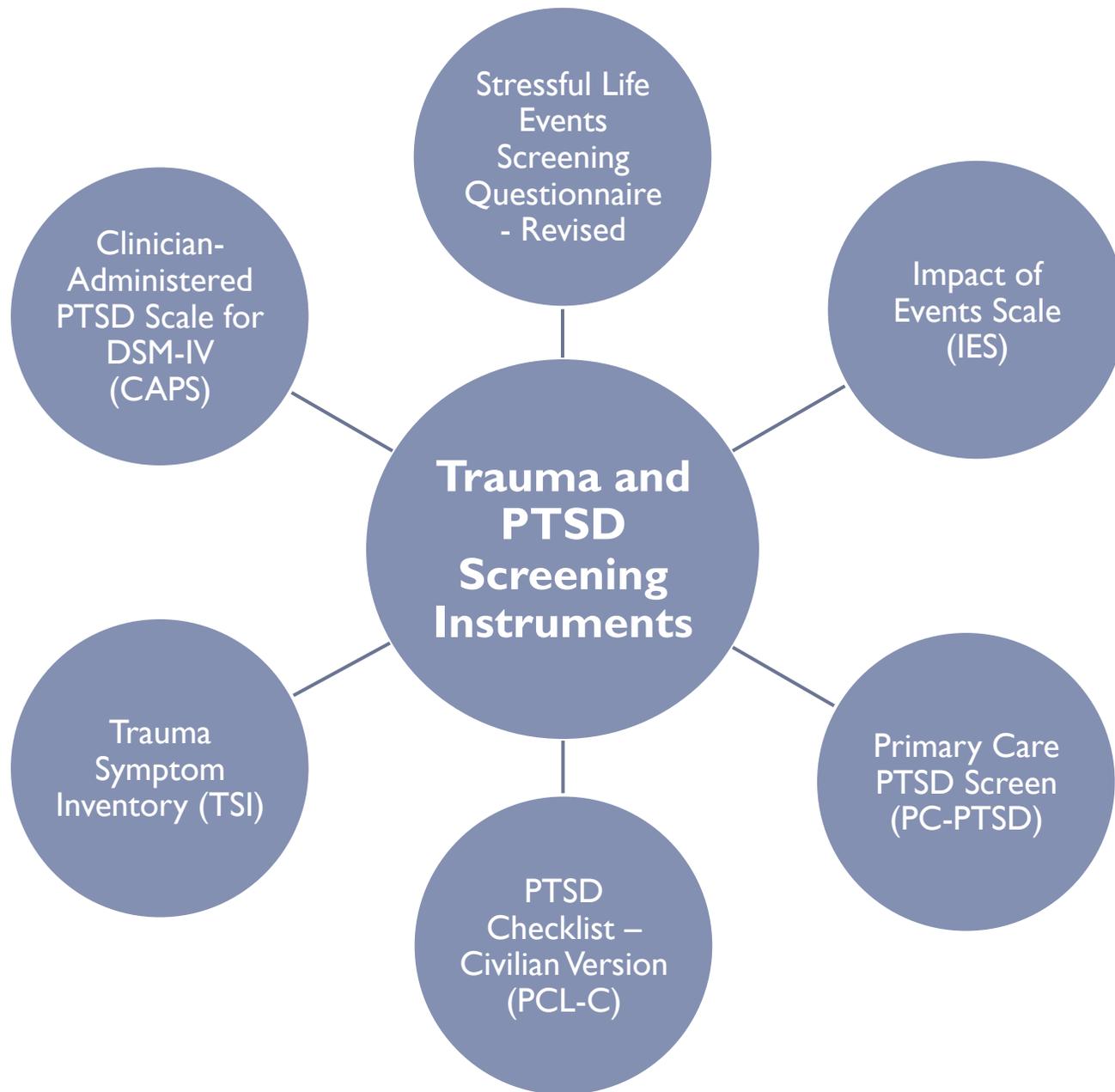
- ▶ Routine screening for MH, SA, and trauma/PTSD
- ▶ Identify acute symptoms
- ▶ Focus on areas of functional impairment that would prevent effective program participation

Assessment

- ▶ Examine longitudinal interaction of disorders
- ▶ Review participant motivation over time







COD Assessment Domains

- ▶ Substance Use Disorders
- ▶ Mental Disorders
- ▶ Interactive Nature of Disorders
- ▶ Functional Impairment
- ▶ Risk Assessment
- ▶ Psychosocial Background and History

Risk Assessment Instruments



(Adapted from Peters, SAMHSA , 2011)

Evidence-Based COD Treatments

- ▶ Integrated treatment for CODs (e.g., IDDT)
- ▶ Cognitive-behavioral treatment
- ▶ Medications (for mental and SA disorders)
- ▶ Contingency management
- ▶ Motivational enhancement
- ▶ Relapse prevention
- ▶ Trauma-focused treatment
- ▶ Assertive Community Treatment (ACT)
- ▶ Modified Therapeutic Communities

Cognitive-Behavioral Treatment Curricula

- ▶ **Co-Occurring Disorders**
 - ▶ Illness Management and Recovery (IMR)
 - ▶ Integrated Group Therapy for Bipolar Disorder and Substance Abuse
 - ▶ Cognitive-Behavioral Therapy for PTSD
 - ▶ Seeking Safety (SA and trauma/PTSD)
- ▶ **Criminal Thinking and Substance Abuse**
 - ▶ Criminal Conduct and Substance Abuse
 - ▶ Thinking for a Change
 - ▶ Reasoning and Rehabilitation

Illness Management and Recovery (IMR)

- ▶ **Major Components of IMR**
 - ▶ Psychoeducation
 - ▶ Behavioral tailoring
 - ▶ Relapse prevention
 - ▶ Coping skills training
 - ▶ Social skills training
- ▶ **Related Programs**
 - ▶ Social and Independent Living Skills (SILS)
 - ▶ Wellness Recovery and Action Plan (WRAP)

Integrated Group Therapy for Bipolar Disorder and SA

- ▶ **Cognitive-Behavioral Strategies**
 - ▶ Symptom monitoring
 - ▶ Identify and restructure core beliefs
 - ▶ Linking thoughts to situations, mood, behaviors
 - ▶ Thought distortions and evidence gathering
 - ▶ Skills training and behavioral problem-solving
- ▶ **Adaptable for range of MH disorders/settings**

Features of COD Treatment

- ▶ 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 COD Programs

- ▶ More staff intensive
- ▶ Dually credentialed staff
- ▶ Highly structured treatment and supervision services
- ▶ Increased program duration (e.g., more than one year)
- ▶ Pace of treatment is slower
- ▶ Flexible progression through court-based program

Innovations in Court-Based COD Treatment

- ▶ Stage-specific, integrated treatment groups
- ▶ Gender-specific interventions (e.g., groups, tracks)
- ▶ Specialized COD/MICA groups
- ▶ Intensive case management and wraparound services
- ▶ Linkage with transition living centers/halfway houses
- ▶ MH peer supports (e.g., peer relapse specialists)
- ▶ Specialized COD 12-step groups (Double Trouble, Dual Recovery Anonymous)

What type of specialized programs and supervision can be provided by problem-solving courts for people with co-occurring disorders?

Options for Court-Based COD Programs

- ▶ COD dockets (smaller, more frequent hearings, informal)
- ▶ Programs embedded within problem-solving courts
 - Treatment groups for persons with CODs (e.g., MICA groups)
 - Tracks for persons with CODs
 - Multiple tracks (separate groups, separate/mainstream, mainstream)
 - Single track (group treatment, COD education, individual counseling)
- ▶ Transfer between drug courts, mental health courts, COD dockets

Adaptations for Jurisdictions with Limited Resources (e.g., rural courts)

- ▶ Blended screening and assessment to address MH, SA, and PTSD/trauma
- ▶ Education about CODs for all participants
- ▶ Add one COD group 1- 3 times weekly
- ▶ Individual counseling for participants with CODs
- ▶ Engage participants in COD-specific 12-step groups (Dual Recovery Anonymous, Double Trouble)
- ▶ Modify approaches for status hearings and supervision
- ▶ Liaison with community provider(s) re. medications

Modifying Court Hearings

- ▶ More frequent court hearings may be needed
- ▶ Hearings provide a good opportunity to recognize and reward positive behavior change
- ▶ Less formal, smaller, more private
- ▶ Greater interaction between judge and participants
- ▶ Include mental health professionals

Community Supervision and CODs

- ▶ Specialized caseloads (MH/COD)
- ▶ Smaller caseloads (e.g., < 45)
- ▶ Sustained and specialized officer training
- ▶ Promote active engagement in SA and MH treatment
- ▶ Dual focus on treatment and surveillance
- ▶ Specialized caseloads more effective with CODs
 - ▶ Lower rates of revocation, arrest, incarceration
 - ▶ Better linkage with community treatment services

Community Supervision and CODs

- ▶ **Problem-solving approach**
 - ▶ Higher revocation threshold
 - ▶ Wide range of incentives and sanctions
 - ▶ Flexible application of sanctions; emphasis on education and support vs. compliance and sanctions
 - ▶ Avoid sanctions that remove participants from treatment
 - ▶ Relationship quality important (trust, caring, fairness, avoid punitive stance) – “firm but fair”

Source: Skeem et al., 2006, 2009



Summary of Key Points

- ▶ CODs - good target population for court programs
- ▶ Use blended screening and assessment approach
- ▶ Features of evidence-based COD treatment:
 - ▶ Integrated and multi-component (MH, SA, criminality)
 - ▶ Use cognitive-behavioral techniques
 - ▶ Variety of interventions and curricula available
- ▶ Specialized court-based COD programs have unique features and use a variety of innovative approaches
- ▶ Several options for designing COD programs (COD dockets, embedded programs, transfer strategies)

For More Information

- ▶ **Council of State Governments Justice Center**
 - ▶ National Reentry Resource Center
 - ▶ Criminal Justice/Mental Health Consensus Project

- ▶ **SAMHSA's GAINS Center**
 - ▶ Peters, R.H., & Osher, F.C. (2004). Co-occurring disorders and specialty courts. Delmar N.Y: The National GAINS Center

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MODULE 5: DESIGNING POLICIES AND PROCEDURES FOR PROGRAM PARTICIPATION

Module 5: Designing Policies and Procedures for Program Participation helps you design program policies and procedures that comply with relevant laws.

Learning Objectives

1. Understand how a mental health court program can be designed to protect legal rights
2. Describe how to design a referral process for your program
3. Identify considerations for determining the duration of an individual's participation in the mental health court

Elements



Prep Work

Provides background reading to introduce you to the topics discussed in this module. All resources are available for free online. You will need access to a computer to complete this step. *Estimated completion time: 30 minutes.*



Presentation

Covers the key concepts of this module in depth, and teaches you everything you need to know to complete the module's activities. Presentations consist of between 35 and 45 slides. You control the pace of the presentation by clicking from one slide to the next. You will need access to a computer to complete this step; to play the presentation's audio and video features, you must have Adobe Flash Player installed on your computer. *Estimated completion time: 45-60 minutes*



Quiz

Reinforces your knowledge of the concepts you learned in the module. You will need access to a computer to complete this step. *Estimated completion time: 10 minutes.*

Q & A

Please type your questions into the chat box

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FEATURED FORUM DISCUSSION

What are your opinions on the value of trauma treatment vs trauma-informed care?

Dr. Gene Griffin, Professor, Department of Psychiatry, Northwestern University Medical School, writes:

"... when working with a traumatized child it is more important to look at the entire life of the child and infuse trauma-informed care into as many aspects of the child's life as possible. ..."

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Webinar Archive: Women Engaged in the Criminal Justice System

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ANNOUNCEMENTS, EVENTS, & PRESS RELEASES

Watch Recent Consensus Project Webinars Online

During the month of July, the Consensus Project hosted three webinars that focused on different aspects of the mental health/criminal justice intersect. At each of these events, mental health and criminal justice practitioners from across the country delivered presentations and then responded to questions from attendees during a moderated question and answer session hosted by a Council of State Governments staff member. If you were unable to attend the original webinars, or attended but would like to review the presentations again, as with all webinars hosted by the Consensus Project, these events have been archived online. (To access a list of archived webinars, click [here](#).)

Grant Report Reviews Impact of Mental Health Courts

In association with the National Criminal Justice Reference Service, the National Institute of Justice has released *Criminal Justice Interventions for Offenders with Mental Illness: Evaluation of Mental Health Courts in Bronx and Brooklyn*. This study identifies characteristics of the Bronx and Brooklyn Mental Health Courts (MHCs) that may contribute to participants' criminal justice outcomes, compared to the outcomes of other offenders with mental health disorders.

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MEDIA CLIPS

LegalTimes - Online (DC) – Study Shows D.C. Community Court Program Lowered Reoffending Rates

KUOW News (WA) – New Mental Health Crisis Facility To Serve King County

Cheboygan Daily Tribune (MI) – Juvenile mental health court being considered

The Portland Press Herald (ME) – If someone's on the brink, he's there to talk them down

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- The Consensus Project is continually updating its website with materials relevant to the CJ and MH fields.
- consensusproject.org

Peer-to-Peer Connections

<http://consensusproject.org/forums/>



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