Co-Occurring or Mental Health Court - They're the same thing, right?

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Disclosure

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Session Objectives

Attendees will:

1. Be able to identify the differences between Co-Occurring Courts and Mental Health Courts and the individuals each serves.
2. Learn practical strategies for their teams to implement when working within these two courts.
3. Learn evidence-based strategies and promising services for those with serious mental illness.

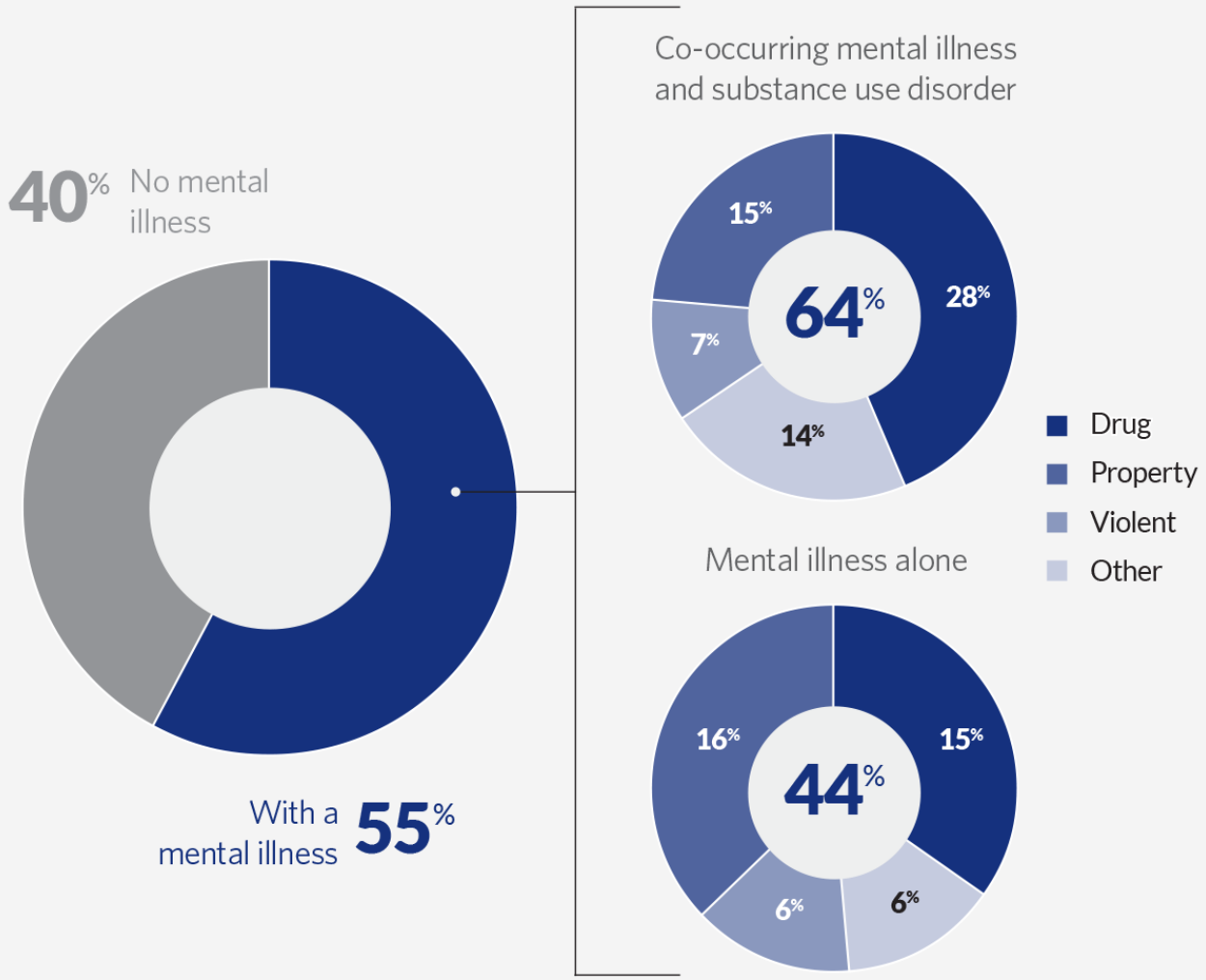
Why another specialty court?

- Individuals with mental illness are disproportionately represented in the criminal justice system. Compared to the general population, individuals with mental illness are three times more likely to interact with police (Magee et. al. 2021).
- While 18 percent of the general population has a mental illness, 44 percent of individuals in jails and 37 percent of those in prison have a mental illness. (Bronson, et. al. 2017.)
- Jails and prisons have become the nation's largest psychiatric hospitals. There are more individuals with severe mental illness in the Los Angeles County Jail or New York's Riker's Island than there are in any psychiatric hospital in the nation (Torrey, 2019).

Adults on probation with a mental illness are more likely to be arrested than those without.

Source: Pew analysis of Substance Abuse and Mental Services Administration, "National Survey on Drug Use and Health" (2015-2019). *https://www.datafiles.samhsa.gov/data-sources*.

Percent of adults on probation who were arrested, by mental illness alone or co-occurring with substance use disorders

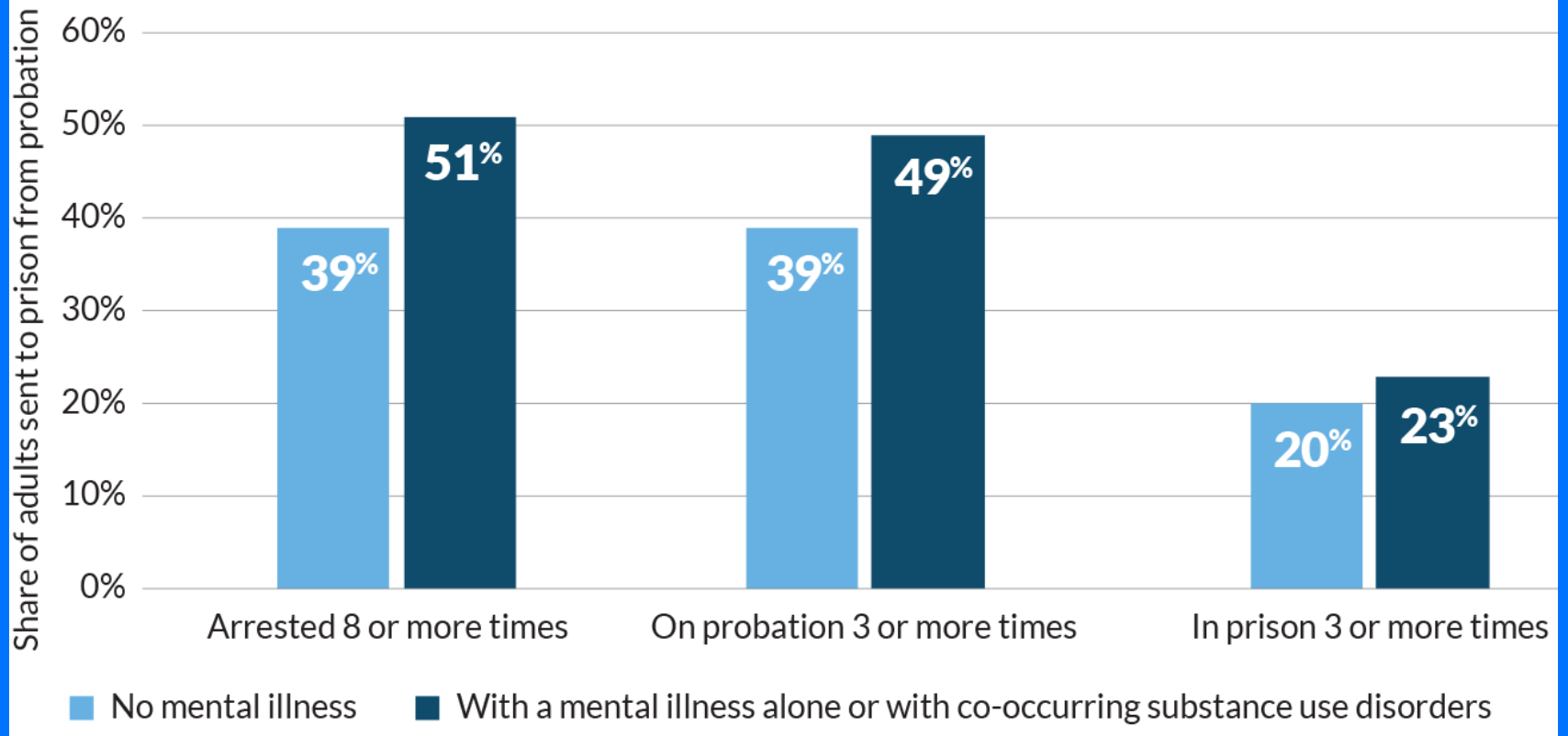


Note: Percentages may total more than 100% because of rounding.

Figure 5

Among People Sent to Prison From Probation, Those With a Mental Illness Reported More Past Criminal Justice System Involvement Than Those Without a Mental Illness

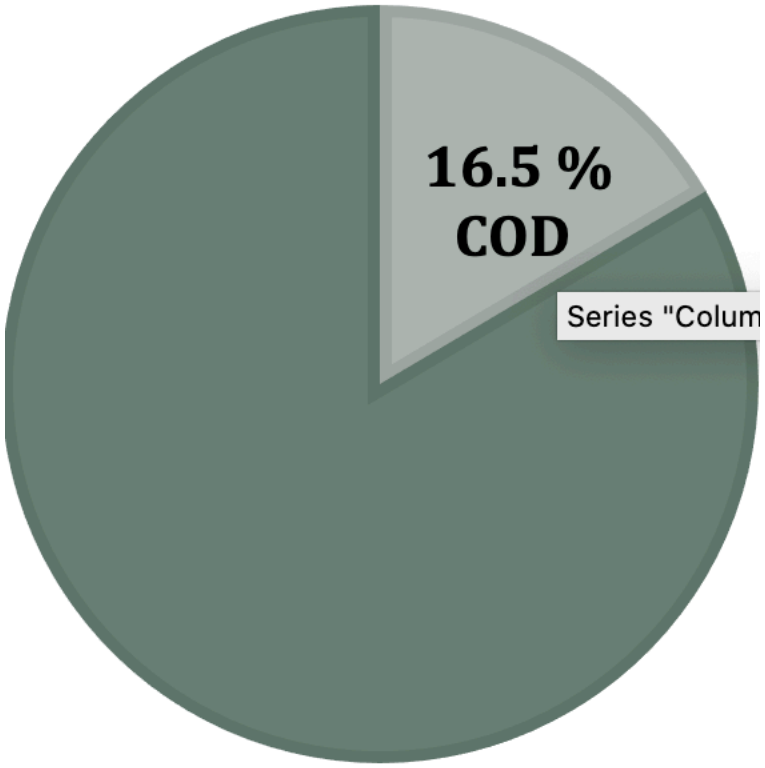
Percent of individuals sent to prison from probation, by type of criminal justice system involvement and mental illness



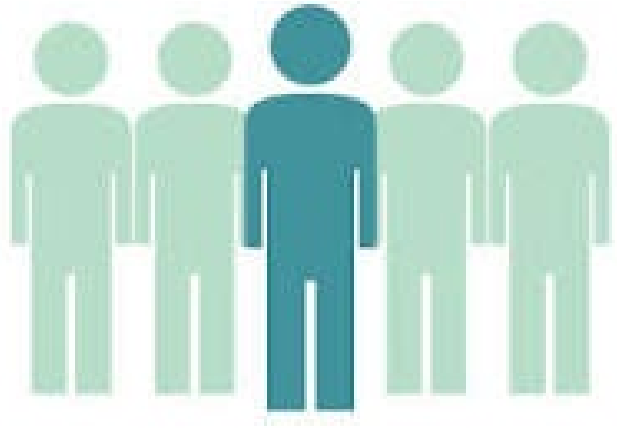
Source: Pew analysis of United States Bureau of Justice Statistics, "Survey of Prison Inmates, United States, 2016" (2021), https://doi.org/10.3886/ICPSR37692.v4.

PREVALENCE

46.3 MILLION
Met DSM-5 criteria for SUD
NIDA, 2021



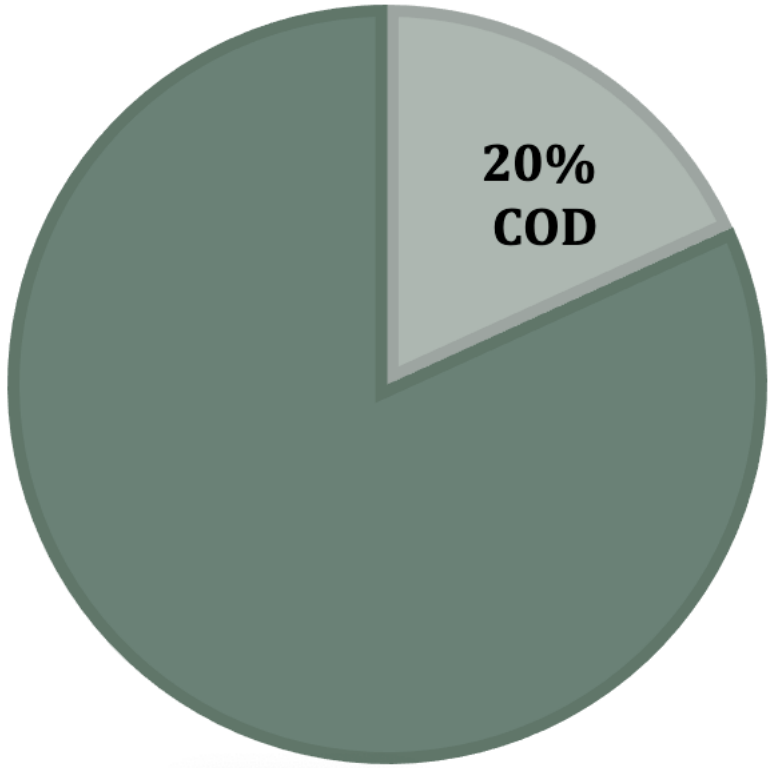
U.S. Population 12 years + older



1:5 individuals engaged treatment who have a COD

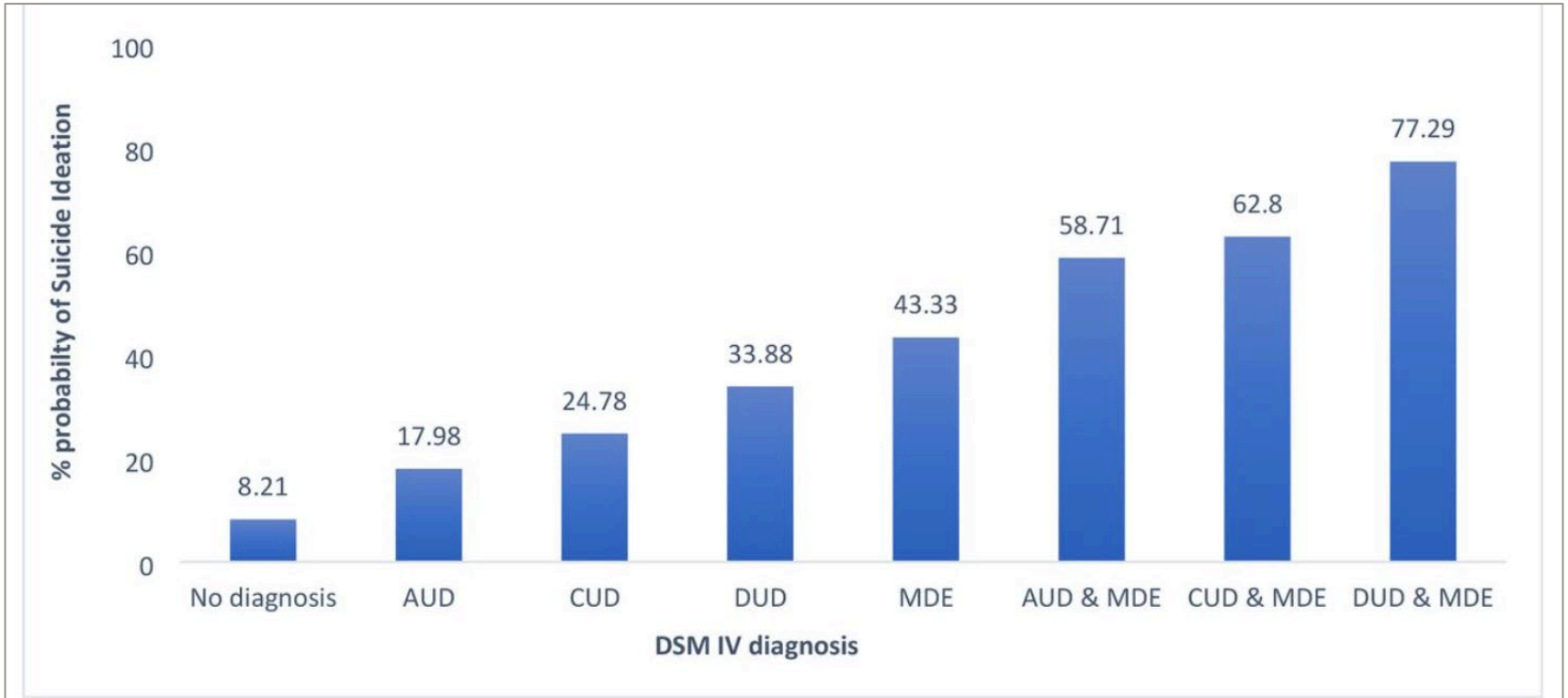
BETWEEN 10-30 % OF ADULTS WITH COD RECEIVED TX FOR BOTH CONDITIONS

57.8 MILLION
Met DSM-5 criteria for AMI
NIH, 2021



U.S. [illegible]B years + older
Leader Lines 1

PREVALENCE RATES OF SUICIDE IN INDIVIDUALS WITH CO-OCCURRING DISORDERS



AUD - Alcohol use disorder, defined DSM-IV Alcohol Abuse /or Dependence diagnoses.; CUD - Cannabis use disorder, defined DSM-IV Cannabis Abuse /or Dependence diagnoses; DUD - Drug use disorder, defined as DSM-IV diagnoses of drug abuse/or dependence diagnoses on opiates, sedatives, tranquilizers, amphetamines hallucinogens, heroin, cocaine, inhalants, and/or other drug except cannabis.; MDE - Major depressive episode, defined DSM-IV diagnosis of major depressive episode.

Mental Illness & Criminogenic Risk

Research has found that arrestees with mental illness inhabit the following characteristics more than people without mental illness:

- A greater number of criminal associates
- Increased time spent with these associates
- Higher scores on measures of criminal attitudes
- Higher number of antisocial/criminal personality traits
- More extensive history of conduct problems
- Greater substance use than arrestees without mental illness

Bartholomew & Morgan (2015)

Public Law 106-515, Part V: Mental Health Courts, Section 2201 (Nov. 13, 2000)

Define Mental Health Courts as programs that provide:

1) continuing judicial supervision, including periodic review, over preliminarily qualified offenders with mental illness, mental retardation, or co-occurring mental illness and substance abuse disorders, who are charged with *misdemeanors or nonviolent offenses*; and

2) the coordinated delivery of services, which includes—

    (A) **specialized training** of law enforcement and judicial personnel to identify and address the unique needs of a mentally ill or mentally retarded offender.

Public Law 106-515, Part V: Mental Health Courts, Section 2201 (Nov. 13, 2000)

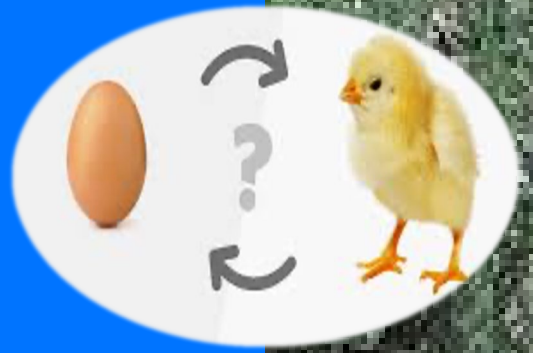
(B) **voluntary** outpatient or inpatient mental health treatment, in the **least restrictive** manner appropriate, as determined by the court, that carries with it the possibility of **dismissal of charges or reduced sentencing** upon successful completion of treatment;

(C) **centralized case management** involving the consolidation of all of a mentally ill or mentally retarded defendant's cases, including violations of probation, and the coordination of all **mental health treatment** plans and **social services**, including **life skills** training, such as **housing** placement, **vocational training**, **education**, **job placement**, **health care**, and **relapse prevention** for each participant who requires such services; and

(D) continuing supervision of treatment plan compliance for a term not to exceed the maximum allowable sentence or probation for the charged or relevant offense and, to the extent practicable, **continuity of psychiatric care** at the end of the supervised period.

Pathways to Comorbidity

- **Shared risk factors**
- **Mental illness may contribute to substance use and addiction.**
- **Substance use and addiction can contribute to the development of mental illness.**



SHARED RISK FACTORS

GENETICS / EPIGENETICS	• Complex interactions among multiple genes • Genetic interactions with environmental influences
BRAIN	• Brain circuitry: reward, decision making, impulse control, emotional regulation • Neurotransmitter system: dopamine, serotonin, glutamate, norepinephrine
ENVIRONMENT	• Chronic stress, trauma, and adverse childhood experiences, access • Protective factors
TRAUMA / ACES	• Nervous system gets easily "stuck on high" (hypervigilant, panicky, manic, angry, nervy) or "stuck on low" (depressed, anhedonia, lethargic)
STRESS	• Stress responses are mediated through the hypothalamic-pituitary-adrenal (HPA) axis which affects motivation, learning, and adaptation • Leads to decreased behavioral control and increased impulsivity

SLEEP OR APPETITE CHANGES — Dramatic sleep and appetite changes or decline in personal care.

MOOD CHANGES — Rapid or dramatic shifts in emotions or depressed feelings, greater irritability.

WITHDRAWAL — Recent social withdrawal and loss of interest in activities previously enjoyed.

DROP IN FUNCTIONING — An unusual drop in functioning, at school, work or social activities, such as quitting sports, failing in school or difficulty performing familiar tasks.

PROBLEMS THINKING — Problems with concentration, memory or logical thought and speech that are hard to explain.

INCREASED SENSITIVITY — Heightened sensitivity to sights, sounds, smells or touch; avoidance of over-stimulating situations.

APATHY — Loss of initiative or desire to participate in any activity.

FEELING DISCONNECTED — A vague feeling of being disconnected from oneself or one's surroundings; a sense of unreality.

ILLOGICAL THINKING — Unusual or exaggerated beliefs about personal powers to understand meanings or influence events; illogical or "magical" thinking typical of childhood in an adult.

NERVOUSNESS — Fear or suspiciousness of others or a strong nervous feeling.

UNUSUAL BEHAVIOR — Odd, uncharacteristic, peculiar behavior.

CHANGES IN SCHOOL OR WORK — Increased absenteeism, worsening performance, difficulties in relationships with peers and co-workers.

COMMON COMORBIDITIES BY SUD

	Anxiety	Depressive	BiPolar & Related	Personality (APD, BPS)	Trauma/ Stressor Related	Schizophrenia Spectrum / Psychotic	Feeding & Eating	Sleep - Wake
Alcohol	x	x	x	*x*	x	x		
Cannabis		x	x				x	
Caffeine	x	x	x		x		x	x
Inhalants	x	x		x				
Stimulants				x	x			
Hallucinogens				x				
Opioids	x	x	x	*x*	x			
Sedatives	x	x	x	*x*				
Nicotine	x	x	x	x	x			

What's in a name?

Mental Health Treatment Court (MHTC):

- A specialized court that diverts individuals with serious mental illness (SMI) from jail/prison into treatment and supervision.
- Focus on treating and managing mental illness (e.g., schizophrenia, bipolar disorder).

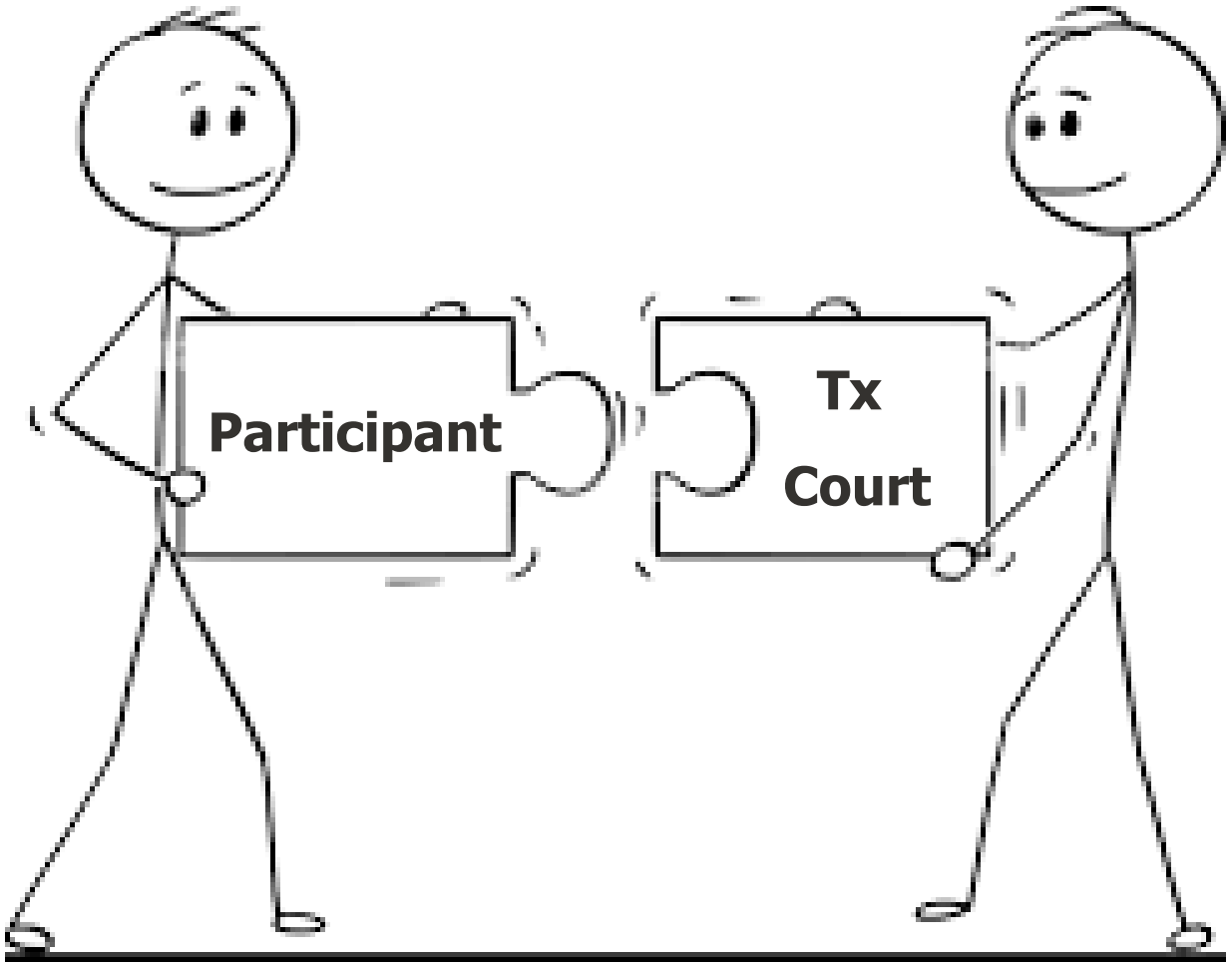
Co-Occurring Disorder (COD) Treatment Court:

- A specialized court that addresses individuals with both a serious mental illness and a substance use disorder (SUD).
- Dual focus on mental health and substance use treatment simultaneously.

Key Similarities

Targeting the Right Participants

Matching participants' assessed risks, needs, and responsivity concerns to the right program structure, services, & supports



Risk, Needs and Responsivity

- Risk Principle: Tells us WHO
- Need Principle: Tells us WHAT
- Responsivity Principle: Tells us HOW

  Examples:

  - *Mental Health*
  - *Trauma History*
  - *Cognitive or Developmental Deficits*
  - *Homelessness*
  - *Parental responsibilities*

Target Population

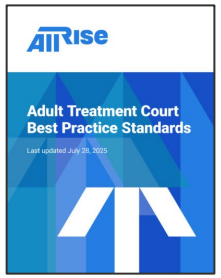
Criteria	Mental Health Court	Co-Occurring Disorder Court
Moderate – High SUD	Maybe	X
Qualifying MH Disorder	X	X
Criminogenic Risk	Moderate - High	Moderate - High

Team Composition

Team Member	Mental Health Court	Co-Occurring Disorder Court
Judge	X	X
Coordinator	X	X
Prosecutor	X	X
Defense Attorney	X	X
Supervision Officer	X	X
Law Enforcement Officer	X	X
SUD Counselor	Optional	X
MH Counselor	X	X
Peer Support Specialist	Optional	Optional
Evaluator	X	X

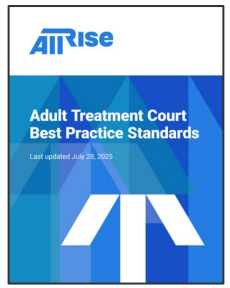
Services/Supports Provided

Services/Supports	Mental Health Court	Co-Occurring Disorder Court
Case Management	X	X
SUD Treatment	Less Common	X
Detoxification / Relapse Prevention	Less Common	X
Drug Testing	Less Common	X
Mental Health Treatment	X	X
Medication Management	X	X
Housing	X	X
Life Skills	X	X
Teaching/Monitoring ADLs	More Common	Less common
Family Services	X	X
Education/Employment Services	X	X



Best Practice Standards

- All candidates for and participants in treatment court are **screened for co-occurring substance use and mental health or trauma symptoms** as soon as possible after arrest or upon entering custody and are **referred for an in-depth assessment** of their treatment needs where indicated.
- Assessors are trained to administer screening and other assessment tools validly, reliably, and in a manner that **does not retraumatize or shame participants** and receive at least annual booster training to maintain their assessment competence and stay abreast of advances in test development, administration, and validation.
- Participants are **rescreened** if **new symptoms** develop or if their **treatment needs** or **preferences** change.
- Co-occurring substance use and mental health or trauma disorders are treated using an **evidence-based integrated treatment** model that **educates participants** about the mutually aggravating effects of the conditions and teaches them effective ways to **self-manage** their recovery, recognize potential warning signs of symptom recurrence, to address emerging symptoms, and seek professional help when needed. take steps



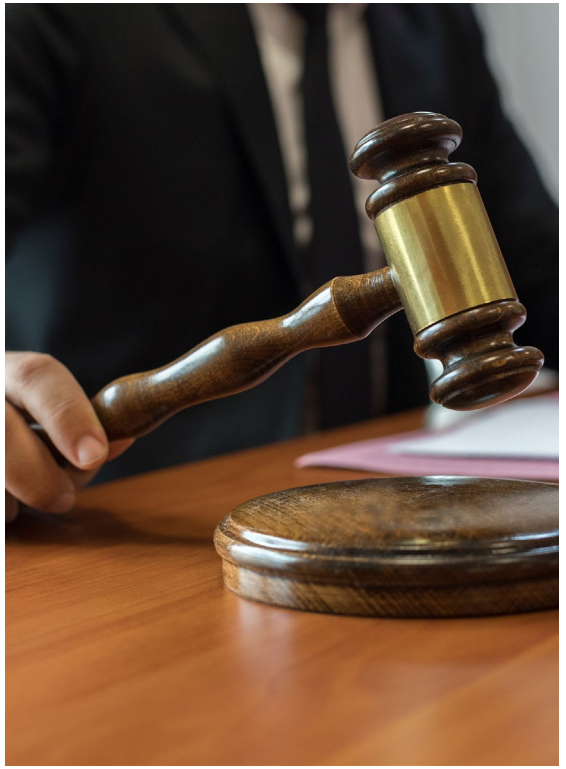
Best Practice Standards, cont'd

- Counselors or therapists receive at least 3 days of **pre-implementation training** on integrated treatments for co-occurring disorders, **receive annual booster training** to maintain their competency and stay abreast of new information on evidence-based treatments, and are clinically supervised at least monthly to ensure continued fidelity to the treatment models.
- Participants with mental health disorders receive unhindered **access to psychiatric medication** regardless of whether they have a substance use disorder.
- Participants inform the prescribing medical practitioner if they have a substance use disorder and execute a **release of information** enabling the prescriber to communicate with the treatment court team about their progress in treatment and response to the medication.
- **All members of the treatment court team receive at least annual training on trauma-informed practices** and ways to avoid causing or exacerbating trauma and mental health symptoms in all facets of the program, including courtroom procedures, community supervision practices, drug and alcohol testing, and the delivery of incentives, sanctions, and service adjustments.

Shared strategies for both MH and COD Courts

Considerations for MH and COD Courts

- The key to treating participants with SMI/COD is flexibility.
- People with difficulty thinking, concentrating, or controlling emotions may not be able to successfully participate in standard therapeutic groups or 12-step programs.
- Remaining flexible and using individualized criteria does not mean the participant faces no rules or expectations for change.
- Courts might need to apply a different paradigm to participants with SMI/COD to achieve best outcomes, revisiting standardized responses to participant failures.



Adjust Expectations While Adhering to Standards

- Provide flexible and adaptable case management to accommodate fluctuating symptoms or crisis situations that may arise due to mental health challenges.
- Consider the role of psychiatric medications in the participant's overall treatment plan. Some participants may be prescribed medications that could impact their substance use recovery, but they should not be penalized for legitimate use of prescribed medications.
- Offer positive reinforcement and incentives for engagement in mental health treatment, therapy, or psychiatric appointments, as well as for progress in substance use recovery. Celebrate milestones like medication adherence or managing symptoms effectively.

Expectations & outcomes for individual participants may vary. However, the 10 Key Components and Adult Drug Court Best Practice Standard hold true for all treatment courts.

THE BIG 6

- Step 1: Know Who Your Participants Are and What They Need
- Step 2: Adapt Your Court Structure
- Step 3: Expand Your Treatment Options
- Step 4: Target Your Case Management and Community Supervision
- Step 5: Expand Mechanisms for Collaboration
- Step 6: Educate Your Team

Chip Away at Learned Helplessness

- Learned helplessness is the belief that someone is unable to control or change their situation, so they give up even when opportunities for change become available.
- Anger, bitterness, resentment, and entitlement are roots of learned helplessness and the enemies of progress.
- Build self-efficacy.
- Help clients develop an internal locus of control and release the belief that things happen to us rather than playing any role in our own outcomes.

Practice empathy AND accountability

- The court's role is to be **firm but compassionate**, holding participants **accountable** for their actions while also recognizing the complexities of their mental health conditions and providing the appropriate **support** to help them succeed.
- Offer **tailored interventions** that take the participant's unique mental health needs into account while still emphasizing the importance of recovery steps.
- Explore and understand the **underlying reasons** why one may be failing to comply with treatment or court orders, rather than assuming willful noncompliance.
- **Offer positive reinforcement** when the participant shows effort, even if they haven't yet fully met all of the court's expectations.

Stay vigilant against manipulation

- Clients high-risk in criminal thinking, attitudes, and personality are very skilled at manipulation.
- When successful at gaining special consideration for criminal behavior based upon the belief it is due to their mental illness, some may do so as often as permitted. This derails success and perpetuates criminal behavior.
- Strive to identify if behavior is a result of mental illness or criminal thinking. Be objective and open to the belief that both factors can be at play.

Remain alert to criminogenic needs

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Adjust your pace

- Outcomes may come slower than expected.
- Cognitive Behavioral Assignments that may typically be assigned as homework may require 1:1 assistance and in smaller increments (i.e., a page or 2 at each session).
- Participants may need several attempts to reach achievements such as earning a driver's license, passing the GED/TASC, and securing independent housing.

Promote self efficacy

- Empower participants to believe in their ability to succeed and take control of their own recovery process.
- Set small, achievable goals by breaking down larger treatment or legal requirements into smaller, manageable steps that participants can accomplish. This helps participants build confidence as they experience success in achieving these goals.
- Encourage peer support and mentorship by involving individuals who have successfully navigated the system and managed their mental health recovery. Peer mentors can model self-efficacy by sharing their recovery stories and how they overcame obstacles.

Utilize ISSA to create system of accountability that is supportive

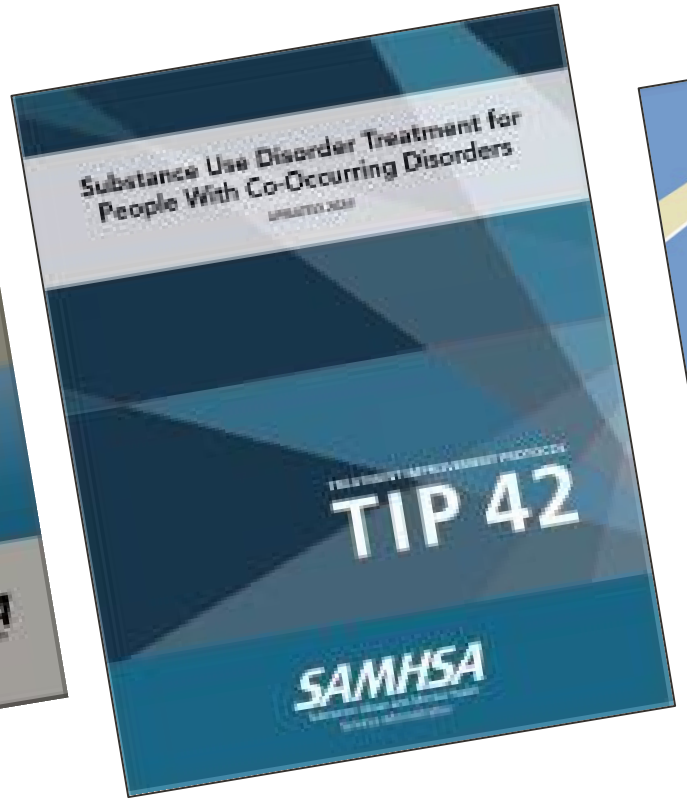
- When participants miss an appointment or fail to meet a goal, focus on understanding why and collaborating on a plan to address the underlying issues.
- Offer consistent, positive reinforcement for effort and progress, not just results
- Encourage participants to regularly reflect on their progress, challenges, and the steps they have taken toward recovery.
- Encourage participants to view challenges as opportunities for growth rather than as indications of failure.
- Focus on the participant's strengths & assist them to identify their personal assets (e.g., resilience, past successes, coping mechanisms) that they can build upon to enhance their recovery.

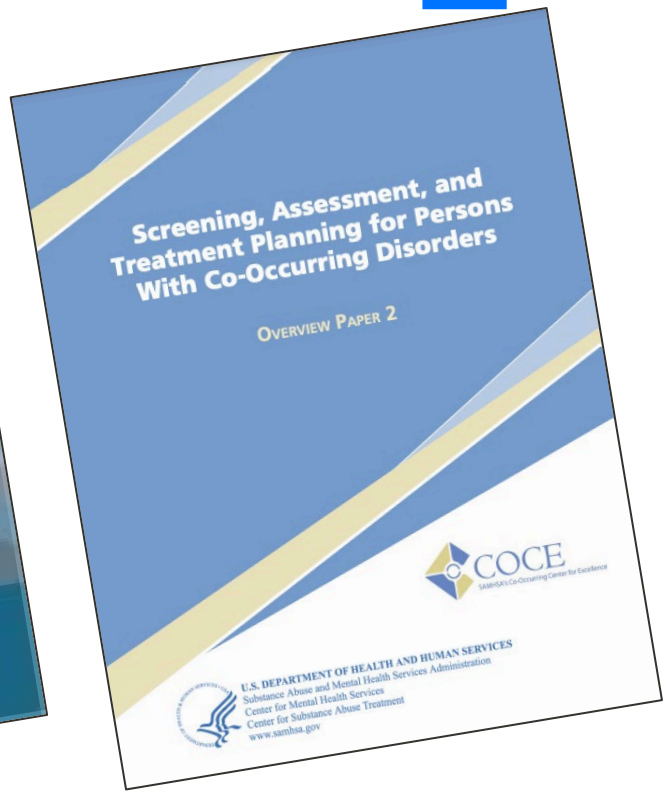
Redefine Success

Not everyone may complete supervision, remain abstinent, or avoid re-arrest, but…

- Did they lower their criminogenic risk?
- Did they improve relationships with loved ones?
- Did they connect to community services that they were previously unaware of or reluctant to engage with?
- Did they learn skills to better manage their mental illness or substance use disorder?
- Are they staying involved in treatment, psychiatric care, or medication management?
- Did they learn a new prosocial skill?
- Did they have positive interactions with the criminal justice system?
- Did they develop a stronger sense of self-efficacy, including feeling capable of managing their symptoms or reaching out for help when needed?

Additional Resources





References

- Brady KT, Haynes LF, Hartwell KJ, Killeen TK. Substance use disorders and anxiety: a treatment challenge for social workers. *Soc Work Public Health*. 2013;28(3-4):407-423. doi:10.1080/19371918.2013.774675.
- Farrugia PL, Mills KL, Barrett E, Back SE, Teesson M, Baker A, Sannibale C, Hopwood S, Rosenfeld J, Merz S, Brady KT. Childhood trauma among individuals with co-morbid substance use and post traumatic stress disorder. Ment Health Subst Use. 2011 Nov;4(4):314-326. doi: 10.1080/17523281.2011.598462. PMID: 21984884; PMCID: PMC3188414.
- Grant BF, Stinson FS, Dawson DA, et al. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Arch General Psych.* 2004;61(8):807–816.
- Mahgoub M, Monteggia LM. Epigenetics and psychiatry. Neurotherapeutics. 2013 Oct;10(4):734-41. doi: 10.1007/s13311-013-0213-6. PMID: 24092614; PMCID: PMC3805856.
- National Survey of Drug Use and Health (NSDUH); https://samhsa.gov/data/release/2021-national-survey-drug-use-and-health-nsduh-releases
- NIDA. 2021, August 3. Introduction. Retrieved from https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/introduction on 2023, October 4
- Onaemo VN, Fawehinmi TO, D'Arcy C. Risk of suicide ideation in comorbid substance use disorder and major depression. PLoS One. 2022 Dec 7;17(12):e0265287. doi: 10.1371/journal.pone.0265287. PMID: 36477246; PMCID: PMC9728854.

References, continued

- Prochaska JJ, Delucchi K, Hall SM. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. J Consult Clin Psychol. 2004 Dec;72(6):1144-56. doi: 10.1037/0022-006X.72.6.1144. PMID: 15612860.
- Smith, John. Co-occurring Substance Abuse and Mental Disorders: A Practitioner's Guide. Lanham, MD: Jason Aronson, 2007. Print
- Stamm, K., Lin, Luona, & Christidis, P. (2018, March). Mental disorders most frequently treated by psychologists. *Monitor on Psychology, 49*(3). Retrieved from http://www.apa.org/monitor/
- Taylor GMJ, Baker AL, Fox N, Kessler DS, Aveyard P, Munafò MR. Addressing concerns about smoking cessation and mental health: theoretical review and practical guide for healthcare professionals. BJPsych Adv. 2021 Mar;27(2):85-95. doi: 10.1192/bja.2020.52. Epub 2020 Sep 10. PMID: 34513007; PMCID: PMC7611646.
- Weinberger AH, Platt J, Esan H, Galea S, Erlich D, Goodwin RD. Cigarette Smoking Is Associated With Increased Risk of Substance Use Disorder Relapse: A Nationally Representative, Prospective Longitudinal Investigation. J Clin Psychiatry. 2017 Feb;78(2):e152-e160. doi: 10.4088/JCP.15m10062. PMID: 28234432; PMCID: PMC5800400.
- Wolitzky-Taylor K, Operskalski JT, Ries R, Craske MG, Roy-Byrne P. Understanding and treating comorbid anxiety disorders in substance users: review and future directions. J Addict Med. 2011 Dec;5(4):233-47. doi: 10.1097/ADM.0b013e31823276d7. PMID: 22042216.

References, continued

- Prochaska JJ, Delucchi K, Hall SM. A meta-analysis of smoking cessation interventions with individuals in substance abuse treatment or recovery. J Consult Clin Psychol. 2004 Dec;72(6):1144-56. doi: 10.1037/0022-006X.72.6.1144. PMID: 15612860.
- Smith, John. Co-occurring Substance Abuse and Mental Disorders: A Practitioner's Guide. Lanham, MD: Jason Aronson, 2007. Print
- Stamm, K., Lin, Luona, & Christidis, P. (2018, March). Mental disorders most frequently treated by psychologists. *Monitor on Psychology, 49*(3). Retrieved from http://www.apa.org/monitor/
- Taylor GMJ, Baker AL, Fox N, Kessler DS, Aveyard P, Munafò MR. Addressing concerns about smoking cessation and mental health: theoretical review and practical guide for healthcare professionals. BJPsych Adv. 2021 Mar;27(2):85-95. doi: 10.1192/bja.2020.52. Epub 2020 Sep 10. PMID: 34513007; PMCID: PMC7611646.
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- Wolitzky-Taylor K, Operskalski JT, Ries R, Craske MG, Roy-Byrne P. Understanding and treating comorbid anxiety disorders in substance users: review and future directions. J Addict Med. 2011 Dec;5(4):233-47. doi: 10.1097/ADM.0b013e31823276d7. PMID: 22042216.

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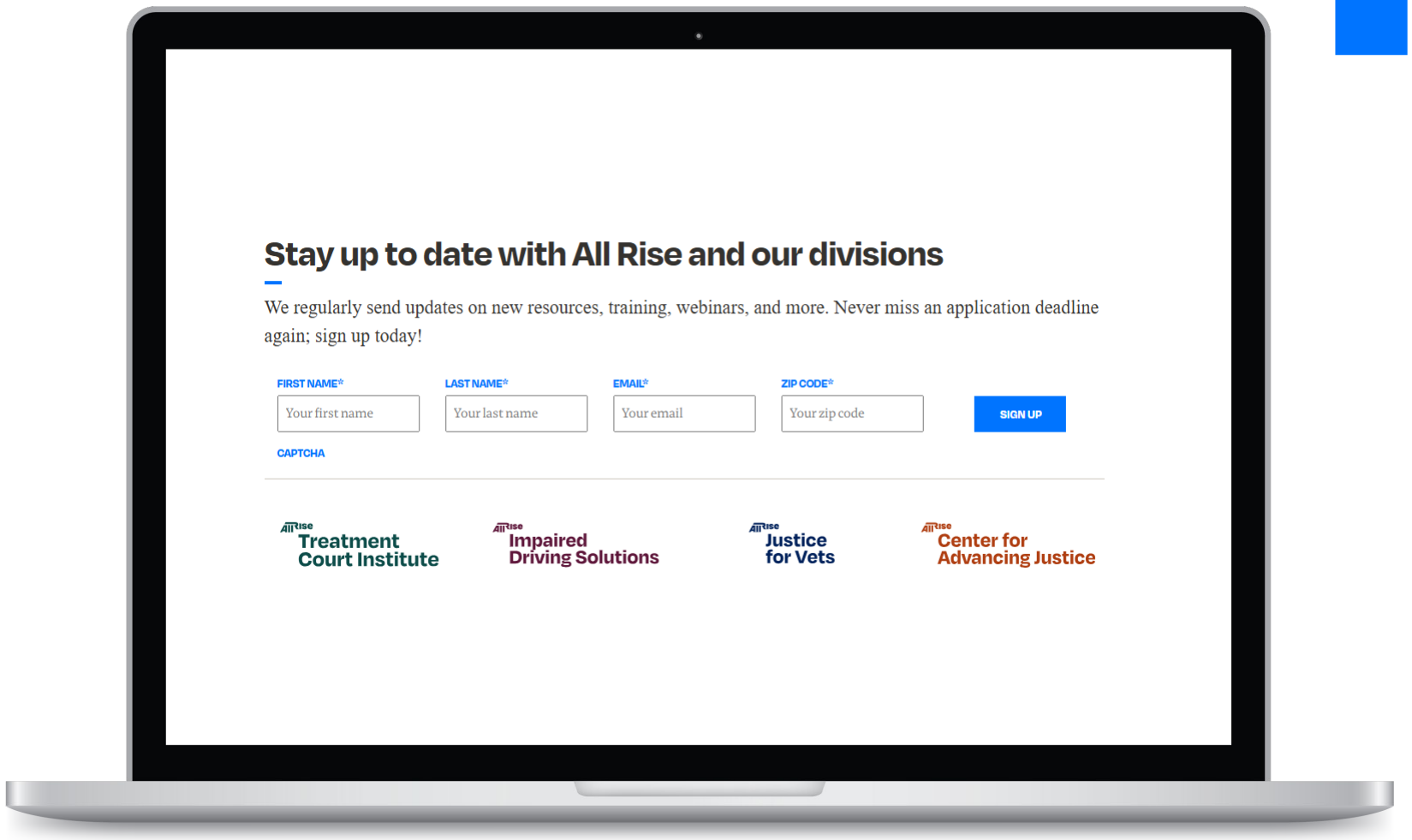

Evaluations

1. On your compatible phone or tablet, open the built-in camera app.
2. Point the camera at the QR code.
3. Tap the banner that appears on your phone or tablet.
4. Follow the instructions on the screen to complete the evaluation.
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Questions?

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