Co-Occurring Disorders & The Criminal Mind

By Julie Otis, BS, CADAC II
OBJECTIVES

1-Develop a connection between behavior choices & behavioral health disorders
OBJECTIVES

2-Learn how stigma creates a whirlwind of distrust between counselors, self & society
OBJECTIVES

3-Explain how integrated treatment is essential to improving the well-being of the client and decreasing the likelihood of recidivism
WHAT IS A CO-OCCURRING DISORDER??

- According to the Substance Abuse and Mental Health Services Administration, 2014 resulted in 7.9 million adults in the United States suffering from a co-occurring disorder, also known as a dual diagnosis.

- Often occurs when an individual self-medicates with substances to relieve emotional difficulties.

- “Clients with co-occurring disorders (COD) typically have one or more disorders relating to the use of alcohol and/or other drugs as well as one or more mental disorders” (Psychology Today, 2018).
DSM-V TERMINOLOGY

- Substance-Related and Addictive Disorders (p.481)
- Divided into two groups: Substance Use Disorders & Substance-Induced Disorders
- Examples of Substance-Induced Disorders include: intoxication, withdrawal, and other substance/medication-induced mental disorders (psychotic disorders, bipolar & related disorders, depressive disorders, anxiety disorder, obsessive-compulsive & related disorders, sleep disorders, sexual dysfunctions, delirium & neurocognitive disorders.
- Every type of dysfunction does not lead to a disorder, whether that be substance use, physical impairments or abnormalities or cognitive, behavioral and emotional systems. What is abnormal behavior? Labeling everything can theoretically cause more problems which we will discuss later.
DSM-V TERMINOLOGY CONT...

The substance-related disorders encompass 10 separate classes of drugs:

1) Alcohol
2) Caffeine
3) Cannabis
4) Hallucinogens
5) Inhalants
6) Opioids
7) Sedatives, hypnotics, anxiolytics
8) Stimulants
9) Tobacco
10) Other/unknown substances
DSM-V & FORENSIC USE

• The use of this established system assists the court in determining the need for involuntary civil commitment.

• Determination should not solely be based on the clinical diagnosis of a DSM-V mental disorder because the criteria and descriptions do not imply that the individual meets the legal definition for the presence of a mental disorder or a specified legal standard, such as competence or disability.

• Impairments, abilities and disabilities vary widely across diagnostic categories.

• Additionally, one cannot assume that the presence of a mental disorder automatically assumes that the individual was unable to control his/her behavior at a particular time.

• In the state hospital system, a forensic psychologist determines if an individual is competent or not to stand trial (ICST).
DISEASE VS. CHOICE

• Not all use is a disease, not all substance use disorders are the same, & note everyone is affected in the same manner.

• No one would choose addiction, would they? This is a common question posed by individuals who have never gone through the experience of addiction and all that encompasses this event.

• Even if first use is a choice, repeated use leads to brain changes that reduce the capacity to stop. Individuals addicted to substances can’t just say “NO”.

• Many view abusing substances as a personality flaw, a lack of morals, or just overindulgence. However, does calling the addiction a disease essentially excuse behavior and label these individuals as victims?

• Unlike a poor choice or a character flaw, a disease must have commonalities and defining characteristics that all who suffer from it must have.
DISEASE VS. CHOICE CONT...

• We must start looking at addiction from the perspective of what is going on inside the person’s brain rather than as a set of behaviors in order to fully understand it and correctly diagnose it. In addition to observing behaviors and decision making, ask the right questions.

• WE ARE ASKING THE WRONG QUESTIONS.

• According to the book *Why Can’t Johnny Just Quit: A Common Sense Guide to Understanding Addiction* by Kyle Oh, the difference is **EUPHORIA**. Ask your client: how did the drug make you feel? Do you have a feeling of being on top of the world and feeling like a million bucks? Do you want to chase this feeling? One example from the book is that people who are truly hooked on heroin experience extreme joy before they pass out. Identifying the root of the problems and providing the client with alternative solutions is an easy fix.

• This book also addresses predisposed genetics and medical findings, but that is a topic for another time. 😊
DISEASE VS. CHOICE CONT...

• We only look at the person’s behavior rather than trying to understand what is going on inside the person’s brain. Many black and white thinkers fixate solely on deterring and punishing behaviors as a way to change the brain.

• Some treatments operate on the premise that if one is taught the errors of his ways and how to implement different coping skills, the addiction can be cured.

• The misconceptions that drinking excessively and using drugs to escape emotional pain are signs of addiction is demonstrating a tunnel vision of judgement based on actions rather than intent.
According to the Texas Department of Health:

“Addiction is a pathological relationship with a mood or mind-altering substance or behavior which renders one powerless and produces harmful consequences. The addicted person is often the last to accept the disease concept. But parents, spouses, and other people close to the addict are slow in identifying the disorder as an illness. This is because they, too, are simply too involved emotionally with the disease process. Addictions do not exist in a vacuum.”
The American Society of Addiction Medicine (ASAM) issued a public policy statement on alcoholism as a primary disease in 1996. Their statement reads: “Based on many years of clinical experience, reinforced by recent and continuing research into the genetic, biochemical and physiological aspects of the effects of alcohol on living systems and of alcoholics and their families, the American Society of Addiction Medicine finds that alcoholism is a complex primary physiological disease, and neither a primary behavior disorder nor a symptomatic manifestation of any other disease process.”
Since 1956, the American Medical Association (AMA) has formally recognized that addiction is a disease. The recognition of addiction to alcohol or other substances as a disease implies the following:

1) Like other diseases, such as cancer and cardiovascular disease, the illness of addiction can be described.

2) The course of addictive illness is both predictable and progressive.

3) Addiction is a primary disease. It is not merely a symptom of an underlying disorder.

4) Addiction can be treated, but it cannot be cured.

5) Without treatment, addiction can result in premature death or insanity.
The American Psychiatric Association (APA), says “addiction is a serious illness...a chronic illness like heart disease, high cholesterol or high blood pressure.” The APA further states that:

1) Persons with these chronic diseases are prone to relapse.
2) Because substance abuse affects many aspects of an individual’s life, multiple forms of treatment are often required.
3) A combination of medication and individual or group therapy is most effective.
According to the book *Crime & Everyday Life by Marcus Felson*, “the offender seeks to gain quick pleasure and avoid imminent pain” (2002, p. 37). Individuals, whether or not they have committed an illegal act in the past, make choices depending on specific setting, offense and motive. Settings vary moment to moment in their degree of temptation or control, hence the degree of choice they provide. Consider the cue-decision sequence:

1) A person enters a setting.
2) The cues in that setting communicate temptations & controls.
3) These cues are noted and interpreted by the person entering.
4) This person decides whether to commit a criminal act.

Without anyone teaching us the appropriate way to self-control, the various pressures and constraints lead a person to commit an offense.
STAGGERING NUMBERS

• In 2014, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness, and 1.7 million of which were aged 18 to 25.

• Also 15.7 million adults (aged 18 or older) and 2.8 million youth (aged 12 to 17) had a major depressive episode during the past year.

• In 2014, an estimated 22.5 million Americans aged 12 and older self-reported needing treatment for alcohol or illicit drug use

• 11.8 million adults self-reported needing mental health treatment or counseling in the past year.

• Addressing the impact of substance use alone is estimated to cost Americans more than $600 billion each year.

(All data derived from the SAMHSA website & National Survey on Drug Use & Health)
MORE STAGGERING NUMBERS

• In 2016, 28.6 million people aged 12 or older used an illicit drug in the past 30 days

• In 2016, approximately 20.1 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year

• In 2016, 1.4 percent of people aged 12 or older (3.8 million people) received any substance use treatment in the past year, and 0.8 percent (2.2 million) received substance use treatment at a specialty facility.

• An estimated 10.4 million adults in the nation had a serious mental illness (SMI) in the past year, representing 4.2 percent of all U.S. adults.

• An estimated 8.2 million adults aged 18 or older (3.4 percent of all adults) had both AMI and SUDs in the past year, and 2.6 million adults (1.1 percent of all adults) had co-occurring SMI and SUDs in the past year.

• In 2016, there were 11.8 million past year opioid misusers aged 12 or older in the United States.

• The World Drug Report 2018 indicates that opioids account for over 76% of deaths.

• Global cocaine manufacture in 2016 reached the highest level ever reported, with an estimated 1,410 tons being produced.

(All data derived from the SAMHSA website & National Survey on Drug Use & Health)
CO-OCCURRING DISORDER STATS

• Among the 8.2 million adults with co-occurring AMI and an SUD in the past year, 48.1 percent received either substance use treatment at a specialty facility or mental health care in the past year. Meaning, the other half did not receive either type of service.

• An estimated 6.9 percent of adults with these co-occurring disorders received both mental health care and specialty substance use treatment, 38.2 percent received only mental health care, and 2.9 percent received only specialty substance use treatment.

• Among the 2.6 million adults who had co-occurring SMI and an SUD in the past year, 65.6 percent received either substance use treatment at a specialty facility or mental health care in the past year.

• However, about 1 in 3 adults with co-occurring SMI and an SUD did not receive either type of care in the past year. Among adults with co-occurring SMI and an SUD, 12.0 percent received both mental health care and specialty substance use treatment, 51.2 percent received only mental health care, and 2.3 percent received only specialty substance use treatment.

(All data derived from the SAMHSA website & National Survey on Drug Use & Health)
July 6, 2018

Study titled: Health, Polysubstance Use, and Criminal Justice Involvement Among Adults With Varying Levels of Opioid Use

Asked the Question: What is the association between various levels of opioid use and health, co-occurring substance use, and involvement in the criminal justice system?

Tyler N.A. Winkelman, MD, MSc; Virginia W. Chang, MD, PhD; Ingrid A. Binswanger, MD, MPH, MS JAMA Network Open. 2018;1(3):e180558. doi:10.1001/jamanetworkopen.2018.0558
This analysis used the 2015-2016 National Survey on Drug Use and Health to assess the independent association of intensity of opioid use with health, co-occurring substance use, and involvement in the criminal justice system among US adults aged 18 to 64 years.

RESULTS
ENVIRONMENTAL/SOCIAL FACTORS

Factors that influence a higher likelihood of committing a criminal offense:

• Socioeconomic status – living below the federal poverty line, middle class, upper class *ALL ARE AFFECTED* Money is a major contributing factor.
• Having a parent in prison - Children are 5x more likely than their peers to end up in prison if a parent figure is incarcerated.
• Having a parent in the depths of substance abuse – About 9 percent of all children have a parent who abuses illicit drugs and/or is dependent on a substance.
• 1 in 4 children live in an alcoholic home.
Factors that influence a higher likelihood of committing a criminal offense:

- **Psychological factors** - stress, personality traits like high impulsivity or sensation seeking, depression, anxiety, eating disorders, personality and other psychiatric disorders

- **Environmental influences** - exposure to physical, sexual, or emotional abuse or trauma, substance use or addiction in the family or among peers, access to an addictive substance; exposure to popular culture references that encourage substance use
Factors that influence a higher likelihood of being diagnosed with a co-occurring disorder:

- **Criminal history** – The attitudes and behaviors which influence decision making skills morph into justifications for starting the deterioration into substance use and ultimately substance abuse. On the flip side, drugs offer an alternative source of income, at the price of a criminal career (lure of easy money).

- **Employment** – The lack of productivity and copious amount of free time creates financial & behavioral stress, forming the foundation for the bad decisions.

- **Education** - While completing formal education certainly plays a part, education about substances and self-care are vital, especially to prevent a downhill slide. Many people don’t recognize the importance of preventative measures until it’s too late.
Factors that influence a higher likelihood of being diagnosed with a co-occurring disorder:

• **Family support** – The lack of a positive role model within the family system significantly impacts an individual’s life trajectory. Antisocial and deviant behavior is often a reflection of a dysfunctional family life. Increasingly, deviant behavior is seen as evidence of a psychiatric disorder. While medication may be part of the solution, 3 factors tend to get overlooked: parental supervision, disciplinary practices and child-parent attachment. Family structure and dynamics play an enormous role in decision-making.

• **Peer network** – Social learning theory assumes that children acquire either prosocial or antisocial tendencies based on the nature of their interaction with the environment, meaning they will model the behaviors and attitudes of their peers.

**Information derived from the book *Families, Delinquency and crime* by Ronald Simons.**
RELATIONSHIPS & DIMENSIONS OF STIGMA

- Peril
- Aesthetics
- Origin
- Controllability
- Pity
- Concealability
- Course
- Stability
- Disruptiveness

Stigma
• **Self** – The continued impact of social/public stigma can influence an individual to feel guilty and inadequate about his or her condition. In self-stigma, the knowledge that stigma is present within society, can have an impact on an individual even if that person has not been directly stigmatized. The fear of being labeled can also influence stigmatized beliefs provoking an emotional response. Our perception is our reality and vice versa. What we think about ourselves, regardless of the actual stigma created by society, is ultimately our decision maker.
• **Counselors** – Stigma is relevant in other contexts such as towards individuals of varied backgrounds including race, gender, and sexual orientation. Social workers may develop their own biases from their upbringing or even from burnout in their own working roles. Biases can also develop if they are going through a mental illness or substance use disorder. The perception can also be different if the counselor has a family member or friend with a mental illness or substance use disorder. Therapeutic pessimism is a dangerous barrier to recovery. Overall, health professionals may not provide adequate intervention, early detection, or community referral options for individuals with mental or behavioral disorders because of their own stigmatizing beliefs and personal histories.
RELATIONSHIPS

• **Society** – Six dimensions of stigma:

  1) **Peril** - Those with a mental illness are perceived as frightening, unpredictable, & strange. The general population feels fear and discomfort when in the vicinity of someone who has visible symptoms of a mental illness because their behaviors are not within the boundaries of “normal” social cues and norms. If a person’s physical appearance or aesthetics are displeasing, we automatically judge.

  2) **Origin** – Many people are under the impression that most mental illness is derived as a result of biological or genetics factors, essentially believing that the behavior disorder can be controlled. We can relate this belief back to the disease vs. choice battle.
RELATIONSHIPS

• Society – Six dimensions of stigma:
  3) Concealability - Society attributes more stigmatizing stereotypes towards disorders such as schizophrenia, which generally have more visible symptoms, compared to others such as major depression.
  4) Course – How likely is this individual going to recover from their diagnosis. Individuals needing long-term care for their mental care are looked at differently and as if there is no hope, so why try. This is important to reflect upon for those with a mental illness and/or a substance abuse disorder.
RELATIONSHIPS

• **Society** – Six dimensions of stigma:
  5) **Stability** – Patients at psychiatric hospitals are ignored by society and treated as if they no longer matter. Some of these patients have co-occurring disorders; the substance use disorder may remain dormant but cannot be ignored.
  6) **Disruptiveness** - While disorders are frequently associated with an increased risk for poverty, lower socioeconomic status and lower levels of education the stability and disruptiveness of the conditions have implications as to whether an individual will be able to hold down a successful job and engage in healthy relationships, as evidenced by differences in stigma based on social class status.
BLACK SHEEP OF THE FAMILY

• This person is usually considered the “outcast” of the family. Whether this person is addicted to drugs or suffering from a mental illness, we tend to consciously separate ourselves in fear that this “problem” will rub off on us. **Why do we have this fear?** We fear the unknown. Instead of showing empathy and attempting to understand what’s going on underneath the surface, we retreat to our own little perfect world, content to wallow in our own stress, not daring to invite in someone else’s problems.

• Family members adapt to a chemically dependent person by developing behavior that causes the least amount of personal stress. Survival behavior serves to build a wall of defenses for protections from pain.
DYSFUNCTIONAL FAMILY

• Stigma is created when family members do not openly communicate or share feelings. With both addiction and mental illness, the following emotions raise their ugly head:
  Hurt, Guilt, Shame, Fear, Anger, Blaming, Resentment
  Followed by:
  Powerlessness, Self-blame, Fragility, Self-pity, Manipulation
• Creating unrealistic expectations only compounds the stigma.
• The symptoms of a dysfunctional family are rigidity, silence, denial, & isolation. Members of a dysfunctional family cannot talk about what is happening within its members. Denial is strong within a closed family system.
HANDOUT
TRUST & STIGMA

• Clients unwilling to talk openly and honestly about their recovery process when they relapse because of the fear instilled by the judicial system, i.e. punishment versus treatment.

• The 4 Stages of Trust When Your Addicted Loved One Comes Home

  1) Paranoia
  2) Cautious Optimism
  3) Optimism
  4) Confidence
FAMILY ACCEPTANCE OF MENTAL ILLNESS

DO’s
• Attend NAMI family support meetings
• Participate in family therapy sessions
• Provide transportation
• Engage in active listening
• Hold open-ended conversations

DON’T’s
• Judge
• Call names
• Say “get over it”
• Demand unreasonable expectations
• Suffer in silence
Common boundary myths in the book *Boundaries* by Dr. Henry Cloud:

1) If I set boundaries, I’m being selfish.
2) Boundaries are a sign of rebellion
3) If I begin setting boundaries, I will be hurt by others
4) If I set boundaries, I will hurt others
5) Boundaries mean that I’m angry
6) When others set boundaries, it injures me
7) Boundaries cause feelings of guilt
8) Boundaries are permanent and I’m afraid of burning bridges

How can these be applied to someone with a mental illness and/or substance use disorder??
The lack of resources for community mental health services and long-term supportive housing contributes to jails and prisons becoming the mental health caretaker for thousands of people. Even if an individual didn’t come into the prison system with a mental health issue, correctional facilities are breeding grounds for anxiety, depression, panic and psychosis. Individuals will use legal and illegal medications to address the same types of problems. Approximately 11% of male inmates and approximately 22% of female inmates had an overnight stay at a psychiatric facility prior to incarceration (Bureau of Justice).
According to the *Dictionary of American Criminal Justice, Criminology, & Criminal Law* by David Falcone, the definition of deinstitutionalization is as follows:

The process of removing wards of the state from treatment of custodial facilities into open society or community-based programs.

The number of state hospitals left in the country has severely diminished, leaving many untreated and unwell patients with no resources.
State hospitals were no longer needed with new reforms, such as the Community Mental Health Act, and begin closing in the 1990’s. The criminal justice system became the caregiver within the last 20 years. “Jails have been described as the 'treatment of last resort' for those who are mentally ill and as 'de facto mental hospitals' because they fill the vacuum created by the shuttering of state psychiatric hospitals and other efforts to deinstitutionalize people with serious mental illness during the 1970s, which occurred without creating adequate resources to care for those displaced in the community," (“Warehouses For Those With Mental Illnesses”, 2015, para. 3).
HANDOUT
LACK OF MH CARE IN CORRECTIONS

• 1.2 million individuals living with mental illness sit in jail and prison each year.
• The states with less access to mental health care have more adults who are in the criminal justice system.
• Six out of 10 of the states with the least access to mental health care also have the highest rates of incarceration.
• Individuals with untreated mental health conditions may be at higher risk for correctional rehabilitation treatment failure and future recidivism on release from prison because of low follow-up rates.
• Limited number of psychiatrists and psychologists
• Punishment vs. rehabilitation debate
• Untrained staff
• Often, the prison system prioritizes stabilization over true treatment, meaning staff prescribe medication to quell severe behavioral symptoms instead of routine treatment for the underlying illness itself.
• Lack of follow through from using admission mental health screening tools.
PUNISHMENT VS. POSITIVE REINFORCEMENT

According to the *Dictionary of American Criminal Justice, Criminology, & Criminal Law* by David Falcone, the definition of rehabilitation is as follows:

One of the goals of the criminal justice system and penal institutions, seldom found today, as it conflicts with the dominant goal of retribution. The intent of rehabilitation is to reform the offender into a productive member of society, as opposed to the mere warehousing of inmates.
LEGALIZATION/DECRIMINALIZATION

According to the same book, the definition of decriminalization is as follows:

A legislative action removing a type of conduct, formerly deemed criminal, from the jurisdiction of the criminal justice system.
LEGALIZATION/DECRIMINALIZATION CONT...

Pros:
• More money would be put into the community. Look at Colorado, etc.
• Decrease overcrowding of low level offenders
• Cuts the prison population
• Immediate results vs. the length of time prevention & treatment strategies show positive results in the long run
• Stigma decrease

Cons:
• Age and type restrictions
• Who is the taxing authority
• Doesn’t alter negative health effects or violence
• Would this essentially be condoning the absence of effective parenting instead of admonishing the behavior?
LEGALIZATION/DECRIMINALIZATION CONT...

• There are several implications for substance abuse programs if drug use was legalized state and country wide:
  1) Destigmatizing users could help individuals who have become addicted to the substances.
  2) Advocates claim that these people would be more likely to enter treatment and attend programs.

• Even though treatment eludes large numbers of substance abusers, more funding would become available if less was spent on the war on drugs. The National Institute on Drug Abuse (2011) states that only 11 percent of the people who needed treatment actually received it.
• The strongest advocates for keeping drugs illegal are the gangs. They profit the most. The drug trade in Mexico is rampant and responsible for thousands of deaths across the country. The Mexican cartels make millions off manufacturing and selling drugs. The widespread corruption is also a major issue, from the little guy selling on the streets to the politicians and police departments. If the controlled substances were suddenly to become legal across the board and easier to obtain, many drug cartels would lose business!

• We want clients to abide by the law, but when they falter, we need to be their advocate for getting the help they need. We have an ethical responsibility to help them improve their life. A lot of clients are working hard to get past their mistakes.
LEGALIZATION/DECRIMINALIZATION CONT...

• However, when they turn for us for empathy, we can try to understand why they think drugs should be legalized but we cannot condone the behavior.

• The drug epidemic has moved people into the prison system who wouldn’t otherwise wind up there.
According to the *Dictionary of American Criminal Justice, Criminology, & Criminal Law* by David Falcone, the definition of stigmata is as follows:

The criminal label that one must endure after conviction or processing by the criminal justice system, which may lead to secondary deviance.
<table>
<thead>
<tr>
<th>SAY THIS</th>
<th>DON’T SAY THIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person with opioid use disorder</td>
<td>Addict, user, druggie, junkie, abuser</td>
</tr>
<tr>
<td>Disease</td>
<td>Drug habit</td>
</tr>
<tr>
<td>Person living in recovery</td>
<td>Ex-addict</td>
</tr>
<tr>
<td>Person arrested for a drug violation</td>
<td>Drug offender</td>
</tr>
<tr>
<td>Substance dependent</td>
<td>Hooked</td>
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<tr>
<td>Medication is a treatment tool</td>
<td>Medication is a crutch</td>
</tr>
<tr>
<td>Had a setback</td>
<td>Relapsed</td>
</tr>
<tr>
<td>Maintained recovery; substance-free</td>
<td>Stayed clean</td>
</tr>
<tr>
<td>Negative drug screen</td>
<td>Clean</td>
</tr>
<tr>
<td>Positive drug screen</td>
<td>Dirty drug clean</td>
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</tbody>
</table>
RETHINKING HOW WE TALK

• Classifying a client as having a substance use disorder instead of calling them a substance user automatically shifts our brain to believe they need medical treatment over punishment.

• We falsely believe that our clients are abandoning responsibilities in pursuit of a high but what they are really doing is escaping their lows.

• What loved ones think of as personal attacks when they lie, cheat and steal or miss important events, we need to remember the drug is guiding their decisions, not them as a person, the person we love.

• Public images in the media don’t dissuade our youth from trying the drugs; identify feelings and emotions behind the decision making.
JUDGEMENT TOWARDS HOMELESS/JOBLESS

• Problems include: “lack of low-income affordable housing, a large inventory of dilapidated and dangerous housing and high numbers of homeless people” (American Social Welfare Policy p. 336)

• Other problems include: mortgage default, eviction, cash to purchase necessities, high cost of rent, property taxes, credit score, overcrowding, squatters, apartment owner neglect

• Housing discrimination is a huge issue!

• “Homelessness reflects the failure of an overburdened public mental health system, particularly those with mental illness or chronic alcoholism” (American Social Welfare Policy p. 353)

• “Single individuals who experience long-term homelessness have high rates of mental illness and/or substance abuse disorders. Chronic homelessness is strongly correlated with alcohol abuse, schizophrenia, and other mental health problems” (American Social Welfare Policy p. 355). Additionally, the deinstitutionalization of mentally ill patients caused an increase because of the difficulty these individuals faced in accessing supporting housing.
JUDGEMENT TOWARDS HOMELESS/JOBLESS CONT...

• Problems include: lack of low-income affordable housing, a large inventory of dilapidated and dangerous housing and high Society tends to judge and blame the unemployed criticizing their perceived laziness as the reasoning behind their current predicament.

• The idea that everyone should be self-sufficient and that an individual is responsible for his or her own misery is a non-empathetic viewpoint causing unnecessary barriers to services. However, this judgmental attitude does not take into account the mental health stress that may have lead them to this point.

• Anxiety, insecurity, and various other debilitating emotions can lead to homeless and cause unemployment, but the very state of being homeless and unemployed also adds to the emotional distress.
The vicious cycle of homelessness cannot be stopped unless the mental health is addressed first. Stigma towards this population significantly impacts those tasked with caring for the homeless. Peeling back the layers to secure housing and set up services is often blocked by the individual’s past choices and burned bridges. Social workers are tasked with the responsibility to disintegrate this stigma.

Low vacancies and high rent are definitely dead ends for those involved in the criminal justice system. Many housing agencies restrict those with felonies. This severely limits the amount of options for someone re-entering society. Additionally, many of these offenders have limited education background which results in limited employment option which then results in a dead end when searching for affordable housing. It’s an endless cycle.
“Public attitudes, stereotypes, low expectations, and lack of understanding limit the ability of people with DD to integrate fully into the community” (National Council on Disability, 2017, para. 76). The disability rights movement was founded on the belief that people with disabilities have the right to participate fully in society. This contemporary view advocating for independency was marred by the use of the medical model emphasizing deficiency and independence, which is why layering degrees of social support are needed (National Association of Social Workers, 2015).

One example of a company helping to combat the opioid crisis is the Belden electric company in Richmond Indiana. Instead of automatically denying an applicant for failing a drug screen, they offer substance abuse treatment as a condition of their employment.
COMMUNITY RESPONSE

• Social inequality – unequal distribution of opportunities and treatment
• At the community and societal levels, the same undercurrent of addiction stigma keeps drug and alcohol addiction under-diagnosed, under-treated, under-funded and misunderstood by many, especially as compared to other chronic health conditions such as heart disease, asthma and diabetes.
• Often seen as a criminal matter rather than a health issue
• Lack of addiction specific psychiatrists and addictionologists
• “Many functional illicit drug users are forced to live a double life, under constant threat of losing everything because society has decided to scapegoat their particular activity.” (The Invisible Majority: People Whose Drug Use is Not Problematic, 2018).
• Substance users and those with SMI are oppressed population groups
SETTING UP OUR CLIENTS FOR FAILURE

• Hospitals accepting clients only detoxing from certain substances
• Treatment centers not accepting low-income insurance
• No open beds for immediate vacancy
• Raising your hand for help is hard enough; having to wait for an appointment is discouraging and motivation immediately tanks
• Funding going to the wrong places
• Releasing offenders from incarceration with only phone numbers to call
• What else do they need???
INTERNAL STRUGGLES

• **Anger** – Clients tend to turn to substance abuse and criminal activity due to unresolved anger from the past or present. The job of the clinician/practitioner/case manager is to build rapport with the client, seek to understand the client’s specific issues and concerns, begin to separate the substance abuse and the decision-making, peel back the layers, and improve self-awareness and distorted thinking patterns.

  Book recommendation: *Of Course You’re Angry: A Guide to Dealing with the Emotions of Substance Abuse* by Gayle Rosellini

• **Anxiety** – Again, clients tend to abuse substances because of fear and experience extensive worry about situations in their lives, resulting in anxiety attacks and panic attacks. Meaning more pills. How do we stop this cycle?
STIGMA AND UN-MONITORED INTERNAL CONFLICT CAN LEAD TO SUICIDE

• The most critical risk factors for suicide are prior suicide attempts, mood disorders (such as depression), alcohol and drug use, and access to lethal means.

• In 2011, there was a 51% increase in drug-related suicide attempt visits to hospital emergency departments among people aged 12 and older.

• In 2016, an estimated **9.8 million adults** aged 18 or older reported they had thought seriously about trying to kill themselves, **2.8 million** reported that they had made suicide plans, and **1.3 million** made a nonfatal suicide attempt.

• One of the populations at risk for suicide is those with a mental health and/or substance abuse disorder.

• The Suicide Assessment Five-Step Evaluation and Triage is a screening tool used to identify risk factors such as psychiatric diagnoses, severe substance use or dependence, or both.

(All data derived from the SAMSHA website)
INTEGRATED TREATMENT

• Integrated treatment addresses both the substance abuse disorder and the mental health disorder
• Wraparound services
• Multi-systemic treatment planning
• Private vs. public services
• CTI Teams
• Specialized Courts:
  o Drug Courts
  o Mental Health Courts
  o Veteran Courts
  o Domestic Violence Courts
TYPES OF TREATMENT

• AA, NA, etc.
• IOP, OP, In-patient
• Tele-behavioral health
• Drug court
• MAT, MET, CBT, etc.
• Independent providers & private practitioners
• Hospitals
• Community health & behavioral health centers
• Mutual support groups and peer-run organizations
• Community-based organizations
• Schools
• Primary care programs with integrated behavioral health services
• And a variety of other community settings
TREATMENT STRUGGLES & SOLUTIONS

• Funding: Medicaid, Medicare, SAMSHA, Grants, Federal Initiatives, Opioid Crisis declared public health emergency
• People will donate more to homeless cats and dogs then to assist those with mental health and substance use disorders
• Due to the Medicaid expansion, more low-income individuals diagnosed with a substance use disorder are receiving treatment.
• Unable to pass a drug test in order to obtain employment: Pennsylvania is one of six states starting a pilot program providing reemployment services to people with a history of opioid use.
• Treatment programs not accepting certain kinds of insurance
• Rural vs. urban; affluent vs. poor
According to the book *Can’t Catch a Break: Gender, Jail, Drugs and the Limits of Personal Responsibility* by Susan Sered, the following challenges arise for those seeking treatment services:

1) Emergency assistance programs make frequent changes to eligibility criteria
2) Homeless shelters have inconsistent rules
3) Programs close because of funding or change in priorities
4) Clients are forced to chase down required documentation with little or no help
5) Facilities and caseworkers do not communicate with each other
6) Short-term psychotherapy rarely provides real help

...and many more
RESTORATIVE vs. RETRIBUTIVE JUSTICE

• Restorative interventions seek to understand the causes of the behavior and eliminate those factors.

• The community, rather than the justice system alone, should shoulder the burden of dealing with crime.

• Restorative justice is about relationships—how relationships are harmed by crime and how they can be rebuilt to promote recovery and healing.
## Restorative vs. Retributive Justice

<table>
<thead>
<tr>
<th>Restorative Justice</th>
<th>Retributive Justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crime is an act against the State</td>
<td>Crime is an act against another person or the community</td>
</tr>
<tr>
<td>The criminal justice system controls crime</td>
<td>Crime control lies primarily in the community</td>
</tr>
<tr>
<td>Offender accountability defined as taking punishment</td>
<td>Accountability defined as assuming responsibility &amp; taking action to repair harm</td>
</tr>
<tr>
<td>Crime is an individual act with individual responsibility</td>
<td>Crime has both individual/social dimensions of responsibility</td>
</tr>
<tr>
<td>Punishment is effective</td>
<td>Punishment is not effective and is disruptive to community harmony and good relationships</td>
</tr>
<tr>
<td>Victims are peripheral to the process</td>
<td>Victims are central to the process of resolving crime</td>
</tr>
<tr>
<td>The offender is defined by deficits</td>
<td>The offender is defined by capacity to make reparations</td>
</tr>
<tr>
<td>Focus on establishing blame &amp; guilt</td>
<td>Focus on problem solving</td>
</tr>
<tr>
<td>Emphasis on adversarial relationship</td>
<td>Emphasis on dialog and negotiation</td>
</tr>
<tr>
<td>Imposition of pain to punish and deter/prevent</td>
<td>Goal of reconciliation/restoration</td>
</tr>
<tr>
<td>Community on sideline</td>
<td>Community as facilitator</td>
</tr>
<tr>
<td>Response focused on offender’s past behavior</td>
<td>Emphasis on future</td>
</tr>
<tr>
<td>Dependence on proxy professionals</td>
<td>Direct involvement by participants</td>
</tr>
</tbody>
</table>
REHABILITATION FAILURE

“The degree to which our prisons succeed in rehabilitation is questionable,” Rebecca Weiss, a professor at the John Jay College of Criminal Justice. “We’re putting a lot on a system that is overloaded with fairly unclear goals.”
IMPORTANCE OF STABILIZATION

• Individuals suffering from a co-occurring disorder, especially offenders, need structure and organization in their life.
RECOVERY HOUSING

• AKA halfway house, sober living, transitional living, ¾ house, etc.

• One unfortunate, but changing, caveat of recovery housing is that most refuse to accept individuals on maintenance medications. They see someone on MAT as “still using”.

• There is no federal housing assistance dedicated specifically to recovery housing.
RECOVERY HOUSING

• National Council for Behavioral Health’s Building Recovery: State Policy Guide for Supporting Recovery Housing:
  “Recovery housing, recovery residences, recovery homes and sober living homes all refer to a range of alcohol- and drug-free housing models that create mutually-supportive communities where individuals improve their physical, mental, spiritual and social well-being and gain skills and resources to sustain their recovery.”

• National Alliance for Recovery Residences (NARR) Standards:
  All recovery housing must have a clear mission and vision, with forthright legal and ethical codes. This includes requirements to be financially honest with prospective residents. All recovery housing must be recovery-oriented and prohibit the use of alcohol or illicit drugs. All recovery housing must have a role for peers to staff and govern the housing. All recovery housing must uphold residents’ rights.

• The Indiana General Assembly passed Senate Bill No. 402 in 2017 which dictates that recovery housing organizations must pass standards in order to receive funds from the Division of Mental Addiction (DMHA).
WHY IS RECOVERY HOUSING IMPORTANT?

• Peer-to-peer recovery services
• Promote physical, mental, spiritual and social wellbeing
• Stable environment to build resources
• Support network
• Sustained abstinence support, guidance, and information from recovery home members may reduce the probability of a relapse
• Increased member’s sense of responsibility
• Positive companionship
At the beginning of September, the U.S. Department of Housing and Urban Development (HUD) indicated they would be issuing $98.5 million in housing assistance specifically tagged to help those with disabilities.

Ben Carson indicated in early 2018 that HUD would be removing the phrases “free from discrimination” and “inclusive communities” from its mission statement. In particular, the mission statement would instead read: “HUD’s mission is to ensure Americans have access to fair, affordable housing and opportunities to achieve self-sufficiency, thereby strengthening our communities and nation.”

However, in order to get approved for the affordable housing, one must jump through several hoops. Low-income housing is for specific groups of people, including those individuals living with a diagnosed disability. One of the many challenges of this entire process of living is actually obtaining that diagnosis.

Individuals who cannot work because their illness is so debilitating may not have jumped through the appropriate hoops to obtain the diagnosis, let alone meet all the requirements to get approved for housing.
MEDICAL MODEL

According to the *Dictionary of American Criminal Justice, Criminology, & Criminal Law* by David Falcone, the medical model is defined as:

A rational procedural model seeking to remedy the situation with the least invasive method practicable and where coproduction and prevention are assumed to be fundamental components. Attention is focused on the underlying causation of crime & not the symptoms of crime.

- We can connect the co-occurring disorders to criminal behavior from a medical model standpoint by treating the root problems through evidence-based interventions.
EBP INTERVENTIONS

• **Motivational Enhancement Therapy** – Utilizes motivational interviewing techniques to elicit rapid change. While strengthening motivation, the therapist also works with the client to encourage coping skills. This type of treatment works well when clients are treatment-resistant. Elements of MET include developing and expressing empathy, acknowledging the disparity between thoughts and reality, avoiding arguments, accepting resistance as part of the process, and supporting self-efficacy.

• **Cognitive Behavioral Therapy** – Goal-oriented and problem-solving approach. The idea behind CBT is to change patterns of thinking or behavior that are behind people’s difficulties. CBT attempts to change attitudes and behavior by focusing on the thoughts, images, beliefs and how these processes relate to the way a person behaves and deals with emotional problems.
EBP INTERVENTIONS CONT...

- **Dialectical Behavioral Therapy** – DBT Skills training is made up of four modules: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. They are designed to specifically assist individuals in better managing behaviors, emotions and thoughts. In DBT, therapists and clients work hard to balance change with acceptance, two seemingly contradictory forces or strategies.

- **Group Therapy** – According to SAMHSA, people who abuse substances often are more likely to remain abstinent and committed to recovery when treatment is provided in groups, apparently because of rewarding and therapeutic forces such as affiliation, confrontation, support, gratification, and identification. The potential curative forces inherent in a group can be harnessed and directed to foster healthy attachments, provide positive peer reinforcement, act as a forum for self-expression, and teach new social skills.
EBP INTERVENTIONS CONT...

• **Family Therapy** – Addiction is a family disease, a disease that affects all members of a family and creates negative changes in moods, behaviors, relationships within the family, and, often, even physical or emotional health.

• **Contingency Management Therapy** – This strategy has its roots in operant conditioning, which provides the client with positive reinforcement for desired behavior and can also discourage certain behaviors by withholding privileges.
MAT

- There are 3 medications that are commonly used to treat Opiate Use Disorder: Methadone, Buprenorphine (Suboxone), and Naltrexone/Vivitrol.
- MAT is a type of treatment to overcome addiction and the loss of a personal value system.
- In order to determine if MAT is the right step, we want to ask the individual to think about how using got in the way of his/her personal values, the goals they have now in recovery, and how would relapsing interfere with these values and goals.
- The practitioner also must discuss with their client if they would be better able to predict the day’s schedule, if their functioning at home or work would improve, and if exposure to risky situations be reduced if prescribed these medications. MAT can give you back the control.
- Many of those impacted by substance abuse will disregard MAT because they assume it’s just replacing one drug with another. That’s not the case. Recovery is a process, not a black and white deal. Educating = destigmatizing.
WHY THROWING $ @ THE SYSTEM FAILS

- Say No to Drugs campaign – quick fixes or black and white does not work in this world
- DARE program – in your face exaggerations were too authoritarian
- Needle exchange programs (NEPs) help prevent the spread of diseases, but they don’t really address the behaviors and thinking patterns.
- Safe injection facilities – Senator Scott Weiner is proposing the implementation of safe injection centers, locations where heroin and other opiates can be used legally, in a healthy environment. He’s basing his rationale off a 3 year pilot program from a study completed by the US National Library of Medicine indicating that overdose deaths are down 34 percent in sites near Vancouver.
- Clients at big name treatment centers are just numbers; the money is not actually providing more aid, only creating more initiatives

**WE DON’T NEED MORE INITIATIVES UNLESS THEY DUPLICATE CONCRETE GROUND BREAKING EBP WHICH HAVE PRODUCED REAL SIGNIFICANT RESULTS**
Stigma Hinders Response To Opioid Epidemic

A study examined how Americans feel about needle exchanges and safe injection facilities.

• An online survey of more than 1,000 adults found that just **39% of Americans support the idea of needle exchanges**.
• **29% support safe injection sites.**
• **16% of poll-takers** were willing to let a person struggling with opioid use marry into their family.
• **28% were okay with having an opioid-addicted co-worker.**
• **27% rated opioid users as deserving people**—as opposed to worthless.

WHY THROWING $ @ THE SYSTEM FAILS

• According to the Journal of Addictive Medicine’s July/August issue, staff turnover is an issue, with or without funding. The referral process, within and between organizations, suffers greatly because of staff turnover and lack of an efficient communication infrastructure. Organizations do not always hire quality staff, which also cannot be fixed with money. Additionally, learning how to refer a client to the services they need is also a skill that cannot be fixed with money.

• Strategies such as prescription monitoring programs, opioid disposal sites, opening additional treatment centers, and drug rescheduling all have good intentions, but why are the overdose deaths still climbing?

NO MAGIC WAND

• The opioid crisis is getting money, but the money’s just not being applied correctly. However, the mental health crisis is also on the upswing. How do you provide funding for suicide prevention? Printing fliers about calling for help, mobile crisis units or creating crisis text messaging services are good strategies, but the question we really need to be asking is how do we get people to reach out for help? Distorted thinking cannot be “fixed” with money.

• Money should be not be used for initiatives to create new treatment centers, but to improve relationship building skills by hiring quality, empathetic staff. Money vs. quality.
CHRONIC PAIN MANAGEMENT

• The national response to the over prescribing of opiates causes more suffering, but with a different population: those with chronic pain.
• Pain medication restrictions unfairly punish those who are using controlled substances the way they are supposed to. Aggressive methods to shut down and severely limit pain management clinics often results in devastating consequences, especially for the patients.
• Stopping a treatment regiment without warning or a backup plan creates stress, anxiety and may lead to further mental health concerns.
Hidden Voices article on Linked In:

1) What you don’t see in the news along with the countless overdoses are the names of the silent victims of this growing epidemic: men, women and children who are denied the prescriptions they desperately need for chronic pain because the addicts have cried wolf one too many times.

2) How can the crack head down the street obtain more narcotics from a doctor than the unemployed 30-year old living in his parent’s basement with back pain so severe he can’t get out of bed? Instead of treating the addicted, let’s shift our focus to the silent victims who are slowly and literally wasting away not from abusing the drugs, but from not having enough to ease the physical pain to live a normal, functioning life.

3) They didn’t ask for the crying, the moaning, the depression, and the nausea. They are the ones who are getting buried alive. Let’s propose a less restrictive, but impregnable net for the truly injured so they can get properly treated. They didn’t have a choice, but we need to listen to their voice.
RECIDIVISM

Rather than asking “what’s the recidivism rate?” we should ask an entirely different set of questions about justice interventions. Are we really helping people convicted of crimes to form **better relationships** with their families and their law-abiding friends? Are we helping them to **advance their educational goals**? Are they more likely to develop the **skills and abilities** required for **stable employment**? Are we helping them to **respect others** and to **participate positively** in the **civic and cultural life of their communities**?
RECIDIVISM STATS

2018 U.S. Department of Justice Update on Prisoner Recidivism:

A 9-Year Follow-up Period (2005-2014)

(highlighted as a Special Report released in May 2018)

• An estimated 68% of released prisoners were arrested within 3 years, 79% within 6 years, and 83% within 9 years.

• 5% of prisoners were arrested during the 1st year after release and not arrested again during the 9 year follow-up period.
• Address risk factors
• Evaluate family history of use and diagnoses
• Incorporate a guidebook titled *Heroin, Fentanyl, Opioids: A Comprehensive Resource for Families with a Teen or Young Adult Struggling with Opioid Use* written by the Partnership for Drug-Free Kids

• Situational crime prevention involves promoting safe settings, effective procedures, and developing secure products, i.e. making products more difficult to abuse or steal. These are broad strategies that can be applied to substance abuse prevention and mental health recovery because the hope is for the offender to re-evaluate their choices when a deterrent is in place.

• Identify ambivalence and cognitive dissonance
WHY IS RELAPSING A CRIME?

• Relapsing is a symptom of the disease. Individuals should not be punished for a symptom.
• Prosecutors don’t understand that people who suffer from a substance use disorder are not completely able to choose to abstain from drug use. The recovery process is not as easy as just saying no to drugs.
• CTI Officers and Mobile Crisis Units
• Police-Assisted Addiction and Recovery Initiative, or PAARI, a partnership of 390 police departments that has helped 12,000 people get into drug treatment - anyone who showed up at the police station and asked for help overcoming an opiate addiction would get it, without fear of arrest, no matter where they lived or whether they had insurance.
• Probation violations
• Breaking the cycle – walking into a police station, asking for help & receiving a bed instead of handcuffs
CLOSING: ADVOCACY/MACRO

• Community-based action
• “By shifting the public conversation from the “problems of the needy” to the “rights of all human beings”, we can encourage the development of long-term, cohesive, adequately funded institutions” (Sered, 2014, p. 163).
• Housing & vocational services incorporating mental health treatment and substance abuse treatment as opposed to black and white restrictions
• Brainstorming session between community leaders and clients to create unique specialized comprehensive services
• Speaking to major health insurance companies and social security in attempts to redefine definitions & determinations of disability and disease
• Substance users and those with SMI are oppressed populations
ANY THOUGHTS??