Illinois Forensic Associates, Inc.

Dual Diagnosis: Assessment and Treatment

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Definitions/Terminology

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- **Any Mental Illness** (AMI): adults aged 18 or older: the presence of any mental, behavioral, or emotional disorder in the past year that met DSM criteria (*not including substance use disorders)*

- Nationally, **43.4 million adults** aged 18 or older experienced AMI in the past year, corresponding to a rate of **18.2 percent**, ***Illinois 15.86%*** (SAMHSA, 2014/ NIMH, 2015)

- **Serious Mental Illness** (SMI): a disorder which caused substantial functional impairment (i.e., a disorder that substantially interfered with or limited one or more major life activities) and has an urgent need for treatment (*not including developmental and substance use disorders)*

- Among adults aged 18 or older, the national rate of **SMI** is **9.8 million Americans** which equates to **4.0 percent, *Illinois 3.21%*** (SAMHSA, 2014/ NIMH, 2015)

Dual Diagnosis

- Both diagnosable mental illness and substance use
  - (DSM 5: Use Disorder, mild, moderate, severe); co-occurring
- Each can be mild or severe with one being more severe than other; each can vacillate over time
- Substance use can be etiology of MI symptoms; or MI to substance use
- Substance use worsens symptoms of MI
- Symptoms of substance use can mimic symptoms of mental illness, and symptoms of mental illness can be confused with symptoms of substance use

American Society of Addiction Medicine (ASAM)

- Mentally Ill Chemically Addicted (MICA)
- Chemical Abuse and Mental Illness (CAMI)
- Mental Illness Substance Abuse (MISA)
- Substance Abuse and Mental Illness (SAMI)
- Individuals with Co-Occurring Psychiatric and Substance Symptomology (ICOPSS)
- Dual Disorders, Dual Diagnosis, Coexisting, Co-Morbid, Co-Occuirng, Multiple Vulnerabilities (2005)

Statistics

- According to Substance Abuse and Mental Health Services Administration, **7.9 million** persons have **co-occurring disorders** (SAMHSA, 2014)

- **25.7%** of all adults with SMI diagnosed with substance dependence (National Survey on Drug Use and Health, 2009)

- **7.4%** of individuals receive treatment for both conditions

- **55.8%** percent receive **NO** treatment at all (SAMHSA, 2009)

- **68%** of adults with mental disorder also had one or more medical conditions (National Co-Morbidity Survey Replication)

- **70-90%** of offenders use illicit drugs during their lifetime; **50-80% we under influence at time of arrest; 50-70%** of those have **lifetime dx** of abuse or dependence (Tafrate & Mitchell, 2014)

- **75%** of jail inmates with a mental health diagnosis have a co-occurring substance use disorder (SAMHSA, 2009)

Bureau of Justice (2006)	Jail Inmates	State Prisoners
Mental health problem (defined as recent hx (clinical dx or tx)or sx occurred within last 12 months) with current or past violent offense	**44%**	**61%**
Mental health problem and also met criteria for substance dependence or abuse	**76%**	**74%**
Mental health problem and were dependent on or abused drugs	**63%**	**62%**
Mental health problem and were dependent on or abused alcohol	**51%**	**53%**
Mental health problem and used drugs at the time of offense	**34%**	**37%**
No mental health problem and used drugs at the time of offense	**20%**	**26%**

“Forensic”

- What is considered “forensic”:

“Professional conduct is considered forensic from the time the practitioner reasonably expects to, agrees to, or is legally mandated to, provide expertise on an explicitly **psycholegal** issue.”

- “…psychologists are encouraged to consider the potential impact of the legal context on treatment, the potential for treatment to impact the psycholegal issues involved in the case.”

- “As **advisors**, forensic practitioners may provide an attorney with an informed understanding of the role that psychology can play in the case at hand. As **consultants**, forensic practitioners may explain the practical implications of relevant research, examination findings, and the opinions of other psycholegal experts. As **examiners**, forensic practitioners may assess an individual’s functioning and report findings and opinions to the attorney, a legal tribunal, an employer, an insurer, or others (American Psychological Association, 2010; American Psychological Association, 2011a). As **treatment providers**, forensic practitioners may provide therapeutic services tailored to the issues and context of a legal proceeding. As **mediators or negotiators**, forensic practitioners may serve in a third-party neutral role and assist parties in resolving disputes. As **arbiters**, special masters, or case managers with decision-making authority, forensic practitioners may serve parties, attorneys, and the courts (American Psychological Association, 2011b).

Court Ordered:

Substance Use Process Addictions	Fitness Evaluations/ Sanity Evaluations Restoration to Fitness
Domestic Violence Anger Management	Expert Witness Individual Family: Custody Evaluations and Reunification
Sex Offender	

- What makes a good forensic clinician?

  - *Games Criminals Play and How You Can Profit by Knowing Them;* "employees/ officers" = clinicians; applicable to tx.

  - "Firm, fair and consistent" (Allen & Bosta, 1981)

  - "…meet an emergency with cool headed composure" (Allen & Bosta, 1981)

  - Talents, Traits, Abilities and Strengths: "Productively Mellow"
    - Perceived as professional (Allen & Bosta, 1981)

TALENTS, TRAITS, ABILITIES, AND STRENGTHS

Excessively Soft	Productively Mellow	Excessively Hard
spineless	ADAPTABLE	unrelenting
paternal	HELPFUL	demanding
slavish	LOYAL	restrictive
permissive	OPTIMISTIC	impractical
inconsistent	SEEKS EXCELLENCE	perfectionistic
submissive	SUPPORTIVE	indifferent
gullible	CAUTIOUS	suspicious
pretentious	AMBITIOUS	ruthless
solicitous	COMPETITIVE	combative
obligatory	FORCEFUL	dictatorial
lenient	ORGANIZED	rigid
impulsive	QUICK TO ACT	rash
self-conscious	SELF-CONFIDENT	arrogant
docile	TENACIOUS	obstinate
careless	ANALYTICAL	nit-picking
capricious	FAIR	unfeeling
vacillating	FIRM	inflexible
overfamiliar	FRIENDLY	sectarian
obsequious	PRINCIPLED	purist
easily distracted	THOROUGH	obsessive

What's the difference?! (Forensic vs. "General/Regular")

- Results determine conviction and/or sentence
- Manipulation strong for personal gains (also in non-judicial but more motivation to be perceived in favorable light i.e. freedom); "face value"
- Client's perception at onset of assessment/treatment
- Limits of confidentiality: court, lawyer, parole, probation
  - Always state all parties involved must have release of info at onset of tx., no choosing to use or not based on dx
- Lifetime court record
  - Adverse life events that may impact behavior
- Compliance results in successful completion of sentence or nolle pros

Screenings

Screening

- ASAM utilization of screening tools = prevention of, or early intervention, in addiction
  - Identification of early warning signs *can be enough* to change negative drinking or drug use habits

- SAMSHA endorsed screening approach = Integrated Screening, Brief Intervention and Referral to Treatment (SBIRT):
  - Brief process to determine if likely a substance use disorder and at least one co-occurring mental disorder
  - Screening should quickly assesses severity of substance use and identify appropriate level of treatment
  - Having an individual respond to a specific set of questions and scoring those questions
  - Brief intervention should focus on increasing insight and awareness regarding substance use and motivation toward behavioral change
  - Individuals who screen positive may receive a detailed, integrated assessment of current and historical symptoms/behaviors

Screening, Cont'd.

- Examples of screening tools:
  - CAGE Adapted to Include Drugs (CAGE-AID)
  - Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
  - Lie/Bet Questionnaire
  - Mental Health Screening Form III (MHSF-III)
  - Modified Mini Screen (MMS)
  - Michigan Alcohol Screening Test (MAST)
  - Drug Abuse Screening Test (DAST)
  - Texas Christian University Drug Screen; Center for Epidemiologic Studies Depression Scale (CES-D Scale)
  - Social Interaction Anxiety Scale (SIAS)
  - PTSD Checklist (PCL)

- These measures are commonly used, public domain screening tools
- Cover a broad, inclusive range of psychiatric and substance use disorders; **self report**
- Still may require review/follow-up with clients responses especially forensic population

- **Screening** → identify possible presence of a problem

vs.

- **Assessment** → define the problem and result in specific treatment recommendations
  - Detailed chronological history of past symptoms, previous diagnosis, treatment, and impairment; timeline of symptom expression and correlating substance use

Current risk of harm to self or others in both screening and assessment

Assessment

Assessment

- Conduct an assessment with Biological/ Psychological/Social etiology approach for both MI and Substance Use
- Determine level of severity of each diagnosis
- Determine which has the most important treatment priority
- Identify strengths and supports
- Obtain collaborative information when possible (family/current treatment providers/hospitals)

Assessment Cont'd.

- Use objective assessments (qualified clinicians) to assist in diagnosis and severity
  - Mini Mental Status Exam (MMSE)
  - Cognitive Capacity Screening Exam (CCSE)
  - Beck Depression Inventory-II (BDI-II)
  - Beck Anxiety Inventory (BAI)
  - Additional psychological battery
  - Support by subjective assessments (qualified clinicians)

Assessment Cont'd.

- According to ASAM (2005), multidimensional assessment should include:

  Acute Intoxication/ Withdrawal Potential: Past history of serious, life-threatening withdrawal/currently having similar withdrawal symptoms

  Biomedical Conditions and Complications: Any current severe health problems

  Emotional/Behavioral/Cognitive Conditions: Assess any immediate needs such as Imminent danger of harm to self/others, unable to carry/meet ADL's – imminent danger to self or others

  Readiness to Change: Thoughts/feelings towards treatment - treatment coerced, mandated

  Relapse/Continued Use/Continued Problem Potential: Currently under the influence, continued use/problems imminently dangerous

  Recovery Environment: Immediate threats to safety, well-being, and/or sobriety

Distinguishing Diagnostic History

Case of Mr. G

- 45 year old, married, Caucasian male
- Presented to ED after wife called 911 as a result of patient “punching in the door in when he couldn’t open it.”
- Pt. reported being able to “sing and dance in the clouds” and “in moving traffic.”
- Pt. reported impulsive behaviors, such as “…drove to New York (from RI) and “bought a cow for fresh milk everyday.”
- Pt. presented with pressured speech, tangential thought process, elevated mood
- Pt. endorsed current inability to sleep
- Pt. endorsed previous periods of fatigue, sleeping “a lot”, periods of increased appetite and being “sad”
- Family reported hx of pt. having combative, aggressive episodes

Clinical Interviewing Skills

Case of “Mr. Johnson”

Malingering

Malingering

Z76.5

The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs. Under some circumstances, malingering may represent adaptive behavior-for example, feigning illness while a captive of the enemy during wartime. Malingering should be strongly suspected if any combination of the following is noted:

1. Medicolegal context for presentation (e.g., the individual is referred by an attorney to the clinician for examination or the individual self refers while litigation or criminal charges are pending).
2. Marked discrepancy between the individual's claimed stress or disability and the objective findings and observations.
3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.
4. The presence of antisocial personality disorder.

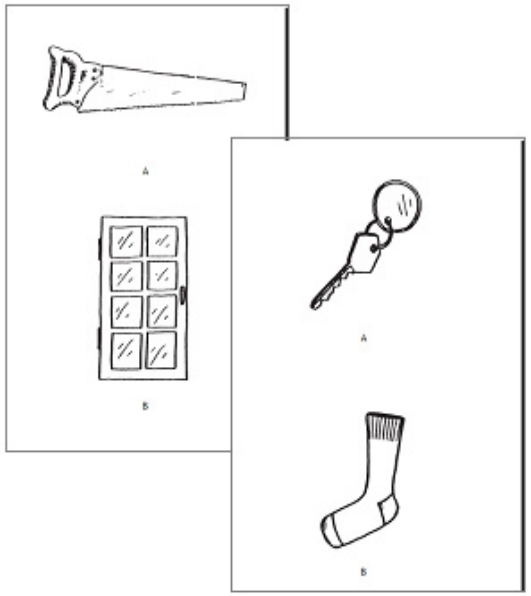
- Malingering vs. Conversion Disorder vs. Factitious Disorder

The primary focus of the SIRS-2 is to assess deliberate distortions, fabrications or exaggeration of self reported symptoms

1. Rare Symptoms: Are you bothered by strange smells wherever you go?
2. Symptom Combinations: Do you have a need to wash your hands frequently? Is it related to any unique or special powers?
3. Improbable or Absurd Symptoms: Do you have unusual beliefs about automobiles? Do you believe they have their own religion?
4. Blatant Symptoms: Do you have any major problems with fighting evil forces?
5. Subtle Symptoms: Do you have any major problems with waking up early in the morning?
6. Severity of Symptoms; “unbearable”
7. Selectivity of Symptoms; random in endorsement
8. Reported vs. Observed Symptoms

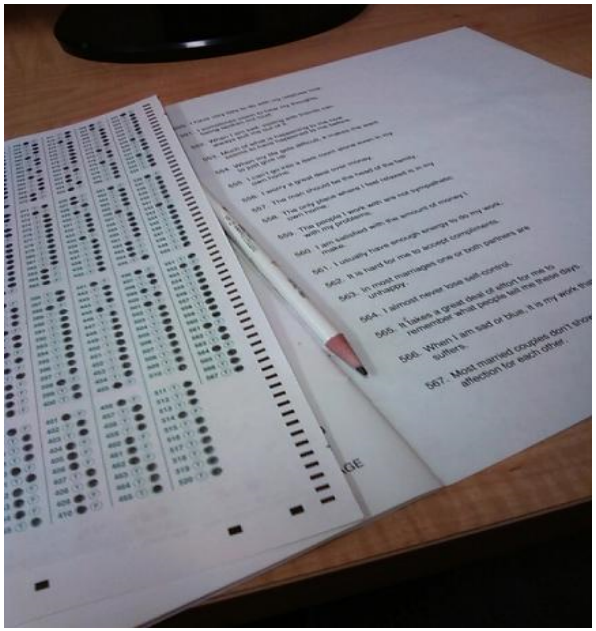
The Test of Memory Malingering is a “visual recognition test designed to help psychologists and psychiatrists distinguish between malingered and true memory impairments.”

TOMM is sensitive to malingering and insensitive to a wide variety of neurological impairments, which makes it very reliable



Minnesota Multiphasic Personality Inventory-2

MMPI-2 most widely used and widely researched personality assessment; 567 items are designed to evaluate thoughts, emotions, attitudes, and behavioral traits that comprise personality



Reports

Report Writing

- Language used
  - Reported
  - Stated
  - Clinical assessment resulted in a diagnosis of…
  - Record review indicated…
  - Clinical judgement
  - With a reasonable degree of clinical certainty…
- Subjective vs. objective assessments
- Justify
- Remember will be court record ; APA Ethics for Forensic Psychologist

Treatment

Treatment Overview

- Goal: return to healthy, productive functioning in family, work and community
- Least restrictive level of care (ASAM); evidence based approaches
- No singular treatment is appropriate for everyone
  - Based on drug of choice
  - Baseline functioning: cognitive, behavioral, medical (including pregnancy)
  - History of use/treatment attempts
  - Consider age, gender, trauma history, current legal status
- At least 3 months to significantly reduce or stop substance use; best outcomes with longer durations (National Institute on Drug Abuse (NIDA), 2012)

Treatment Cont'd.

- Detox does not address psychological, social, behavioral problems; does not typically produce long term recovery (NIDA, 2012)

- Level of care may need to be adjusted to meet needs as more information is disclosed/uncovered/changes

- Medications may be utilized as an effective component of treatment *when in conjunction* ***with behavioral treatment programs*** (NIDA, 2012)
  - Opioids
  - Alcohol
  - Benzodiazepines
  - Barbiturates
  - Nicotine
  - Psychotropic medications

Treatment Cont'd.

- Concurrently treat the individual biologically, psychologically and socially; integrated treatment
- Integrative treatment **most** effective → treated at the same time, in the same place, by the same treatment team (Hazeldon, 2014)
- Integrative treatment produces **better** outcomes for individuals with co-occurring mental and substance use disorders (SAMHSA, 2014)
- Individualized treatment planning unique to the offender (U. of N. M., 2011)
- Aftercare (community based) (U. of N. M., 2011)

Impediments to Integrative Treatment

- Thorough assessment for appropriateness for level of care/program
- State and Federal funding limitations
- Insurance approval
- Limited dual diagnosis centers/ Limited beds
- Criminal justice system
  - While incarcerated, limited jail based tx. offered/provided
  - If/when treatment approved by courts, co-occurring disorder must be stabilized prior to transfer which can be difficult with limited formulary medication
  - Shorter jail episodes (U. of N.M., 2011)
- Agencies collaborating effectively for continuity of care
- Compliance (to all integrative tx. recommendations)
- Resistance

Treatment Cont'd.

- Success not solely determined by voluntary inception; mandated treatment have demonstrated **as favorable** outcomes as voluntarily onset (NIDA, 2012)

- Illinois Department of Human Services; Division of Alcoholism and Substance Abuse (DASA) "independent evaluation":

"…reported use of alcohol decreased from 59% at admission to 30% six months post treatment; marijuana from 30% to 6%; cocaine from 37% to 6 %; heroin from 24% to 6 %" (DASA, 2015)

- Treatment success rate for "reducing drug use" is 40-60%; comparable to success rates for asthma and hypertension (DASA, 2015)

Evidence Based Therapies

- Cognitive Behavioral Therapy
  - Identify and correct problematic, maladaptive behaviors
  - T-F-B
  - Development of coping skills
  - Alcohol, Marijuana, Cocaine, Methamphetamine and Nicotine (NIDA, 2012)

- Contingency Management Interventions/Motivational Incentives
  - Giving tangible rewards to reinforce desirable behavior
  - Incentive based interventions can be effective in treatment retention and abstinence
  - Voucher Based Reinforcement (VBR)
  - Cautionary for co-morbid gambling
  - Alcohol, Stimulants, Opioids, Marijuana, Nicotine (NIDA, 2012)

Evidence Based Therapies, Cont'd.

- Community Reinforcement Approach Plus Vouchers
  - Intensive 24 week outpatient treatment
  - Counseling focused on improving family relations, skills to minimize drug use, vocational counseling, aid in development of new recreational activities and social supports
  - Antabuse
  - Clean urinalysis (cocaine) receive vouchers
  - Alcohol, Cocaine, Opioids (NIDA, 2012)

- Motivational Enhancement Therapy
  - Counseling approach to "resolve ambivalence" about involvement in treatment and ceasing drug use (NIDA, 2012)
  - Assessment, feedback session, 2-4 individual sessions
  - Goal to stop use and facilitate treatment entry
  - Motivational interviewing principles and development of coping skills
  - Alcohol, Marijuana, Nicotine (NIDA, 2012)

Evidence Based Therapies, Cont'd.

- The Matrix Model
  - Receive direction, support education regarding self help groups from therapist
    - "…teacher and coach fostering a positive encouraging relationship to reinforce positive behavior change" (NIDA, 2012)
  - Utilize detailed treatment manuals
  - Monitored by urinalysis
  - Stimulants (NIDA, 2012)

- Family Behavior Therapy
  - Address substance use with at least one significant other
  - Aim to improve home environment
  - Rewards provided by significant other when behavior goals are met
  - Especially beneficial for youth population

Treatment, Cont'd.

- Dual Diagnosis Capable (DDC) vs. Addiction Only Services (AOS), (ASAM, 2011)
  - DDC accept co-occurring disorders
  - MI generally stable
  - Independent functioning so MI does not interfere with addiction treatment
  - Collaboration with mental health assessment and treatment
  - Psychotropic medication monitoring
  - Integrated treatment and discharge planning

- Dual Diagnosis Enhanced (DDE)
  - More intense supervision/stabilization needed
  - Not as unstable as current harm to self or others or one on one/24 watch
  - Integrated discharge planning

Specialized Assessment/Treatment

Specialized Assessment/Treatment

- Psychosexual Risk Evaluation, Sex Offender Specific Treatment
- Domestic Violence Treatment; Risk evaluation prior to conviction/sentence
- Fitness Evaluations; Restoration to Fitness Treatment
- Insanity Evaluations
- Moral Reconation Therapy (MRT); Cognitive Behavioral Treatment System
  - "Prevent recidivism, instill more positive identity, change poor decision making and behavior patterns into more positive pro-social, honest, goal oriented directions & ready clients for work/school/volunteer" (Correctional Counseling, 2015)
- "Addicted Offenders": CBT, REBT (Tafrate & Mitchell, 2014)
- "Substance Abusing Judicial Clients": Social and Community Responsibility Therapy (SCRT), (Tafrate & Mitchell, 2014)

Specialty/Problem Solving Courts

Specialty/Problem Solving Courts

- Nexus needed; may require specialized screenings, assessments and/or treatments
  - All have clinical/diagnostic criteria along with legal
  - Consider court requirements of reporting
- Drug Court
- Mental Health Court
- Veterans Court
- Adult Redeploy Court

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