

Inpatient Approaches to Co-occurring Substance Use Disorders in Texas



Jeff R. Bearden, LCSW
Michael T. Jumes, Ph.D.
Stacey L. Shipley, Psy.D.
North Texas State Hospital

Overview

- The evolution of COPSD in Texas
- COPSD treatment considerations
- Implications for Violence Risk Assessment

The evolution of COPSD in Texas

Theoretical underpinnings

Swartz, Swanson, Hilday, Borum, Wagner & Burns, 1998

- Substance abuse problems, medication noncompliance, and low insight into illness operate together to increase violence risk.
- Noncompliance and substance abuse may be mutually reinforcing problems
 - substance impairment may impede medication adherence
 - noncompliance may lead to self-medicating with alcohol or illicit drugs.
 - It is possible that both noncompliance and substance abuse result from some other factor such as general disaffiliation from treatment or unspecified personality traits.

Theoretical underpinnings

Swartz, Swanson, Hilday, Borum, Wagner & Burns, 1998

- Untreated psychopathology and distress may lead to alcohol and other drug abuse.
 - Risk of violence may then increase because of substance use, increase of psychiatric symptoms, or the influence of criminal environments in which illicit drugs are procured.
 - Violent behavior may damage supportive social and therapeutic relationships and may precipitate involuntary commitment or incarceration.

TDMHMR and TCADA

- For many years, inpatient substance abuse services were provided by state hospital substance abuse units, under the auspices of the Texas Department of Mental Health and Mental Retardation (TDMHMR).
- In 1993, substance abuse services were separated and put under the auspices of the Texas Commission on Alcohol and Drug Abuse (TCADA).

Changes

The need for treatment of co-occurring substance use disorders was recognized and a “COPSD” policy was established.

Support for Integrated Treatment

Swartz and colleagues, 1998

- The combination of medication noncompliance and alcohol or substance abuse problems was significantly associated with serious violent acts in the community.
- Alcohol or other drug abuse problems combined with poor adherence to medication may signal a higher risk of violent behavior among persons with severe mental illness.

Support for Integrated Treatment

Swartz and colleagues, 1998

- Reduction of such risk may require carefully targeted community interventions, including integrating mental health and substance abuse treatment.
- As these problems compound one another, conventional separate-track mental health and substance abuse treatment is unlikely to succeed.

COPSD

- A Departmental Rule (Texas Admin. Code) was promulgated with requirements including:
 - Training of staff to competency in assessing and treating co-occurring disorders
 - Routine assessment of all persons admitted who had hx of substance use
 - Specific treatment interventions for co-occurring disorders if conditions warranted

COPSD

The Rule was implemented in 2003. The COPSD Assessment was incorporated into the electronic medical record and services organized and delivered according to the rule in each of the state hospitals

More Changes



- **TDMHMR and TCADA were consolidated with the Texas Dept. of Health to create the Department of State Health Services as part of a major overhaul of health and human services in 2004**

Our Experience

- 96% of persons admitted to Maximum Security Unit meet the criteria for assessment
 - About 45% need and receive COPSD interventions while in MSU
- 100% of the adolescents served in the Adolescent Forensic Program are assessed and treated according to criteria in the rule
- % of persons served in the non-MSU forensic settings are assessed and served



Treatment Considerations

Recovery...

“Let’s *help you work yourself* out of your role as patient”

Developmentally appropriate, consider emerging and entrenched personality and behavioral factors

Recovery: Treatment or corrections?

“The primary goals guiding resource allocation in the criminal justice system are completion of legal processing, protection of public safety, and punishment...Contrasting goals of the treatment and justice systems may discourage application of some evidence-based practices [such as] use of tangible reinforcement for positive behavior, and pharmacological treatments to assist in reducing or stabilizing symptoms (Chandler, et al. (2004) p. 439).”

Diversion model: keep 'em out!

Hartford and colleagues, 2006

Although formal pre-trial diversion programs exist, most remain *informal*:

- Training for first responders vary
- Outcomes measurement is spotty
- Access to services is more loose.

Successful pre-trial programs are deliberately designed

- Mental health, substance abuse and criminal justice agencies are coordinated
- “No refusal” drop-off policies appear critical

Correctional model: Lock 'em up!

Peters and colleagues, 2004

Mental health and correctional populations co-vary

- In 1999, 16% of inmates were persons with mental illness; a large proportion had co-occurring substance use disorders

Modified therapeutic community (TC) models are used

- Screening and referral
- Incentives for participation
- Assessment
- Drug testing
- Clinical services

Collaboration between prisons, community supervision and treatment agencies using interdisciplinary staff is critical

Correctional model: Lock 'em up!

Van Stelle, and colleagues, 2004

Institutional therapeutic community program completion was associated with better outcomes

Mental health and substance use diagnoses were unrelated to program completion

Risk ratings and psychopathy (PCL-SV) scores impacted treatment completion

- A single type of negative behavior (e.g., offense type) not associated with program termination
- Multiple samples of behavior predicted program completion

Inpatient treatment model: Get-R done!

cf. Herman, et al., 1997

Treatment principles

- Biopsychosocial context
- Independent vs. co-occurring illness onsets
- Simultaneous treatment required
- Profound denial confronted

Solid inpatient programs integrate substance use and mental health treatment

Inpatient treatment model: Get-R done!

cf. Herman, et al., 1997

Treatment stages and targets

- **Acute Symptom Stabilization** – Admission, assessment → symptom stabilization
- **Engagement** – process therapies and psychoeducation → participation in therapeutic activities
- **Persuasion Awareness** – education → knowledge of MH and SA
- **Active Treatment** – professional and self-help therapeutic approaches → knowledge, motivation, perception of treatment effectiveness
- **Relapse Prevention** – discharge planning → sobriety and psychological health, goals setting, community re-entry

Integration

- Correctional and treatment approaches have the same goals: public safety and reduced recidivism
- *Integrated* treatment is a must
- *Assessment* is key to determining motivation, potential barriers to change, treatment progress
- *Communication* within teams, among agencies increases likelihood of favorable outcomes

Implications for Violence Risk Assessment

Case Example 1

- **Schizophrenia, Paranoid Type, Chronic**
- **History of substance dependence**
- **Incompetent to Stand Trial for Attempted Murder**
- **History of drug dealing. First inpatient treatment was in 1984 at the age of 23, after he became drunk and threatened to kill his parents.**
- **Current craving for illicit substances, he stated, “Their first mistake was putting me into a private hospital. I was smuggling drugs and alcohol into a private hospital.”**

Case Example 2

- **NGRI- Murder X2; Schizophrenia, Paranoid Type**
- **“I went back and asked my mom to stay with her. I had bought a gun because I was scared. I was smoking crack and a dude choked me in my house.” Between 1991 and 1995, he was working in a drug house. Used on average of \$60 to \$80 worth of crack per day.**
- **“I hear voices. That’s what causes everything. Voices cause me to do my crime. The voices told me to kill my mother and brother. They told me how to do it...I do what my mind says.”**

Case Example 3

- **NGRI- Murder; Schizoaffective Disorder, Bipolar Type; ASPD; prior Polysubstance Dependence**
- **LSD, cocaine, heroin, marijuana, and amphetamines...drug of choice being alcohol (age 11). Pt reported that he drank “a whole case of tall boys” the night before the homicide.**
- **“It’s just something in the beer that doesn’t go in my system. I could drink whiskey, bourbon, or scotch no problem. It’s something in the beer, the yeast, the hops...that I’m allergic to. It’s not the alcohol.”**

Mental Illness and Violence (Monahan, 1997/ Resnick)

- There is a weak relationship.
- Most mentally ill people are not violent.
- Substance abuse is a much greater risk factor than mental illness.

Mental Illness/Diagnosis

- The higher the number of psychiatric diagnoses, the greater the rate of violence.
- The presence of 2 or more psychiatric diagnoses approximately doubles the risk of violence (Swanson, 1990).

Forensic Patient Population

- Majority of insanity acquittees are dually diagnosed with both persistent mental illness as well as chronic substance abuse disorders.
- Although patients can be stabilized and conditionally released...

Forensic Patient Population

- There is a high risk for relapse due to chronicity and severity of their conditions.
- This can mean relapse of potentially lethal violence.

Violence Risk

- Approximately ½ of patients in schizophrenic spectrum dx meet criteria/or lifetime diagnosis of substance abuse disorders

(Krakowski, 2005; Cuffel et al., 1994).

- Past violent acts and substance abuse disorders are foremost risk factors

Violent Recidivism Substance Abuse and Psychopathy

- Psychopathy strongest predictor
- (N = 202 violent male offenders with psychotic diagnoses) (Tengstrom et al., 2000).
 - 48% recidivism rate among psychopaths compared to 14% for nonpsychopaths
 - Substance Abuse increased risk for nonpsychopaths but not for psychopaths.

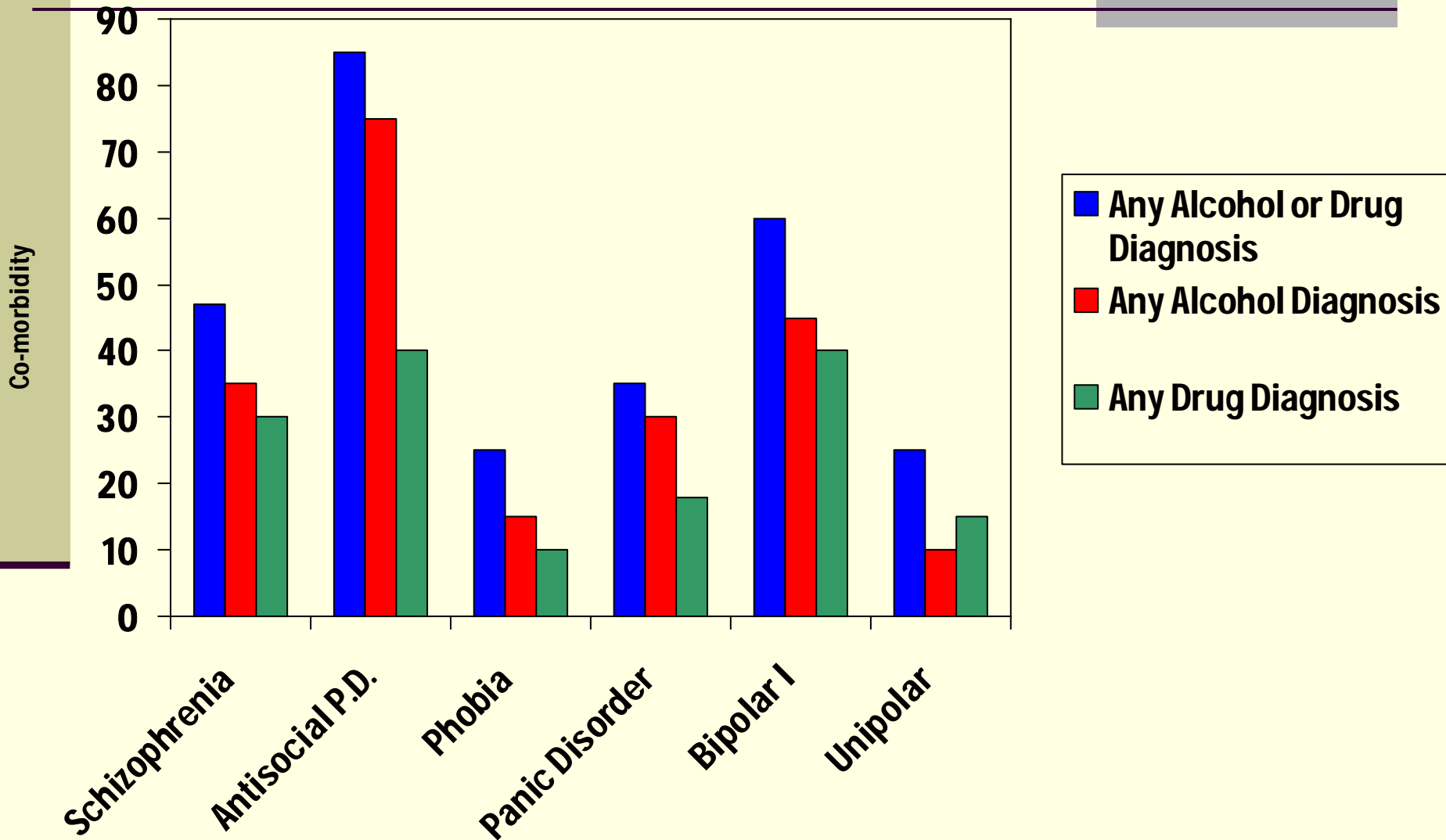
Psychiatric Patients with Co-morbid Substance Abuse Disorders

- Constitute the greatest risk for violence
- Psychiatric patients must be considered a high risk for aggression if co-morbid Alcohol Dependence exists (Pihl & Hoaken, 1997)

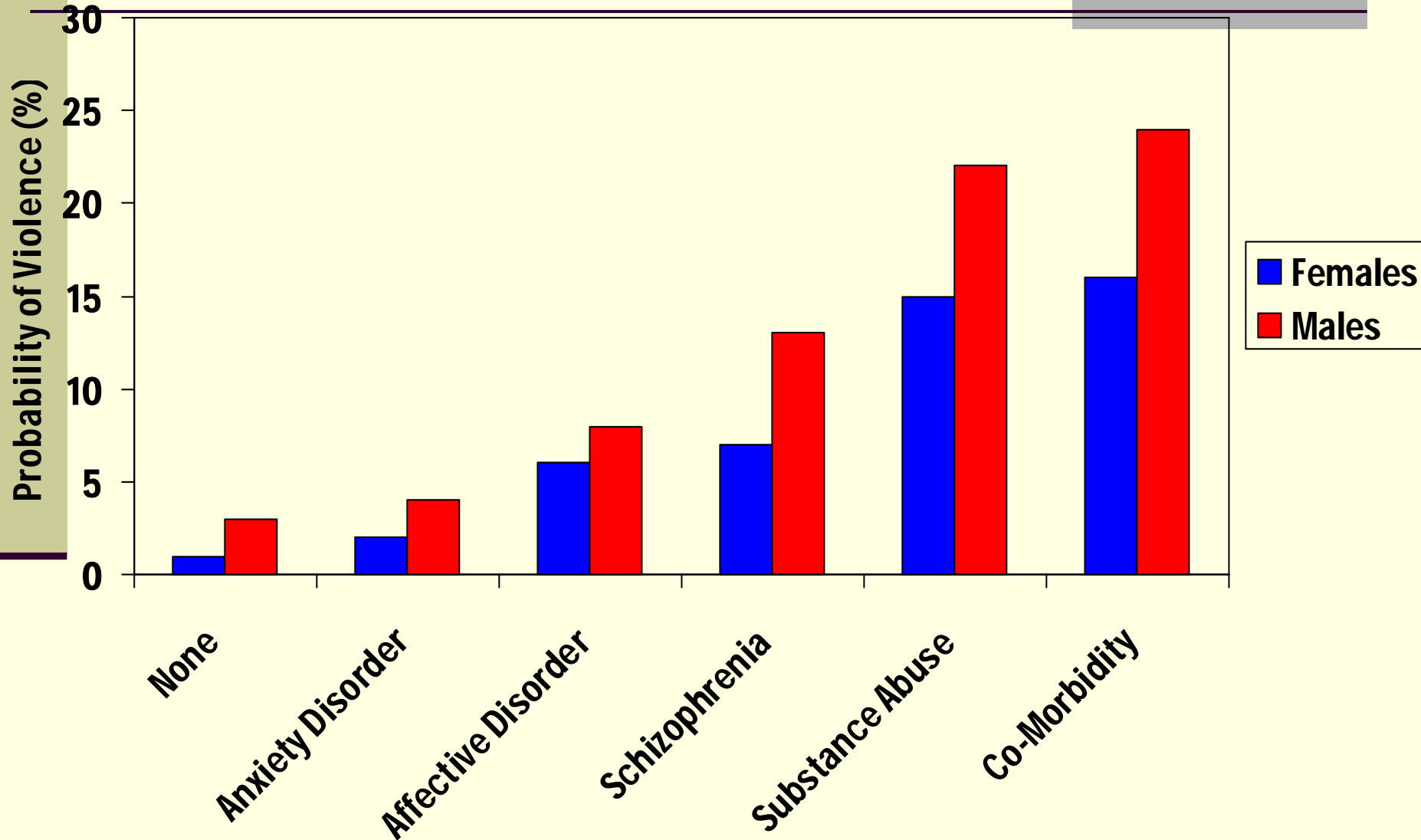
Psychiatric Patients with Comorbid Substance Abuse Disorders

- Psychostimulants can increase delusions & hallucinations in patients with psychotic disorders
- Patients with histories of both paranoid delusions & psychostimulant abuse are at higher risk for violence

Co-Morbidity of Drug and Alcohol Diagnoses with Prominent Other Diagnostic Categories (Pihl & Hoaken, 1997)



Probability of Violent Behavior in a One-Year Period By Diagnostic Class (Pihl & Hoaken, 1997)



History of Substance Abuse

- Steadman, et al. (1998) found that patients discharged from psychiatric hospitals who do not exhibit symptoms of alcohol or drug abuse are about as safe as their non-patient neighbors.
- The combination of substance abuse with other major psychopathology is more volatile than either alone.

History of Substance Abuse

- Substance abuse tripled the rate of violence in non-patients in the community & increased the rates of violence by discharged patients by up to 5 times.
- In a sample of patients with schizophrenia (Schwartz et al., 2003): manic symptoms & substance abuse were strongly related with more extreme homicidality.

Alcohol

- Review of 26 studies involving 11 countries found
 - 62% of violent offenders had been drinking shortly before crime
 - Rate of intoxication was roughly double for violent crimes

(Murdoch, et al., 1990)

Co-morbid Disorder and Violent Offenses

- Early 1970's to late 1990's % of pts using substances at time of violent offense & regular substance use in the 12 months prior to detention, has risen 3 fold (D'Silva & Ferriter, 2003).
- Rising prevalence of substance use in this population highlights necessity for drug & alcohol tx programs in secure settings.

Evaluating Risk for Violence

In Institutional Settings

Dangerousness Review Board Recommendations

- Manifest Dangerousness
 - Risk for Unauthorized Departure
 - Substance Abuse as a Risk Factor

Conclusions

- Integrated treatment is a must
- Assessment is essential as is communication within teams & among agencies to increase likelihood of favorable outcomes
- Violence risk is greatly increased by the presence of co-occurring disorders
- Treatment of both mental illness and substance abuse promotes public safety and reduced recidivism

Contact Information

- jeffry.bearden@dshs.state.tx.us
- michael.jumes@dshs.state.tx.us
- stacey.shipley@dshs.state.tx.us