Mental Health
FACTS IN BRIEF

Co-Occurring Mental Illness and Substance Use Disorders (CODs)

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Individuals with both mental illness and substance use disorders ("co-occurring disorders" or "CODs") are commonly before the courts. Within the broad categories of mental illness and substance use disorders, a COD might involve bipolar disorder and methamphetamine use disorder, posttraumatic stress disorder and opioid use disorder, or any combination of two or more conditions or disorders. Non-psychiatric conditions also co-occur (e.g., heart disease and asthma).

Co-occurring conditions complicate clinical treatment and recovery (e.g., by impacting medication management) and also have implications for justice involvement. For example, criminal recidivism and risks to parental rights or housing stability can increase when substance use co-occurs with mental illness.

This *Mental Health Facts in Brief* reviews the history and issues presented by co-occurring mental illness and substance use disorders and the strategies courts can use to address them.

BRIEF HISTORY

Mental illness and substance use disorders historically were separated both legally and clinically, a separation that still prevails today. In a matter before the court, this means either condition might be considered independently as a mitigating, aggravating or relevant factor, but the interaction of the two conditions typically is not explicitly embedded in the legal framework. For example, laws establishing qualifying conditions for civil commitment or criminal responsibility may contain language about either mental illness or substance use but not about their co-occurrence. Clinical approaches for the conditions have also been on separate tracks, making effective court referrals to treatment problematic.

Although not always readily available to patients, an integrated response to CODs has emerged as a best practice in clinical settings. However, in justice systems, integrated clinical information, recommendations and referral options about CODs still may not reach the courts. Even issues such as confidentiality laws continue to be distinct for mental illness (covered federally by the Health Insurance Portability and Accountability Act [HIPAA]) and primary substance use disorders (covered by 42 CFR Part 2). To the degree they are not addressed, CODs continue to impact health and functional outcomes for justice-involved individuals.

The common perception that substance use is purely volitional and mental illness medical has only complicated matters further. In recent years, the genetic, neuroscientific and other non-behavioral roots of substance use disorders have become better understood.

COMMUNITY POLICIES AND PRACTICES

Policies and practices that address CODs are proliferating. For example, an increasing number of juvenile and adult systems are screening for both mental illness and substance use disorders rather than for just one or the other. Guidelines have been issued by numerous agencies and organizations endorsing the use of these tools and taking other steps to promote identification and response to CODs in the justice system. In specialty courts, co-occurring treatment court dockets are being created. In reentry, the APIC model (Assess, Plan, Identify, Coordinate) is being widely used to improve transitions from correctional settings to the community for individuals with CODs. Meanwhile, data from mental health courts and other sources implicating CODs in recidivism increasingly motivates greater attention to co-occurrence.

Among the leading policies and practices that have emerged are the following:

- Specific screening for youth and adults with co-occurring mental illness and substance use disorders.
- Information-sharing through court orders or signed releases to allow the exchange of privileged medical information between the courts and treatment providers that comply with HIPAA and/or 42 CFR Part 2 .

- Implementation of evidence-based practices found to reduce the risk of recidivism associated with CODs
- Utilization of more flexible sanctions and rewards for participants with CODs in treatment courts.
- Evaluation for CODs in parents and youth involved in the child welfare system.
- Referrals for appropriate medication treatment that simultaneously addresses both the mental health symptoms and substance use needs of respondents and defendants with CODs (e.g., combined psychiatric medication with medication assisted therapies known to be effective for specific substance use disorders).

SUPPORTING EVIDENCE

The National Institute of Drug Abuse estimates that approximately 50% of people with mental illnesses will develop a substance use disorder over the course of their lifetimes, and 50% of those with substance use disorders will develop a mental health condition. Data from several studies have documented co-occurrence in specialty court populations (e.g., CODs in 30% to 40% of participants in drug courts and 75% to 80% of those in mental health courts). It is also well-documented that juveniles with substance use disorders often have co-occurring mental health conditions such as depression and anxiety.

A scientific understanding of why such co-occurrence is so prevalent is still evolving. Theories include the presence of common risk factors in both disorders and the possibility that one of the disorders may act as a catalyst for development of the other. Genetic factors that might influence how the brain responds to substances are also being investigated, as is the role of environmental circumstances such as trauma. Among circumstances under study is the possibility that the environment can also modify genetic processes in a way that affects an individual's susceptibility to substance use disorders and/or mental illness.

Because mental illness and substance use disorders so often manifest in adolescence and early adulthood, research is additionally focusing specifically on brain development and CODs in these age groups. This research could be important to the justice system because this is often also the time when court involvement begins.

On an independent but related track, research and development of medications for substance use disorders are ongoing. Medication assisted treatment (often called "MAT") is an example that may hold promise for individuals with co-occurring mental illness as well.

CONSIDERATIONS

Does the individual before the court have a COD?
If so, are both or all conditions being effectively addressed in an integrated approach?

What providers in the region are available to treat individuals with CODs?
What are the eligibility criteria for such treatment, if any, and can the court refer to these providers?

Are resources or partners available to the court to provide useful information or facilitate treatment (e.g., a local Medicaid office, state or county mental health agency)?

Has the court identified practices that overlook the interaction of mental illness and substance use disorders and addressed them in its orders?
Examples are orders that require sobriety before mental health treatment can begin or that prohibit medication assisted therapy for a person with mental illness.

SUMMARY

Mental illness and substance use disorders that co-occur can worsen the course of each disorder if both are not treated. Co-occurrence can also negatively impact the outcome of justice involvement. Because courts see so many individuals with CODs, the justice system is in a unique position to increase the likelihood that co-occurring disorders are addressed to the benefit of both the individuals and the system.

RESOURCES

- National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. Comorbidity: Substance use disorders and other mental illnesses (August 2018). Retrieved from National Institute of Drug Abuse (https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses)
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SJI State Justice Institute

NCSC National Center for State Courts