MI²

A BRIEF INTRODUCTION TO MENTAL ILLNESS AND CLIENT MANAGEMENT

Disproportionate Representation

1. Mental Illness
2. Co-occurring disorders “dual diagnosis”
3. Developmental Disabilities

- Deinstitutionalization (1960s)
  - Before: Hospitalization for long-term care
  - Now: ER/psych units full, max out at 72 hours = “revolving door” of jails
  - Recidivism is a matter of functioning, lack of social support, and resources

Mental Illness

- SPMI/SMI
  - Serious and Persistent Mental Illness
  - Rare in general community- only 1% of the population is diagnosed with schizophrenia.
  - However, a 2009 national study conducted in jails found ***17% of males and 34% of females have either a major depressive disorder, a bipolar disorder, a schizophrenic spectrum disorder, or PTSD*.**
- Chemical imbalance myth
  - **True**: Mental state impacted by psychotropic medication
  - **False**: Mental illness is ***caused*** by chemical imbalances
  - Medication alone is a “band-aid,” treats symptoms only
  - Antipsychotic medications are sedatives/tranquilizers

The Big Three (SPMI)

1) Bipolar I(*)
    - Depression and mania. Mania characterized by no sleep, excessive energy, risk taking, irritability (sometimes up to four manic episodes per year if rapid cycling)

2) Schizophrenia(*)
    - Positive symptoms: auditory or visual hallucinations, paranoia, expressed delusions
    - Negative symptoms: avolition- serious avoidance of daily tasks; affective deficits- dead pan, monotone

3) Schizoaffective disorder(*)
    - Symptoms of schizophrenia plus mood disorder (depression/mania). Double whammy

(*)**NOT ATTRIBUTABLE TO DRUG OR ALCOHOL USE!**

Core Psychotic Symptoms

Delusions

- “Fixed beliefs that are not amenable to change in light of conflicting evidence.”
- Bizarre vs not bizarre
- Specific types: persecutory, grandiose, erotomanic, somatic
- Context and culture are important

Hallucinations

- “Perception-like experiences that occur without an external stimulus”
- Vivid and clear
  - Falling asleep/waking up doesn’t count
  - Self-talk doesn’t count
- Any sensory modality

ONLY MATTERS TO YOUR CASE,

IF IT MATTERS TO YOUR

Co-occurring Disorders

Dual diagnosis = co-occurring

- Both a substance use disorder (SUD) and a mental illness

ALL MENTAL DISORDERS increase chances of having a drug/alcohol-use disorder

- 70%-74% of persons in the justice system who have mental disorders also have co-occurring substance disorders
- Can also be SPMI

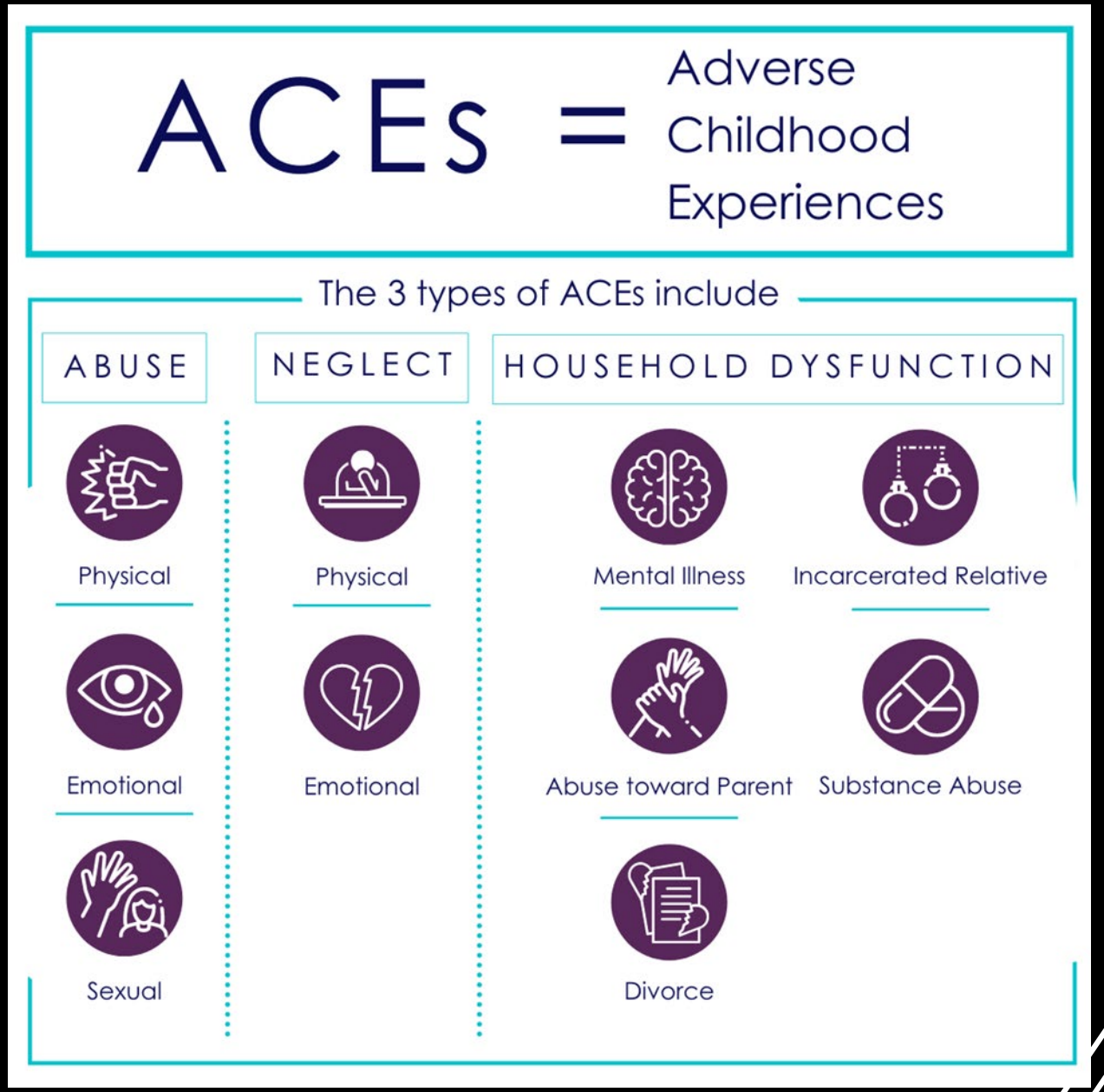
Characteristics of Drug Users

Traumatized

NDCI says up to 85% of drug court participants have a trauma history

Erratic, risk-taking, *violent,* poor self image, hopeless, can also be psychotic

No trust in authority figures



Two Rules to Live by

1. Check yourself before you wreck yourself

- Sometimes it is your job to take it on the chin
- Recognize power differential

2. Call a thing a thing

- Straight talk always
- No promises, no jargon = TRUST

Many symptoms of SPMI and co-occurring disorders overlap with PTSD.

Having trouble with a client who is belligerent, distrustful, and manipulative? …They may be a survivor of sexual trauma and/or other chronic stressors. This behavior has kept them alive. Don't take it personally.

Differential Diagnosis

Is this drugs or mental illness?

- Which came first?
- Impossible to distinguish-
  - May take UP TO ONE YEAR for the “fog to lift” depending on drug, method of use, length of use, etc.

Not sure where to start?
Pick DRUG TREATMENT

- Get back on “meds?” Nah. Only after stabilized/engaged in recovery
- Sobriety is always step one

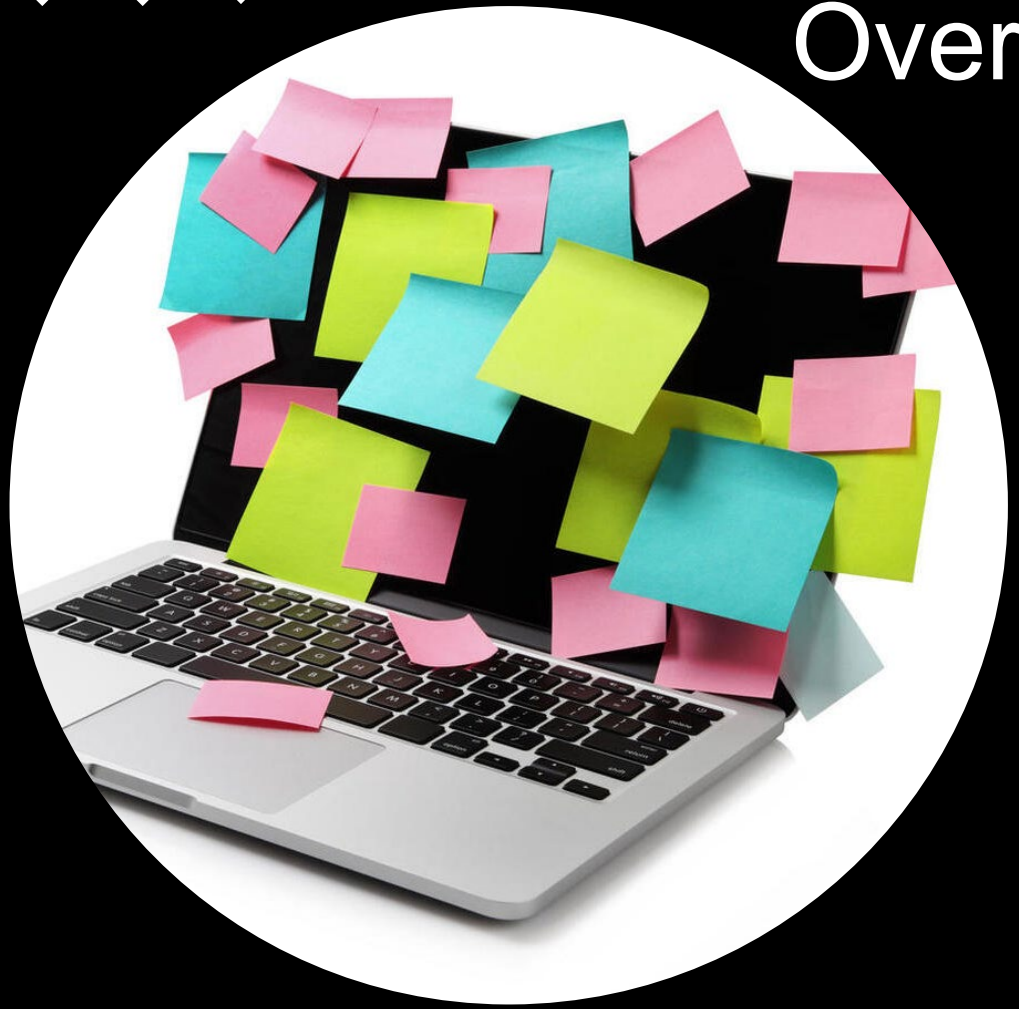
Intellectual Disability

AKA Developmental Disorder

- **Intellectual deficits**
  - Information processing (basic comprehension), reasoning, problem solving, judgement, learning from experience, academic learning
- **Adaptive deficits**
  - Poor hygiene, inability to learn or complete basic tasks- laundry, cooking, grocery shopping, managing a budget, keeping a job

Only diagnosed through psychological testing- FSIQ of 70 or lower (adaptive scores factored in, too). Onset in developmental stage (birth to 18)

The Way, Way, Way Overlooked



ID overlooked in the criminal justice system.

- **"Yes guys"**: *FAKE GOOD, indecisive, sweet, easy to want to help.*
- **"No guys"**: belligerent, poor impulse control, unlikeable. Appear to make informed decisions but call back insisting you promised X-Y-Z and you didn't. Unlikeable.

- Likely to push back against competency or using diagnosis in mitigation.

Recap

Clients with mental illness, co-occurring disorders, and/or intellectual disability can present as…

- delusional
- paranoid
- guarded
- sleep deprived
- risk-taking
- irritable
- withdrawn
- not anchored in reality
- …ALL REALLY DIFFICULT TO MENTAL STATES TO DEAL WITH. These clients can be unlikeable and hard to be around. “Is this guy a jerk or is he mentally ill?” Uh….yes.

Knife Fight!

Most of your difficult clients, aren't ***actually*** mentally ill

Best personal interest vs. Best legal interest

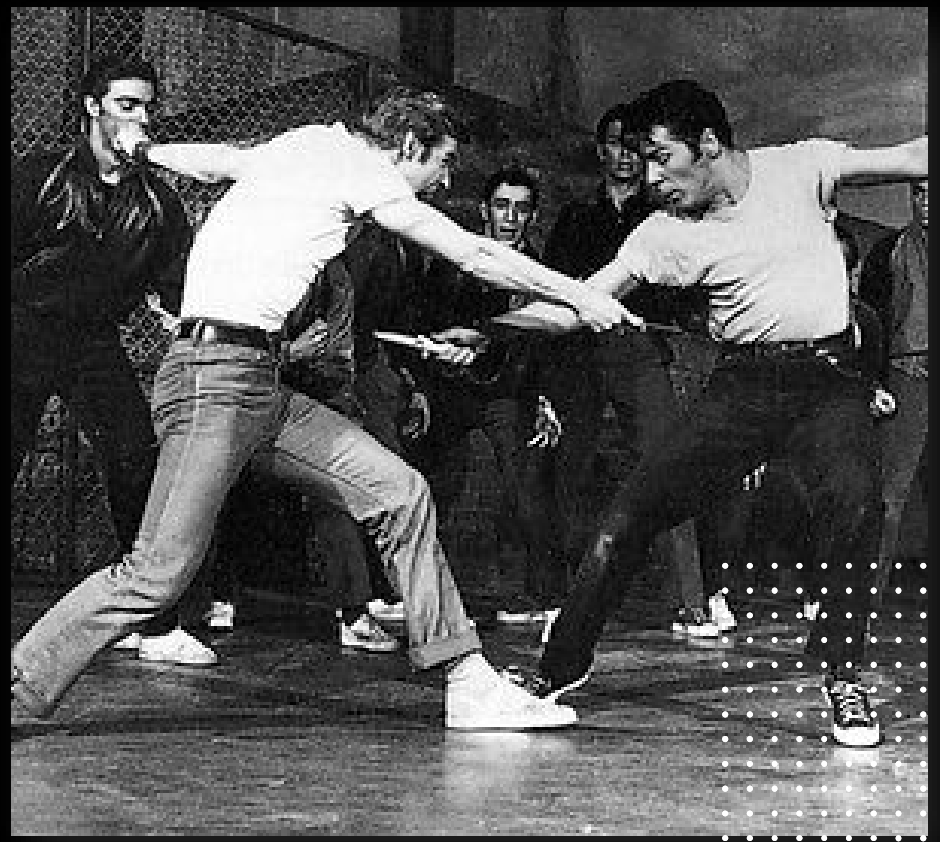
- Emotional content/ realities
- Counterintuitive behavior may be your lack of grasping

Interaction patterns (Interpersonal Psychotherapy)

- Entrenched ways of managing people/ situations (personality disorders/ issues)

Maybe they just don't get it, yet

- Gravity/ "givens" of their current situation
- Adaptive denial (normative to grief)



MOTIVATIONAL INTERVIEWING (MI)

What is MI?

“A person-centered communication method of fostering change by helping a person explore and resolve ambivalence”

- Evidence-based
  - Researched application in healthcare, mental health, education, human services, **and criminal justice**

MI is particularly helpful in situations when

Ambivalence is high

When people are stuck in mixed feelings about change

Confidence is low

When people doubt their ability to change

Desire is low

When people are uncertain about whether they want to make a change

Importance is low

When the benefits of change and the disadvantages of the current situation are unclear

YOU MAY BE THINKING…

- But I'm not here to help them change, I'm here to resolve their case

- **Psychologically speaking,**
  - The "change" process occurs whenever we are confronted with major decisions (including case resolution)
  - All the more applicable when being forced to accept ugly options

- Thus, like it or not, **you are here to shepherd them through a change process**

The “spirit” of MI

Partnership

- Collaborative (You are the legal expert; they are the expert of their life)

Evocative

- Draws out the client’s values, priorities, and reasons for change/acceptance

Acceptance of autonomy

- The options are the options, but the client gets to choose

Compassion

- Meet the client where they are, leave judgement at the door

THE RIGHTING-REFLEX

Knowing does NOT equal doing.

“You’re wrong, and I’ll tell you why”

Transtheoretical Model of Change

Progression

Regression

Precontemplation

- No change because no problem

Contemplation

- Aware of problem, action is needed, balancing pros/cons

Preparation

- Plan of action, concrete, SMART

Action

- Behavioral steps (meeting w/counsel, plea, PSI, post-release arrangements)

Maintenance/Termination

- Post release stuff

RULEs of MI

Resist the Righting Reflex

- Don’t “right”, reflect

Understand the client: motivation & world

- Avoid the question-answer trap (by reflecting)
- Avoid the premature-focus trap (more reflecting)

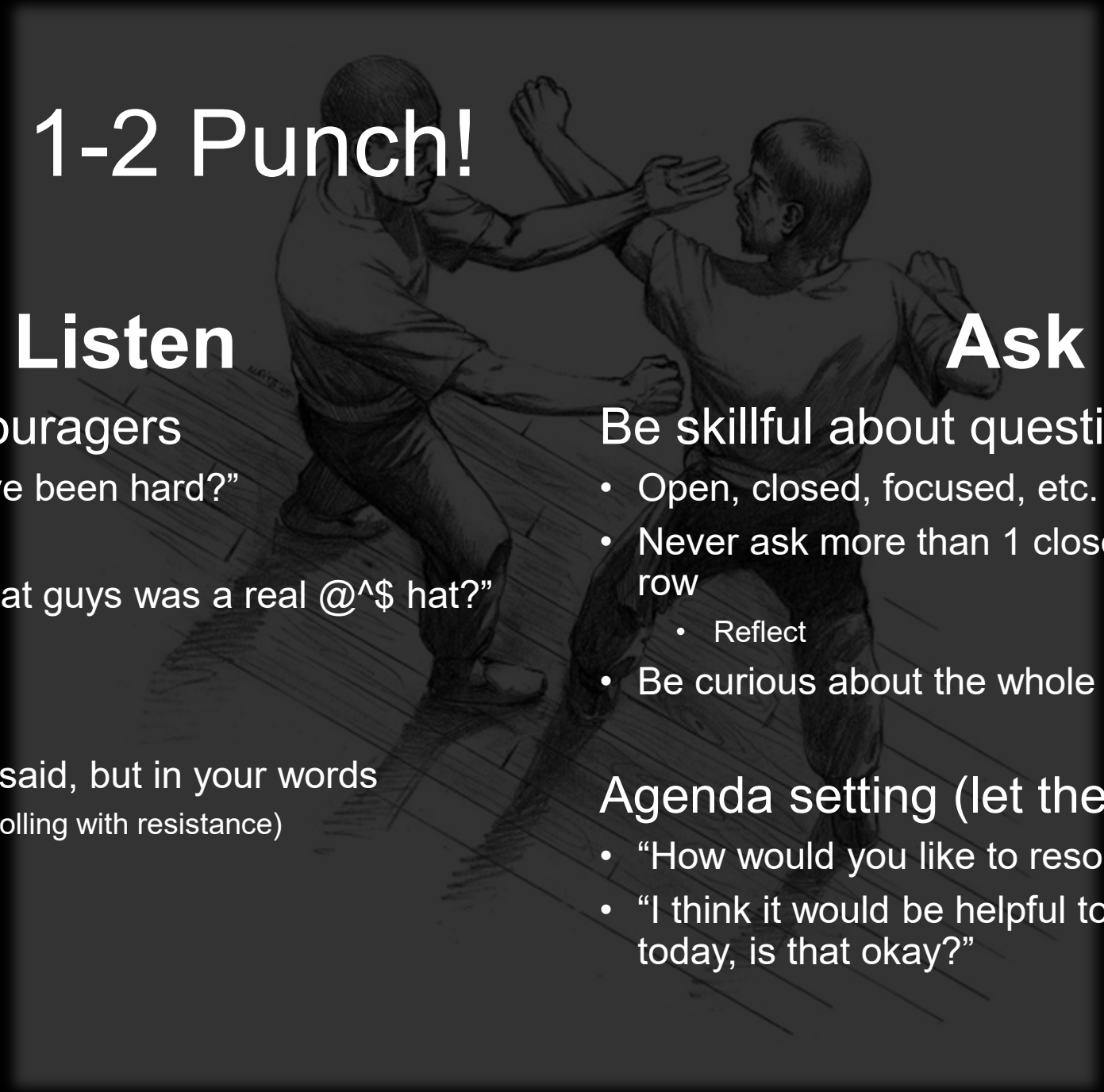
Listen empathically

- Asking questions is not listening
- Also, this is basically constant reflection!

Empower with facts

- Reflect their own motives/ values

The MI 1-2 Punch!



Listen

Minimal encouragers

- “That must have been hard?”
- “Tell me more”
- “Sounds like that guys was a real @^$ hat?”

Reflect!

- Say what they said, but in your words
  - Resistance (rolling with resistance)
  - Change Talk

Ask

Be skillful about questions

- Open, closed, focused, etc.
- Never ask more than 1 closed question in a row
  - Reflect
- Be curious about the whole person

Agenda setting (let the client do it!)

- “How would you like to resolve this?”
- “I think it would be helpful to review discovery today, is that okay?”

Change talk (DARN)

Desire

- What a client wants
- “wish” “want” “like”

Ability

- A client's capacity
- “can” “could” “able”

Reason

- Why change
- Stories and life events

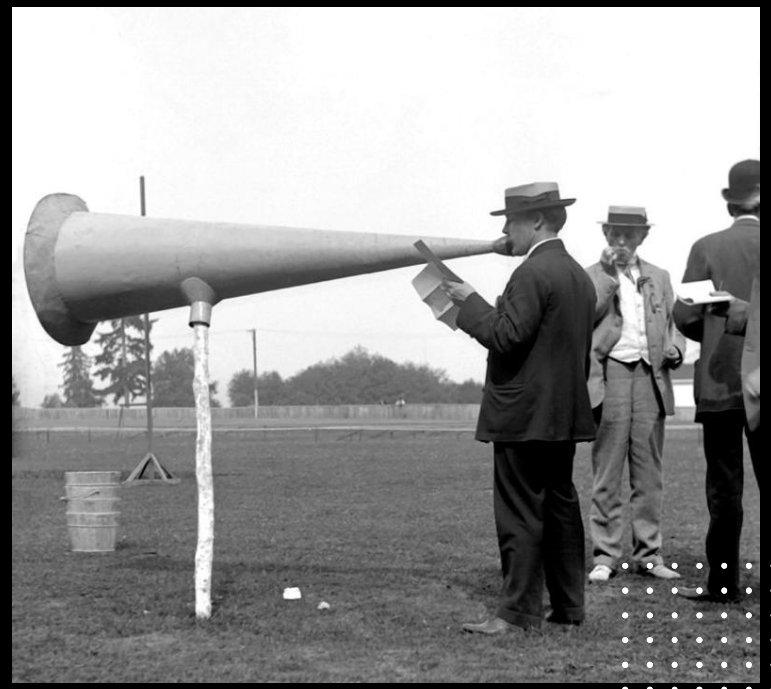
Need

- Imperatives
- “must” “got” “need”

Empower with Facts

Informing

1. Keep the Righting Reflex in check
2. Provide clear, concise information
3. Elicit responses from the client
4. Ask for permission before giving advice AND, root your advice in their DARN
5. If client regresses, retreat to asking and listening



Moving Through Change

"Stages" of Change	Translation
• Precontemplation	• No
• Contemplation	• Maybe
• Preparation	• Planning
• Action	• Action
• Maintenance/ Termination	• Integration

Build relationship
Get to know your client (their goals)
Review discovery

Avoid!!!
- The Premature Focus trap
- The Question-Answer trap

Connect to services

Drop the rope

Signs of Regression

- You are making all the arguments “for”
- Client is making all the arguments “against”
- Repeating yourself

Drop the rope to progress

- Reflect, reflect, reflect
- Let the facts be the bad guy

Modifications to MI

- Intellectual disability
  - Age-appropriate explanation
- Active psychosis
  - File competency?
  - Reach out to jail MH staff
- Delusional disorder
  - File competency IF delusions directly impact case
    - (mens rea, motive, rational defense)
  - Otherwise: roll with delusions

State-wide Resources

- **Funding**
  - TAM Medicaid- virtually all clients qualify if court-ordered to treatment/on probation with MH/SUD assessment and treatment conditions. Good for one year regardless of income change.
  - UHPP Utah Health Policy Project
- **Mental Health**
  - United Way 211 United Way 211 - Home (211utah.org) (not an easy website to navigate, phone call is helpful)
  - Map- behavioral health resources by county Location Map | DSAMH (utah.gov)
- **Substance Use Disorder and Co-Occurring Disorders**
  - TAM Medicaid Approved Providers Table XVII Targeted Adult Medicaid (TAM) Agencies (utah.gov)
  - Residential programs may not be available in your area, but TAM is accepted statewide.
  - Only co-occurring disorders eligible for residential ("inpatient") Substance Use Disorder Treatment (rehab). Virtually NO residential programs for MH only…back to the ER.
- **DSPD** Intake Process | Services for People with Disabilities (utah.gov)
  - Apply online. Will need school or private records that indicate IQ score (before 18). Often performed by school psychologists for Special Education eligibility and development of IEP.