

Criminal Justice

# ***Response***

**To people with mental illness  
arrested or incarcerated in Tennessee**

**Module 3  
Co-Occurring Disorders**

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## **Module Three:** **Co-Occurring Disorders**

**Length of Presentation:** 30 minutes – 1 hour

### ***Handouts and Materials:***

- 3-1 *Substance Abuse and Mental Illness*
- 3-2 *Signs and Symptoms: Mental Illness vs. Substance Abuse*
- 3-3 *Integrated Treatment of Mental Illness & Substance Abuse*
- 3-4 *Integrated Treatment Programs in Tennessee: Mental Illness & Substance Abuse*
- 3-5 *Mental Retardation*
- 3-6 *Mental Retardation and Crime*
- 3-7 *Mental Retardation and Mental Illness*
- 3-8 *Resources: Mental Retardation/Developmental Disability*
- 3-9 *Other Disabilities and Mental Illness*
- 3-10 *Criminal Justice Procedures for Individuals with Disabilities*
- 3-11 *Resources: Other Disabilities*
- 3-12 *Response: Service Linkage for People with Co-Occurring Disorders*

### ***Motivational rewards:***

- *Small candies; or*
- *Raffle Tickets.*

### ***[Instructor note:***

*When teaching law enforcement officers, emphasize recognizing co-occurring disorders and referral to services.*

*When teaching correctional officers emphasize recognition, assessment and facility-based treatment.*

*When teaching probation and parole, emphasize recognition, ongoing assessment and community-based treatment, housing supports and services.*

*For brief version only cover the section on mental illness and substance abuse. Do only one scenario from the Response exercise.]*

### **Objectives**

- To understand co-occurring substance abuse and mental illness;
- To identify behaviors that would suggest substance abuse and/or mental illness;
- To understand co-occurring mental retardation and mental illness;
- To distinguish between mental illness, and mental retardation.
- To understand other co-occurring conditions;
- To identify signs and symptoms that might indicate conditions co-occurring in an individual with mental illness.

## **DISCUSSION**

### **Co-Occurring Disorders**

Individuals with mental illness frequently have additional disorders that “co-occur”. The most common co-occurring conditions are:

- Substance abuse disorders,
- Mental retardation; and
- Physical disabilities such as traumatic brain injury.

Because the behavioral problems associated with mental illness are compounded and complicated by these other conditions, people with co-occurring disorders have:

- More frequent contact with the criminal justice system;
- More behavior problems when incarcerated;
- More difficulty connecting to effective services in the community upon release; and
- Are more likely to be re-arrested.

There are too few services or supports for these individuals. Most professional agencies are ill-equipped to handle their multiple challenges. Few landlords will rent to them, especially if they have criminal records. The sad fact is that many individuals with co-occurring disorders become repeat offenders, sometimes because there is nowhere else for them to go. Criminal justice personnel can play a role in reducing this problem.

## **Co-Occurring Mental Illness and Substance Abuse**

### **The Problem**

Mental illness and substance abuse often go together. It’s a big problem. Studies have shown that 7 to 10 million Americans have at least one mental disorder and at least one substance-related disorder in any given year.

*[Instructor: Review Handout 3-1: Substance Abuse and Mental Illness, ONLY section on “The Problem”.]*

A significant number of individuals with co-occurring disorders are involved in the criminal justice system, but many are not recognized due to lack of effective screening and assessment. Offenders and inmates with untreated co-occurring disorders are more likely:

- To cycle frequently through the criminal justice system;
- To be sentenced to more time in correctional facilities;
- To have more behavior problems;
- To be at increased risk for suicide;
- To drop out of treatment or have less successful treatment outcomes; and
- To violate conditions of probation and parole.<sup>1</sup>

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<sup>1</sup> Ibid.

## **What to Do**

Screening and assessment are the keys.

***[Instructor: Review Handout 3-1: Substance Abuse and Mental Illness, section on What to Do: Assessment.]***

Screening and assessment for mental illness and substance use disorders should be available in all justice settings:

- Arrest,
- Pre-trial detention,
- Courts,
- Jails,
- Prisons, and
- Probation/ parole.

Assessment should be a cooperative effort between criminal justice facilities, mental health agencies and substance abuse treatment providers using standardized screening and assessment protocols.

Assessment is a continuing process, some parts (such as blood alcohol level tests) are done while the person is intoxicated. Other parts are best delayed for 4 – 6 weeks until the individual is clean and sober, in order that psychiatric symptoms may be distinguished from those that are substance-induced.

***[Instructor note: Suggested screening instruments are included in Module 6 of this curriculum. If there are questions about it you can either hand it out and review it at the end of the session or ask participants to wait until that session is covered.]***

## ***Treatment***

***[Instructor: Review Handout 3-1: Substance Abuse and Mental Illness, section on What to Do: Treatment.]***

The criminal justice system can play a vital role in increasing treatment success for individuals with co-occurring disorders. Assessment can be a part of every phase of the offender's interaction with the criminal justice system. Treatment should be provided in correctional settings and during probation or parole.

***[Instructor: Review Handout 3-1: Substance Abuse and Mental Illness, section on Criminal Justice Response.]***

**Discussion:**

*[10-minute limit.*

**Optional:** *Award a raffle ticket to participants who talk about their experience. ]*

- In your work, what situations have you encountered where the individual appeared to have co-occurring mental illness and substance abuse?
- What challenges did that individual present to your work or your facility?
- Were you able to resolve those challenges? If so, how?
- Was one or the other condition ruled out in assessment?
- Based on the information you have heard today, what else could you have done?

**Signs and Symptoms: Mental Illness vs. Substance Abuse**

Individuals with mental illness are often mistakenly thought to be abusing substances and vice versa, because signs of one condition may mask or mimic signs of another condition. Drug tests are available to help clarify the picture, but symptoms of mental illness may be present while the person is detoxifying and may or may not go away when the person is clean and sober.

Handout 3-2 is for your reference and compares some of the signs and symptoms of common psychiatric disorders and commonly abused drugs.

*[Instructor: Refer to Handout 3-2: Signs and Symptoms: Substance Abuse vs. Mental Illness. Do not read through it in class unless participants have specific questions.]*

**Integrated Treatment**

*[Instructor: Refer to Handout 3-3: Integrated Treatment of Substance Abuse and Mental Illness.]*

Integrated treatment for co-occurring mental illness and substance abuse involves several stages and often takes place in several agencies and settings. Handout 3-3 shows the phases of:

- Assessment and diagnosis;
  - Can be in an inpatient or outpatient setting or a correctional setting;
  - Usually takes place in several stages as the individual is detoxified;
  - May require contacting kin to get some of the information;
- Stabilization;
  - Medication for substance abuse stabilization is to alleviate serious physical symptoms of withdrawal;
  - Psychiatric medication is to alleviate symptoms of mental illness;
  - Medication must be monitored carefully to avoid drug interactions;
  - Stabilization of mental illness takes longer, but hospital may return the individual to the correctional facility before psychiatric stabilization is complete;

- Engagement;
  - Treatment usually takes place in a community setting (or correctional facility);
  - Confrontation consists of empathic, but straightforward questions and observations of the effects of substance abuse on the individual's life;
- Prolonged Stabilization;
  - Very important that prolonged stabilization of a probationer be monitored by the probation officer;
- Recovery;
  - Criminal justice personnel should encourage the individual to maintain recovery through self-help attendance and active participation in treatment.

Note that the family, or whoever is close to the individual, is involved in most phases of treatment. This is to reinforce the individual's recovery and to reduce family behaviors that would "enable" the individual's addiction.

Integrated treatment is not widely available in Tennessee, but Handout 3-4 contains contact information for some of the programs that do exist.

*[Instructor: Refer to Handout 3-4, Dual Diagnosis Programs in Tennessee.]*

**Optional Presentation:** Ask a provider from an integrated treatment program to briefly address participants on what the agency does, eligibility criteria and how to access the program on behalf of offenders and inmates. This informs participants and also raises the awareness of the provider of the needs of the criminal justice population. It can help facilitate good working relationships.

Ask the provider to speak for *10 minutes*. Allow *5 – 10 minutes* for questions.

## Dual Diagnosis: Mental Retardation and Mental Illness

Mental retardation is often confused with mental illness, but the two conditions are very different. Some people with mental retardation also have a mental illness. People with dually-diagnosed mental retardation and mental illness become involved in crime, often through misunderstanding. In an effort to sort out some of this misunderstanding we will begin by looking at mental retardation.

*[Instructor: Review Handout 3-5: Mental Retardation.]*

### Mental Retardation and Crime<sup>2</sup>

- Studies show that Individuals with mental retardation are no more likely to commit crimes than the average person<sup>3</sup>.
- Data from programs for offenders with mental retardation found:
  - Most offenders with mental retardation were arrested for committing misdemeanors and less serious felonies (White & Wood, 1986)<sup>4</sup>. (Illinois Mentally Retarded and Mentally Ill Task Force, 1988)<sup>5</sup>.

As more people with mental retardation move out of institutions and into the community, they are becoming involved in the criminal justice system as:

- Victims,
- Witnesses, or
- Suspects.

*[Instructor: Review Handout 3-6: Mental Retardation and Crime, beginning with the second paragraph.]*

### Mental Retardation and Mental Illness,

Many people, including criminal justice personnel, make the mistake of confusing mental retardation with mental illness. It is important to understand that these disorders are separate and distinct conditions.

*[Instructor: Review Handout 3-7: Mental Retardation and Mental Illness, ONLY the chart: Mental Retardation/ Mental Illness.]*

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<sup>2</sup> Davis, Leigh Ann (2000) People with Mental Retardation in the Criminal Justice System. Retrieved from: <http://www.thearc.org/fags/crimqa.html>: August 1, 2000.

<sup>3</sup> Ellis, J., & Luckasson, R. (1985). Mentally retarded criminal defendants. *George Washington Law Review*, 53 (3-4), 414-493.

<sup>4</sup> White, D. & Wood, H. (1986). The Lancaster County, Pennsylvania, Mentally Retarded Offenders Program. *Prison Journal*, 65 (1), 77-84.

<sup>5</sup> Illinois Mentally Retarded and Mentally Ill Offender Task Force. (1988, July). Mentally retarded and mentally ill offender task force report. Springfield: Author.

### **Dual Diagnosis: Mental Retardation and Mental Illness**

- Studies estimate that 10 to 20 percent of the people with mental retardation have a co-occurring mental illness.
- The significant advances in mental health treatment made over the last 20 years are rarely adapted for use with people who also have mental retardation.
- There are still many areas where resources are very hard to find.

*[Instructor: Review Handout 3-7: Mental Retardation and Mental Illness: section on Treatment.]*

Treatment for dual diagnosis is in its infancy in Tennessee. There are few models of best practice nationally and few agencies that have adopted those best practices. Correctional release planners and probation/parole officers may have a hard time finding housing, treatment and rehabilitation programs for probationers and parolees.

*[Instructor: Refer to Handout 3-8:Resources: Mental Retardation/ Developmental Disabilities.]*

### **Discussion:**

*[10-minute limit.*

**Optional:** *Award a raffle ticket to participants who talk about their experience. ]*

- In your work, what situations have you encountered where the individual appeared to have a dual diagnosis of mental illness and mental retardation?
- What challenges did that individual present to your work or your facility?
- Were you able to resolve those challenges? If so, how?
- Was one or the other condition ruled out in assessment?
- Based on the information you have heard today, what else could you have done?

## Mental Illness and Other Conditions

There are several more diseases or disabilities that commonly occur along with mental illness.

- Some, like traumatic brain injury (TBI), result in mental illness because the primary condition affects the brain.
- In others, like HIV/AIDS, behavior associated with mental illness increases risk of infection.
- Others, like hearing or visual impairment, produce conditions of daily living that may trigger mental illness such as major depression or anxiety disorder.
- Others, such as autism, may have characteristics that are similar to mental illness. Treatment for those characteristics is the same, but there are differences in the course of treatment, rehabilitation and recovery.
- Still others, such as thyroid deficiency, have symptoms that are often mistaken for mental illness, but treatment for the primary condition removes the symptoms of mental illness without psychiatric treatment. Symptoms of the disease “mimic” mental illness.

The difference between mental illness and most other disabilities with similar characteristics, is that symptoms of mental illness are intermittent, whereas most of the others either stay the same or have a gradual deteriorating course that may or may not be halted with treatment.

**The main point:** When offenders are incarcerated with behavioral and emotional symptoms, it is advisable to conduct a thorough physical examination to rule out other conditions. If the other conditions are treated, psychiatric symptoms may either go away, or become clear. If mental illness is still apparent, it can be diagnosed and treated correctly. Correct diagnosis will prevent human suffering as well as time and costs in treatment.

*[Instructor: Review Handout 3-9: Mental Illness and Other Disabilities]*

Individuals with mental illness co-occurring with other disabilities present special challenges to the criminal justice system. People with disabilities have the same rights as anyone else, but in order to communicate effectively, criminal justice personnel may have to make accommodations.

*[Instructor: Review Handout 3-10: Criminal Justice Procedures for Individuals with Disabilities.]*

Referral can be difficult for individuals with mental illness and co-occurring disabilities. A few resources are listed on Handout 3-11.

*[Instructor: Refer to Handout 3-11: Resources: Other Disabilities.]*

## **Response: Service Linkage for People with Co-Occurring Disorders**

### **[Notes to Instructor:**

*Refer to Handout 3-12: Response: Service linkage for people with co-occurring disorders.*

- *Read client scenarios to the class  
(Choose those most appropriate to the audience.)*
- *After each scenario is read, ask participants to suggest the best approach to linking the individual to supports and services.*
- *After participants respond, read the “solution” segment from the instructor handout.*
- *Ask participants to discuss how that solution would or would not have worked in their local area.*
- *Reward participation by giving a small piece of candy to each participant who suggests approaches, As the exercise progresses, place a large candy bar in view of the audience. At the end of the exercise, give the candy bar to the student whose participation was most helpful.*

*Alternative: Distribute raffle tickets to each person who responds. See instructor notes at beginning of module 2.]*

## Handout 3-1

### Substance Abuse and Mental Illness

#### The Problem

7 – 10 million Americans have at least one mental illness and abuse at least one substance in any given year. Abuse of one or more substances occurs in:

- 56% of individuals with bipolar disorder;
- 47% of individuals with a psychotic disorder (schizophrenia, schizoaffective disorder);
- 32% of individuals with depression; and
- 27% of individuals with anxiety disorders.<sup>6</sup>

Individuals with mental illness who abuse substances are:

- More likely to have marital and social problems;
- More likely to have employment problems;
- More likely to commit aggressive, violent acts;
- More likely to have legal problems;
- More likely to be arrested and incarcerated;
- Less likely to engage in treatment; and
- Less likely to successfully complete treatment.

Why do individuals with mental disorders abuse substances?

- To experience a new mental/emotional state;
- To manage or reduce psychiatric symptoms;
- To kill time, avoid boredom;
- To make friends;
- To shed the label of “mental patient”;
- To avoid withdrawal symptoms (when addicted).<sup>7</sup>

#### What to Do

##### Assessment

Screening and assessment for mental illness and substance use disorders should be available in all justice settings: arrest, pre-trial detention, courts, jails, prisons, and probation/ parole. Assessment should be undertaken collaboratively between criminal justice facilities, mental health agencies and substance abuse treatment providers using standardized screening and assessment protocols. Assessment is a continuing process, some portions best delayed for 4 – 6 weeks until the individual attains sobriety, in order that psychiatric symptoms may be distinguished from those that are substance-induced.

##### Treatment

Factors in successful treatment of offenders with co-occurring disorders:

- Treatment addresses both mental illness and substance abuse,
- One provider (either mental health or substance abuse) is designated as the responsible party, but collaboration with the other provider is required,
- Criminal justice personnel, usually probation/parole, monitor the process.<sup>8</sup>

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<sup>6</sup> Regier, D., Farmer, M., Rea, D. et al (1990) Comorbidity of mental disorders with alcohol and other drug abuse: Results from the epidemiological catchment area study. *Journal of the American Medical Association* 264: 2511-2518.

<sup>7</sup> Pepper, B., Hendrickson, E. (199 ) Working with Seriously Mentally Ill Substance Abusers, Arlington County Mental Health Department.

Mandatory treatment is usually necessary because the majority of individuals with co-occurring disorders will not voluntarily participate in either substance abuse programs or mental health treatment.

The best approach is to treat co-occurring disorders in a program that integrates substance abuse and mental health treatment. If that is not available, one agency should be assigned to be responsible for treatment coordination and communication between the mental health and the substance abuse programs. When the offender realizes that both provider agencies and the courts are communicating, he or she is more likely to follow through with treatment.

Treatment professionals often notice that after treatment has begun to improve mood, social relationships and quality of life, the client becomes more motivated to continue with treatment after court order or probation/parole expires.

## **Criminal Justice Response**

### *Law Enforcement*

- Ensure that offenders suspected of substance use are tested;
- If using substances, place offenders in detoxification unit;
- If not, refer for psychiatric assessment.

### *Corrections*

- Ensure that offenders/inmates are detoxified prior to referral for assessment;
- Refer offenders/inmates to mental health and substance abuse programs for assessment and treatment;  
Contract with community providers to provide individual and group counseling in the correctional facility;  
Train correctional medical staff to provide facility-based mental health and substance abuse treatment;
- Establish self-help groups in jail. Co-occurring group is best (DRA, Double Trouble): participants are less likely to be pressured by peers to stop taking psychiatric medication.

### *Probation/ Parole/ Community Corrections*

- Ensure that probationers participate in treatment,
  - For both mental illness and substance abuse;
- Lack of participation constitutes Violation of Parole;
- Integrated treatment program is best;
- Negotiate with one agency to be in charge of treatment plan;
  - Coordinating with other agency,
  - Monitor inter-program collaboration;
- When probationer knows of collaboration, treatment participation increases.

### *Courts*

- Ensure that defendants are connected to treatment;
- Include mental health and substance abuse treatment as conditions of probation;
- Refer offender to mental health treatment and substance abuse treatment;
- Mandate one agency to be responsible for treatment plan; and
  - Charged with coordinating with program from other system.

**Handout 3-1**  
**Substance Abuse and Mental Illness**

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<sup>8</sup> The GAINS Center (1997). *Screening and assessment of Co-Occurring Disorders in the Justice System*, New York: Policy Research.

## Handout 3-2 Signs and Symptoms: Mental Illness vs. Substance Abuse

| Mental illness/ Substance  | Signs and Symptoms   |
|--|--|
| depression   | Sleep disturbance, sad mood, low energy, suicidality, guilt, hopelessness, inability to experience pleasure  |
| alcohol  | Euphoria, slurred speech, loose muscle tone, loss of fine motor coordination, staggering gait, loss of judgment. Impairment of balance, vision, hearing and reaction time. At higher BAC: dysphoria, anxiety, restlessness.<br><b>Withdrawal:</b> nausea, sweating, shakiness, anxiety, delirium tremens, hallucinations, seizures.  |
| heroin<br>(smack, H, skag, junk)   | Euphoria, warm skin flush, dry mouth, heavy extremities, alternately wakeful and drowsy state.<br><b>Withdrawal:</b> drug craving, restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes ("cold turkey"), kicking movements ("kicking the habit").  |
| inhalants<br>(glue, gas, solvents:<br>poppers, bold, rush)   | Euphoria, loss of inhibition and control. <b>Complications:</b> hearing loss, limb spasms, heart attack, sudden death. Damage to brain, liver and kidney, bone marrow,   |
| mania  | Insomnia, hyperactivity, hypersociability, expansiveness, grandiosity, elation   |
| cocaine<br>(crack, C, snow, flake,<br>blow)  | Euphoria, rapid speech, reduced need for sleep or food, mentally alert, restlessness, irritability, anxiety, paranoia, headache, constricted blood vessels, dilated pupils, nosebleeds, intestinal problems, "tracks". Increased temperature, heart rate, and blood pressure.<br><b>Complications:</b> intense craving, heart attack, stroke, seizure, respiratory failure. Combined with alcohol can cause sudden death.                  |
| methamphetamine<br>(speed, meth, chalk, ice,<br>crystal, glass)  | Euphoria, wakefulness, increased physical activity, decreased appetite,<br><b>Complications:</b> shortness of breath, hyperthermia, irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, aggressiveness   |
| Prescription drug abuse:<br>stimulants   | Increased alertness, attention, increased blood pressure, heart rate, respiration. High doses: irregular heartbeat, fever, heart attack, lethal seizures, hostility, paranoia.   |
| anxiety and panic  | Sense of impending doom, intense fear, chest pain, rapid heartbeat, shortness of breath, dizziness, sweating, abdominal distress   |
| Prescription drug abuse:<br>benzodiazepines,<br>barbiturates   | Calmness, drowsiness, drug dependence. Combined with other medications can cause: heart attach, respiratory problems<br>Sudden withdrawal: seizures  |
| Marijuana<br>(pot, herb, weed, grass,<br>widow, ganja, and hash)   | Euphoria, relaxation, dry mouth, rapid heartbeat, loss of coordination and balance, slower reaction times, "red eyes".<br>Long-term effects: impairment in memory, thinking, learning and problem solving; distorted perception.   |
| psychosis  | Hallucinations (auditory or visual), delusions, paranoia, social withdrawal, confusion, incoherent or reduced speech, odd movements  |
| LSD<br>(acid)  | Intense emotions, delusions, visual hallucinations. Changed sense of time and self, "cross over" sensations, hearing colors, seeing sounds. Physical signs: dilated pupils, fever, increased heart rate and blood pressure, sweating, loss of appetite, sleeplessness, dry mouth, tremors.<br>Long term effects: flashbacks, schizophrenia, depression.  |
| PCP<br>(angel dust, ozone, wack,<br>rocket fuel. Combined with<br>marijuana: Killer joints,<br>crystal supergrass) | Feeling of strength, power, invulnerability, numbing of the mind, drop in breathing, blood pressure, heart rate, nausea, vomiting, blurred vision, flicking up and down of the eyes, drooling, loss of balance, dizziness, seizures, coma. Psychological effects: craving, hallucinations, delusions, paranoia, disordered thinking, catatonia. Behavior: Violence, suicide attempts. Long term use: memory loss, depression, weight loss. |

## Handout 3-3 Integrated Treatment of Mental Illness & Substance Abuse<sup>9</sup>

| <b>Substance Abuse Treatment</b>   | <b>Mental Health Treatment</b>  |
|--|---|
| <b>ASSESSMENT AND DIAGNOSIS</b>  |   |
| Substance abuse history  | Psychiatric history   |
| Drug screening   | Medical and physical history  |
| Previous treatment history   | Previous treatment history  |
| Family background  | Family background   |
| Strength of support system   | Strength of support system  |
| Vocational background  | Vocational background   |
| Self-help group participation  | Peer-run program participation  |
| <b>TREATMENT: STABILIZATION</b>  |   |
| Detoxification   | Stabilize Acute Psychiatric Illness   |
| Usually inpatient  | Usually inpatient   |
| Usually need medication  | Medication  |
| 3-5 days (alcohol)   | 2 weeks to 6 months   |
| Assessment for other diagnoses   | Assessment for substance use  |
| <b>TREATMENT: ENGAGEMENT</b>   |   |
| Begins with empathy from therapist and peers. Work on forgiving selves and others; Education about addiction; Introduction to 12-step approach. Empathic confrontation by therapist and/or peers is almost always necessary. | Medication monitored to manage symptoms, Empathy from therapists and peers, Education about mental illness. Empathic confrontation sometimes necessary. |
| 2 – 12 weeks   | 1-6 months  |
| Multiple relapses often occur before client commits to active, ongoing treatment.  | Multiple relapses often occur before client commits to ongoing treatment.   |
| Education of the family facilitates treatment. Involve them in confronting client's denial and supporting recovery.  | Education of the family facilitates treatment. Involve them in helping client participate in treatment and supporting recovery.                         |

<sup>9</sup> Hamilton, Timothy (1998) Dual Diagnosis Resource Network: Prepared for the BRIDGES Curriculum, Tennessee Mental Health Consumers' Association, Nashville, TN.

| <b>Substance Abuse Treatment</b>   | <b>Mental Health Treatment</b>   |
|--|--|
| <b>TREATMENT: PROLONGED STABILIZATION</b><br>Active treatment, maintenance, relapse prevention   |  |
| Goal: Continued abstinence (one year)  | Goal: Continued stability (one year) rebuilding social and vocational skills   |
| Client consistently attends abstinence support meetings (AA, NA, DRA) usually 3-5 times per week.  | Client consistently takes prescribed medications and attends treatment sessions.<br><br>Individuals with serious mental illness often benefit from peer programs such as a drop-in centers, and from psychosocial rehabilitation programs. |
| Need to focus on asking for help to cope with urges to use substances and drop out of treatment  | Need to focus on asking for help to cope with continuing symptoms and urges to drop out of treatment, or with urge to discontinue medication because symptoms have subsided.   |
| Family needs ongoing involvement in its own recovery support program (ALANON, etc.) to learn empathic detachment and how to set caring limits. | Family needs ongoing involvement in its own recovery support program (AMI, Journey of Hope) to learn empathic detachment and how to set caring limits.   |
| Continuing assessment  | Continuing assessment  |
| <b>RECOVERY: ONGOING</b>   |  |
| Stability precedes growth; no growth is possible unless sobriety is fairly secure. Growth occurs slowly, One Day At A Time                     | Stability precedes growth; no growth is possible unless illness is stable. May be symptomatic, but able to resume social and vocational roles.   |
| Continued work in the self-help program on growing, changing, dealing with feelings (12-steps)   | Continued medication, reduced to maintenance level. Participation in psychosocial rehabilitation, work, school, family, community.   |
| Goal is peace of mind and serenity.  | Goal is wellness and quality of life.  |

Handout 3-3  
Integrated Treatment of Mental Illness & Substance Abuse

### Handout 3-4

## Dual Diagnosis Programs in Tennessee

### Mental Illness & Substance Abuse

| Program  | Address   | City/ZIP           | Telephone                    |
|--|---|--------------------|------------------------------|
| <b>West Tennessee</b>                                      |   |                    |                              |
| Charter Lakeside Behavioral Health System                  | 2911 Brunswick Rd.  | Memphis 38133      | 901-377-4733                 |
| Foundations Associates                                     | 2009 Lamar Ave  | Memphis 38114      | 901-726 6053                 |
| Power Center, Drop-in Center, Foundations Associates       | 1048 S. Bellevue  | Memphis 38106      | 901-946-4678                 |
| Full Circle Community Mental Health Center                 | 1384 Madison Ave.   | Memphis 38104      | 901-274 5991                 |
| Genesis House  | 300 N. Bellevue   | Memphis 38105      | 901-726-9786                 |
| Methodist Hospital   | 1265 Union  | Memphis 38104      | 901-726-8025                 |
| Southeast Mental Health Center                             | 3810 Winchester   | Memphis 38118      | 901-369-1400                 |
| Whitehaven Southwest Mental Health Center                  | 1087 Alice  | Memphis 38116      | 901-774-7811                 |
| <b>Middle Tennessee</b>                                    |   |                    |                              |
| Centennial Parthenon Pavilion                              | 2401 Parman Place   | Nashville 37203    | 615-342-1400                 |
| Centerstone Community Mental Health Centers, A&D Treatment | 620 South Gallatin Road   | Madison 37115      | 615-460-4300                 |
| Foundations Associates                                     | 220 Venture Circle  | Nashville 37228    | 615-256-9002                 |
| MIDAS Program<br>Downtown Clinic                           | 526 8th Avenue South  | Nashville 37203    | 615-862-7900                 |
| Park Center East   | 948 Woodland Street   | Nashville 37202    | 615-650-2900                 |
| Tennessee Christian Medical Center: Addictions Unit        | 500 Hospital Drive  | Madison 37115      | 615-860-0426<br>800-467-8262 |
| VITA, Psychiatric Hospital at Vanderbilt                   | 1001 23 <sup>rd</sup> Avenue South  | Nashville 37212    | 615-327-7078                 |
| <b>East Tennessee</b>                                      |   |                    |                              |
| AIM Center   | 1903 McCallie Avenue  | Chattanooga 37404  | 423-624-4800                 |
| CADAS  | 207 Spears Avenue   | Chattanooga 37405  | 423-756-7644                 |
| Columbia Valley Hospital                                   | 2200 Morris Hill Road   | Chattanooga 37421  | 423-894-4220                 |
| Florence Crittenton Agency                                 | 1531 Dick Lonas Road  | Knoxville 37909    | 865-602-2021                 |
| Comprehensive Community Cares                              | 1914 McCallie Avenue.   | Chattanooga, 37404 | 423-622-9311                 |
| Comprehensive Community Cares                              | 1127 North Broadway   | Knoxville, 37909   |                              |
| Fortwood Center  | 601 Cumberland, Suite A   | Chattanooga 37404  | 423-266-6751                 |
| Helen Ross McNabb Center                                   | 1520 Cherokee Trail   | Knoxville 37920    | 423- 524-5757                |
| Peninsula Behavioral Health Lighthouse Treatment Center    | 6800 Baum Drive   | Knoxville 37917    | 865-558-8880                 |
| Overlook Center  | 100 Main Street   | Madisonville 37354 | 865-442-2425                 |
| Peninsula/Ft. Sanders Hospital                             | PO Box 2000 Jones Bend Rd.  | Louisville 37777   | 865-970-9800                 |
| Positively Living  | 1501 East 5 <sup>th</sup> Ave.  | Knoxville, 37917   | 865-525-1540                 |
| Woodridge Hospital   | 403 N State of Franklin Road  | Johnson City 37604 | 423-928-7111                 |
| <b>Self-Help</b>   |   |                    |                              |
| Dual Recovery Anonymous                                    | <a href="http://draonline.org/meetings_dra/usa/tennessee.html">http://draonline.org/meetings_dra/usa/tennessee.html</a> | Statewide          | 615-742-1000                 |

## Handout 3-5

### Mental Retardation

Mental retardation is:

- A Lifelong disability consisting of impaired intellectual functioning;
- Affects 3% of the population, or 6.5 million Americans as of the 1990 census;
- Caused by any condition that impairs development of the brain before birth, during birth or in the childhood years, including:
  - Genetic conditions,
  - Problems during pregnancy and birth,
  - Childhood diseases and exposure to environmental toxins, and
  - Other conditions associated with poverty such as:
    - Malnutrition, and
    - Inadequate medical care.

There is a wide range in level of disability among individuals with mental retardation.

- About 87% are mildly affected and will be only a little slower than average in learning new information and skills. As adults, many will live independent lives and no longer be viewed as having mental retardation.
- 13%, those with IQs under 50, have serious limitations in functioning. However, with early intervention, a functional education and appropriate supports as an adult, all can lead satisfying lives in the community.

#### Definition of Mental Retardation

- IQ below 70-75;
- The condition is present from childhood; AND
- Significant limitations exist in two or more skill areas:
  - Communication
  - Self-care;
  - Home living;
  - Social skills;
  - Leisure;
  - Health and safety;
  - Learning (reading, writing, basic math);
  - Capacity for independent living;
  - Economic self-sufficiency.

## Handout 3-6

### Mental Retardation and Crime<sup>10</sup>

Individuals with mental retardation are no more likely to commit crimes than the average person<sup>11</sup>. As more people with mental retardation move into the community from institutions, they are becoming involved in the criminal justice system as victims, witnesses, or suspects.

Other criminals often use individuals with mental retardation as accomplices. The person with mental retardation may not understand:

- That he or she is involved in a crime; or
- The consequences of his/her involvement.

He or she may also have a deep need to be accepted and may agree to help with criminal activities in order to gain friendship.

Many individuals unintentionally give "misunderstood responses" to officers, which increases their vulnerability to:

- Arrest,
- Incarceration, and possibly
- Execution, even if they committed no crime (Perske, 1991)<sup>12</sup>.

When confronted by police the individual with mental retardation may:

- Not want disability to be recognized (try to cover it up);
- Not understand rights (but pretend to understand);
- Not understand commands;
- Be overwhelmed by police presence;
- Act upset at being detained and/or try to run away;
- Say what he or she thinks others want to hear;
- Have difficulty describing facts or details of offense;
- Be the last to leave the scene of the crime, and the first to get caught;
- Be confused about responsibility for the crime and "confess" when innocent.

Upon arrest, individuals with mental retardation usually answer affirmatively when asked if they understand their rights, even when they do not understand. They are trying to:

- Gain approval, or
- Hide their disability.

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<sup>10</sup> Davis, Leigh Ann (2000) People with Mental Retardation in the Criminal Justice System. Retrieved from: <http://www.thearc.org/faqs/crimqa.html>: August 1, 2000.

<sup>11</sup> Ellis, J., & Luckasson, R. (1985). Mentally retarded criminal defendants. *George Washington Law Review*, 53 (3-4), 414-493.

<sup>12</sup> Perske, R. (1991). *Unequal justice? What can happen when persons with retardation or other developmental disabilities encounter the criminal justice system.* Nashville: Abingdon Press.

Because of these factors, people with mental retardation are more likely to be:

- Arrested,
- Convicted,
- Sentenced to prison, and
- Victimized in prison (Santamour, 1986)<sup>13</sup>.

Once in the criminal justice system, these individuals are less likely to

- Receive probation or parole, and
- Tend to serve longer sentences due to an inability to understand or adapt to prison rules.

Studies show that 2 to 10 percent of the prison population has mental retardation.

### **Crime Victims with Mental Retardation**

Studies show that people with disabilities are about twice as likely as others to be victimized (Sobsey & Doe, 1991)<sup>14</sup>. Some factors in victimization of persons with mental retardation:

- Victims may not report crimes because they depend on the abuser for basic survival needs.
- When victims do report crimes, police and court officials may not take the person's allegations seriously or be reluctant to get involved.
- People with mental retardation often lack the resources necessary to prosecute (Sobsey, 1994)<sup>15</sup>.

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<sup>13</sup> Santamour, M. (1986, Spring-Summer). The offender with mental retardation. *The Prison Journal*, 66 (7), 3-1

<sup>14</sup> Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Journal of Sexuality and Disability*, 9 (3), 243-259.

<sup>15</sup> Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities*. Baltimore: Paul H. Brookes Publishing Co.

## Handout 3-7

### Mental Retardation and Mental Illness

Mental retardation and mental illness are separate and distinct conditions.

| Mental Retardation   | Mental Illness  |
|--|---|
| <p>A. Refers to significantly below average intellectual functioning.</p> <p>B. Refers to impairment in social adaptation.</p> <p>C. Usually occurs during early development or is present at birth. However, a brain injury or toxemia may cause retardation at any age.</p> <p>D. Mental retardation is permanent, but can be compensated for through education and development.</p> <p>E. A person with mental retardation can usually be expected to behave rationally at his operational level.</p> | <p>A. Has nothing to do with intelligence.</p> <p>B. Characterized by disturbances in thinking, feeling and relating to others or the environment.</p> <p>C. Can strike anyone at any time.</p> <p>D. Mental illness may be temporary or chronic. People with mental illness may relapse and recover once or many times.</p> <p>E. A person with a mental illness may vacillate between normal and irrational behavior. Some people with a mental illness may be erratic, especially when not undergoing treatment.</p> |

### Dual Diagnosis: Mental Retardation and Mental Illness

Studies estimate that 10 to 20 percent of the people with mental retardation have a co-occurring mental illness. The significant advances in mental health treatment made over the last 20 years have been slow to be adapted for use with people with mental retardation. There are still many areas where consumers and families have great difficulty locating appropriate services.

### Treatment for Dual Diagnosis

**Psychopharmacology.** There has been a tendency in the past to over-medicate people with mental retardation and not to carefully monitor the behavioral effects of medications.

**Counseling/Psychotherapy.** People with mild mental retardation can benefit from counseling. Many individuals cope better when another person listens to their problems and provides social support and understanding.

**Cognitive Therapy.** This treatment teaches people with mild mental retardation to recognize the situations in which they get into trouble and to develop alternative behavior and solutions to their problems. Although widely used with the general population, cognitive therapy has been adapted only recently for use with people with mental retardation.

**Behavior Management.** This approach is widely used with people with mental retardation, especially to control behavior problems. The approach often leads to significant behavioral improvements, at least during the time period when the treatment is in effect. Advocates have called for the complete elimination of aversive (punishment) behavior management techniques and the reliance instead on positive behavioral techniques.

**Social Skills Training.** This is a cost-effective, time-limited approach that often produces noticeable improvements in quality of life and interpersonal behavior. Individuals are gradually taught effective social interactions and appropriate social behavior.

## Handout 3-8

### Resources: Mental Retardation/Developmental Disability

| Program   | Address  | City/ZIP                               | Telephone                    |
|---|--|--|------------------------------|
| <b>Statewide</b>                                    |  |  |                              |
| The Arc of Tennessee                                | 44 Vantage Way, Suite 550<br><a href="http://www.thearcctn.org">www.thearcctn.org</a>                        | Nashville, 37228                       | 800-835-7077                 |
| TN Disability Coalition                             | 480 Craighead St., Suite 200   | Nashville, 37204                       | 615-383-9442                 |
| TN Family Pathfinder<br>Internet resource directory | <a href="http://kc.vanderbilt.edu/kennedy/pathfinder/">http://kc.vanderbilt.edu/<br/>kennedy/pathfinder/</a> |  |                              |
| TN Protection and Advocacy                          | 2416 21st Avenue South<br><a href="http://www.tpainc.org">http://www.tpainc.org</a>                          | Nashville 37212<br>Knoxville & Memphis | 615-298-1080<br>800-287-9636 |
| <b>West Tennessee</b>                               |  |  |                              |
| Buffalo River Services                              | PO Box 847   | Waynesboro 38485                       | 931-762-3203                 |
| CS Patterson Training Center                        | PO Box 229   | Trenton 38382                          | 731-855-2316                 |
| Madison/Haywood<br>Developmental Services           | PO Box 11205   | Jackson 38308                          | 731-664-0855                 |
| TN Division of MR Services:<br>West TN Office       |  |  | 800-308-2586                 |
| Division of Rehabilitation<br>Services              |  | Memphis<br>Jackson                     | 901-423-5620<br>731-423-5620 |
| <b>Middle Tennessee</b>                             |  |  |                              |
| Community Development<br>Center                     | 111 Eaglette Way   | Shelbyville 37160                      | 931-684-8681                 |
| Division of Rehabilitation<br>Services              |  | Nashville<br>Columbia                  | 615 741-1606<br>931-380-2563 |
| New Horizons Inc.                                   | 5221 Harding Place   | Nashville 37217                        | 615-360-8595                 |
| Pacesetters   | 2511 Highway 111 North   | Algood 38506                           | 931-537-9100                 |
| Rochelle Center                                     | 1020 Southside Court   | Nashville, 37203                       | 615-254-0673                 |
| Sunrise Community                                   | 171 W. Dunbar Cave Road  | Clarksville 37043                      | 931-648-3011                 |
| Team Evaluation Center                              | PO Box 140500  | Nashville 37214                        | 615-231-5094                 |
| TN Division of MR Services:<br>Middle TN Office     |  |  | 800-654-4839                 |
| TN Rehabilitation Center                            | 460 9 <sup>th</sup> Avenue   | Smyrna, 37167                          |                              |
| TOP Rehabilitation Services                         | 2110 N. Jackson Street   | Tullahoma 37388                        | 931-455-5189                 |
| <b>East Tennessee</b>                               |  |  |                              |
| Greene County Skills                                | 490 Sunnyside Road   | Greeneville 37743                      | 423-639-5351                 |
| Scott Appalachian Industries                        | 591 East Montecello Pike   | Huntsville 37756                       | 423-663-9300                 |
| Team Evaluation Center                              | 600 North Holtzclaw Ave., Suite<br>100   | Chattanooga 37404                      | 423-622-0500                 |
| TN Division of MR Services:<br>East TN Office       |  |  | 888-310-4613                 |
| Division of Rehabilitation<br>Services              |  | Johnson City<br>Knoxville              | 423-434-6934<br>865-594-6054 |



## Handout 3-9 Other Disabilities and Mental Illness

| Disease/ Disability  | Definition   | Signs & Symptoms   |
|--|--|--|
| <p><b>Traumatic Brain Injury (TBI)</b></p>   | <p>Impairment of normal brain function due to a neurological insult, such as open or closed head injury</p>  | <p><b>Perceptual:</b> Change in vision, hearing, smell, taste or touch, disorientation altered sense of balance.<br/> <b>Physical:</b> Headache, fatigue, disorders of movement, seizures, sensitivity to light, sleep disorders, paralysis, unclear speech.<br/> <b>Behavioral/Emotional:</b> Irritability, low stress tolerance, apathy, dependence, denial of disability, inflexibility, suicidality, lack of inhibition (may result in aggression, cursing, inappropriate sexual behavior), flattened/ heightened emotions.</p>                          |
| <p><b>HIV/ AIDS</b></p>  | <p><b>HIV:</b> Virus that causes AIDS. HIV attacks white blood cells that fight off disease.<br/> <b>AIDS:</b> Most advanced form of HIV infection; immune system cannot fight off infections or cancer.<br/> <b>Transmission by:</b><br/> Sexual intercourse,<br/> Shared needles, syringes,<br/> Birth to infected mother.</p> | <p><b>HIV Early stages:</b> Person looks &amp; feels healthy, but white blood cell count decreases.<br/> <b>HIV Intermediate stage:</b> Swollen lymph glands, fatigue, weight loss, unusual rashes.<br/> <b>AIDS:</b> Cancers, viruses, fungi and bacteria attack the brain (dementia), nervous system, kidneys, lungs<br/> <b>Mental Illness &amp; AIDS:</b> Impaired judgment associated with mental illness increases risk of unsafe sex and IV drug use. People with mental illness have a much higher rate of HIV/AIDS than the general population.</p> |
| <p><b>Sensory Disability:</b><br/>Deafness, hearing impairment, Blindness, visual impairment</p> | <p>Impairment or loss of hearing or sight.<br/> Can be a condition at birth, or caused by accident or disease.</p>   | <p><b>Mental Illness and sensory disability:</b> People with sensory disabilities may develop major depression or anxiety as a result of isolation, loneliness, frustration and stresses of poverty. Otherwise, rates of mental illness are the same as for the general population.</p>  |
| <p><b>Autism</b></p>   | <p>A developmental disability that affects the brain, autism impairs social interaction and communication skills. Impairs verbal and non-verbal communication, social interactions, and leisure or play activities. Autism is neither mental retardation nor mental illness.</p>   | <p><b>Emotional/ Behavioral Symptoms</b><br/> Insistence on sameness; resistance to change, difficulty expressing needs; Laughing, crying, showing distress for reasons not apparent to others, prefers to be alone; aloof manner, tantrums, difficulty in mixing with others, resists physical contact, little or no eye contact, inappropriate attachments to objects, apparent over-sensitivity or under-sensitivity to pain, no real fears of danger, not responsive to verbal cues; acts as if deaf although hearing tests in normal range.</p>         |
| <p><b>Thyroid disorders</b></p>  | <p>Under or over-active thyroid can produce symptoms that mimic mental illness. Individuals have been wrongly diagnosed, hospitalized for months, and treated unsuccessfully for psychosis. When treated for a thyroid condition, symptoms of mental illness usually go away.</p>  | <p><b>Emotional/ Behavioral Symptoms</b><br/> <b>Hyperthyroidism:</b> anxiety, tension, mood swings, irritability, distractible over-activity, noise sensitivity, fluctuating depression, sleep and appetite problems, delirium, hallucination.<br/> <b>Hypothyroidism:</b> loss of interest and initiative, slowing of mental processes, poor memory, intellectual deterioration, anhedonia, depression, paranoia, dementia</p>   |



## Handout 3-10 Criminal Justice Procedures for Individuals with Disabilities <sup>16</sup>

| Disability         | Guidelines   |
|--------------------|--|
|                    | <b>Communication</b>   |
| Mental Retardation | When speaking, enunciate clearly and slowly to ensure that the individual understands what is being said. (note 1)   |
|                    | Keep sentences short. Use simple language, speak slowly and clearly. Ask for concrete descriptions, colors, clothing, etc. Break complicated series of instructions or information into smaller parts. Whenever possible use pictures, symbols, and actions to help convey meaning. (note 2)   |
|                    | Don't assume a person with intellectual disability is incapable of understanding or communicating. (note 2)<br>Treat adults as adults; don't treat adults who have mental retardation as children. Give people with intellectual disability the same respect you would show any other individual. (note 3)   |
| Hearing Impairment | Officers are required by the ADA to ensure effective communication with individuals who are deaf or hard of hearing. Whether a qualified sign language interpreter or other communication aid is required will depend on the nature of the communication and the needs of the requesting individual. In one-on-one communication with an individual who lip-reads, an officer should face the individual directly, and should ensure that the communication takes place in a well-lighted area. (note 1) |
|                    | Remove barriers to effective communication – There are physical and environmental obstacles that officers should avoid, reduce or eliminate when communicating with people who have communication disabilities. Obstacles include: noise; rooms that echo; distance between the speaker and the listener; multiple speakers; and movement of people through the room, etc. (note 4)  |
| Speech Impairment  | Be patient, allowing the individual to complete statements at his/her own pace. Avoid cutting off a person's statement, unless required in an emergency or crisis. Do not anticipate or project the individual's thoughts by "cutting in" and attempting to complete his/her statements. (note 4)  |
|                    | <b>Documentation</b>   |
| Visual impairment  | Officers must read out loud in full any documents that a person who is blind or visually impaired needs to sign. (note 1)  |
| Speech impairment  | The simplest solution is to have an officer or clerk assist the person in reading and filling out the form. ... The form itself could also be provided in an alternative format. Providing a copy of the large print will make the form accessible to many individual with moderate vision disabilities. (note 1)  |

<sup>16</sup> A Collection of Overseas Materials Relevant to the Handling of Persons with Disabilities by Law Enforcement Officers. [http://www.eoc.org.hk:8080/CE/investigation/immigration/AnnexE\\_e.doc](http://www.eoc.org.hk:8080/CE/investigation/immigration/AnnexE_e.doc). Retrieved 8/12/2003.

| <b>Disability</b>                    | <b>Guidelines</b>  |
|--------------------------------------|--|
|                                      | <b>Oath Taking</b>   |
| Intellectual/<br>Physical disability | Adjudicators must make reasonable accommodations to allow applicants with disabilities to demonstrate that they understand the nature of the oath and agree to it. Such accommodations can include simplifying questions or allowing the applicant to use predetermined physical motions or signals (such as blinks). (note 5)   |
|                                      | <b>Arrest and Detention</b>  |
| Mental retardation                   | If officers are not sure that a suspect understands his or her rights, they should ask the suspect to explain each phrase of the rights statement in his or her own words. (note 3)  |
| Hearing impairment                   | During interrogations and arrests, a sign language interpreter will often be necessary to effectively communicate with an individual who uses sign language. (note 1)  |
|                                      | Deaf individuals may be handcuffed in front in order for the person to sign or write notes. (note 1)   |
| Chronic illness (diabetes)           | As an example of reasonable accommodation, a rule that prisoners or detainees are not permitted to have food in a cell except at scheduled intervals may be modified to accommodate an individual with diabetes who uses medication and needs access to carbohydrates or sugar to keep blood sugar at an appropriate level. (note 1)   |
|                                      | <b>Transporting</b>  |
| Physical disability                  | Safe transport of individuals who use manual or power wheelchairs might require departments to make minor modifications to existing cars or vans, or to use lift-equipped vans or buses. Departments may consider other community resources, e.g., accessible taxi services. (note 6)  |
|                                      | <b>Seeking Help from Third Parties</b>   |
| Hearing Impairment                   | Officers should generally not rely on deaf individual's family members to provide sign language interpreting. But in some limited circumstances, their help may be essential, for example, in an emergency, when the safety or welfare of the public or the deaf individual is of paramount importance, or in a situation when a deaf individual has been robbed and an officer in hot pursuit needs information about the suspect. (note 1) |
| Note 1                               | "Commonly Asked Questions about the Americans with Disabilities Act and Law Enforcement" - Disability Rights Section, Civil Rights Division, U.S. Department of Justice.   |
| Note 2                               | "A Police Officer's Guide – when in contact with people who have mental retardation." – The ARC ( <a href="http://www.thearc.org/ada/police.html">http://www.thearc.org/ada/police.html</a> ).   |
| Note 3                               | "The Police Response to People with Mental Retardation: Trainers Guide", Police Executive Research Forum (PERF).   |
| Note 4                               | "The Police Response to People with Hearing and Speech Disabilities: Trainers Guide" – PERF  |
| Note 5                               | Immigration and Naturalization Service (INS) News Release April 14, 1999 - INS Implements New Guidance to Improve the Review of Naturalization Cases of Applicants with Disabilities.<br><a href="http://www.ins.usdoj.gov/graphics/publicaffairs/newsrels/natz-dis.htm">http://www.ins.usdoj.gov/graphics/publicaffairs/newsrels/natz-dis.htm</a>   |
| Note 6                               | Police Response to Seizures & Epilepsy: A Curriculum Guide for Law Enforcement Trainers" – PERF, Epilepsy Foundation.  |

**Handout 3-10**  
**Criminal Justice Procedures for Individuals with Disabilities**

## Handout 3-11 Resources: Other Disabilities

| <b>Program</b>   |   |                             |                              |
|--|---|-----------------------------|------------------------------|
| <b>Traumatic Brain Injury</b>  |   |                             |                              |
| Brain Injury Association of Tennessee (BIAT)   | 699 West Main St., Suite 112-B<br><a href="mailto:mail@tnbiat.org">mail@tnbiat.org</a>  | Hendersonville, TN<br>37075 | 615-264-3052                 |
| <b>HIV/AIDS</b>  |   |                             |                              |
| Tennessee HIV/AIDS Resource Directory  | <a href="http://coetenn.bizland.com/ResDirectory">http://coetenn.bizland.com/ResDirectory</a>   |                             |                              |
| AIDS/HIV/STD Hotline:  |   | Tennessee only              | <b>800-525-2437</b>          |
| Tennessee HIV AIDS facts   | <a href="http://www.aidsaction.org/communications/publications/statefactsheets/pdfs/tennessee">http://www.aidsaction.org/communications/publications/statefactsheets/pdfs/tennessee</a> |                             |                              |
| <b>Hearing Impairment</b>  |   |                             |                              |
| League for the Deaf & Hard of Hearing  | 415 4th Avenue South<br><a href="http://www.leagueforthe deaf.com">http://www.leagueforthe deaf.com</a>   | Nashville, TN 37201         | 615-248-8828<br>(voice/TTY). |
| Mental Health Services for Deaf People: Directory<br>By <b>Diane Morton</b><br># DY99-1; \$12.95 | Gallaudet Research Institute<br>Dissemination Office<br>Gallaudet University<br>800 Florida Avenue, N.E.<br><a href="http://gri.gallaudet.edu">http://gri.gallaudet.edu</a>             | Washington, DC<br>20002     |                              |
| <b>Visual Impairment</b>   |   |                             |                              |
| National Federation of the Blind   | 1226 Goodman Circle West<br><a href="http://www.nfb.org/states/tn.htm">http://www.nfb.org/states/tn.htm</a>   | Memphis<br>38111-6524       | 901-324-7056                 |
| Services for the Blind and Visually Impaired,<br>Tennessee Division of Rehabilitation Services   | Citizens Plaza Building, 11th Fl.<br>400 Deaderick Street   | Nashville<br>37248-6200     | 615-313-4914                 |
| <b>Autism</b>  |   |                             |                              |
| Autism Solutions Center  |   | Memphis                     | 901-758-8248                 |
| Autism Society of Middle TN  | 480 Craighead St., Suite 200  | Nashville 37204             | 615-385-2077                 |
| Autism Society of Southeast TN, Tim Pitchford  | <a href="mailto:ASAchat@AOL.com">ASAchat@AOL.com</a>  | Chattanooga                 | 423- 485-1272                |
| Autism Society of East TN  |   | Knoxville                   | 865-637-3914                 |
| Breakthrough Corporation   | P.O. Box 52111<br><a href="http://www.breakthroughknoxville.com">http://www.breakthroughknoxville.com</a>   | Knoxville 37950             | 865-335-3298                 |

## Handout 3-12

### ***Response***

#### **Service Linkage for People with Co-Occurring Disorders**

Individuals who have mental illness in addition to other disabilities present challenges to the criminal justice system. Few community agencies are prepared to offer effective services and supports. Linkages that are successful are often forged through networking and creative approaches to meeting the individual's needs. The following are scenarios of actual individuals. Names have been changed to protect identity.

- Brainstorm with the group about services and supports in your area that could meet the individual's needs;
- After your discussion, the instructor will read what actually happened;
- Discuss your reaction.

#### **Scenario 1:**

A woman, age 35, African American, homeless, with Schizoaffective disorder, cocaine dependency and mild mental retardation has been arrested 43 times for charges such as possession of drug paraphernalia, criminal trespassing, pedestrian solicitation and assault charges. Most of the charges over the years have been misdemeanors. Several years ago she and her children were in a house fire in which one of her children died.

She was recently arrested on robbery charges after accosting a woman on the street. The most recent forensic evaluation found that she was competent to stand trial. Upon returning from the evaluation, she struck her public defender and was sent back to the jail cell where she punched a pregnant inmate. Six weeks passed until the preliminary hearing where charges were dismissed because the victim did not come to court.

#### **Scenario 2:**

A man, age 40, Native American, homeless, with Schizoaffective disorder, posttraumatic stress disorder (PTSD) and alcohol dependence. He has been arrested numerous times mostly for public disturbance and disorderly conduct, and is constantly in and out of jail. He has been referred to case management several times, but because he does not arrive at appointments and the case manager cannot find him, he is dropped from the caseload.

He was recently arrested for disorderly conduct when he jumped off the bridge into the river in a suicide attempt. Once in the river he decided he didn't want to die and began throwing things at passing cars to attract attention.

The court offered him the options of doing 41 days in jail, or going before the mental health court. He was hearing voices and the mental health court would not see him until he was stabilized.

**Scenario 3:**

A man, age 50, African American, with bipolar disorder and alcohol dependence. He has a history of violence and was imprisoned for attempted murder ten years ago when he found his wife with another man. He always appears drunk and has been arrested repeatedly for nuisance crimes such as public intoxication and disorderly conduct. He suffered a stroke several years ago due to toxicity from an accidental overdose of lithium. He is partially paralyzed and has spasmodic movements. His landlady nursed him back to health and continues to care for him. When he was placed in intensive integrated community treatment, arrests slowed to once a month.

Recently he was incarcerated on charges of assaulting an officer during an arrest for public intoxication. He was accused of reaching for the officer's gun, but witnesses thought he might have made a spasmodic movement that was misinterpreted. Preparation of his case was not proceeding well because he was not able to communicate with his defense attorney and was not able to sign papers due to tremors.

**Scenario 4:**

A man, age 23, Caucasian, with moderate mental retardation, pervasive developmental disorder (autism spectrum disorder) and Impulse Control Disorder. He had a history of impulse control and violence dating from childhood and was frequently delusional.

He lived with his family home until he attacked his mother. She called the police and pressed charges of assault in an effort to get services for him. He was arrested and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The family was willing to drop charges if the individual were placed in an appropriate setting. The judge did not want to release him to the streets and required that he remain in jail until a suitable residential placement was arranged. The Howard Jordan Center in Nashville is the only facility in the state equipped to house individuals with mental retardation who are found incompetent to stand trial. Three beds were available, but there were a number of individuals from various regions of the state who needed those beds.

**Scenario 5:**

A woman, age 43, Caucasian, with moderate mental retardation (I.Q. 53), Impulse Control Disorder and Mood Disorder NOS. She had a history of impulsive behaviors including vandalism and self-mutilation and has been banned from local mental health facilities due to her behavior.

She recently threw a tantrum at her group home, and broke several windows. This was the latest in a series of episodes of vandalism. She was arrested, given a felony charge of unlawful destruction of property and probation violation from a previous charge. She has been detained in the county jail for the past 60 days. A forensic evaluation found her incompetent to stand trial and stated that she would probably never gain competency. The judge would only release her to a suitable residential facility. Her family would not and could not take her. There is no facility for women in Tennessee that corresponds to the Howard Jordan Center.

**Scenario 6:**

A man, 48 years old, Caucasian, a homeless veteran with schizophrenia and alcohol dependence. He was recently hit by a car, broke his leg, and has a cast and a walker. When stable, he is intelligent and sweet. He has a fixed delusion of being unworthy and frequently argues with a voice that he identifies as the devil. He is habitually arrested several times a week for public intoxication or criminal trespassing, but is usually released on his own recognizance. Sometimes the judge puts him in jail for 30 days where he becomes stable on Haldol, an antipsychotic medication.

**Scenario 7:**

A woman, age 48, African American, educated, formerly homeless, who has schizophrenia, polysubstance abuse and AIDS with symptoms of dementia. She has been arrested multiple times for criminal trespassing due to her delusional system. She frequently knocked on doors and announced that she was married to the man of the house. When incarcerated at the county jail she became aggressive, bit herself, and tried to spit blood at others.

Most recently she was arrested for criminal trespassing several times in a row. Three times in three weeks, law enforcement officers transported her a considerable distance to the Regional Mental Health Institute. Institute admissions staff stated that they would not accept her because they did not deem that she met commitment criteria of imminent likelihood of danger to self or others.

**Scenario 8:**

A man, age 80, Caucasian, a veteran with posttraumatic stress disorder and Alzheimer's disease. He lives with his ex-wife, but claims he does not know her and has no family. He is often belligerent and has been arrested on public disturbance or disorderly conduct charges about twice a year for the past several years.

He was recently arrested for causing an accident with property damage when he drove his car into the wall of a gas station. He was released on his own recognizance. Because he was not detained and would not be appearing before the court, no forensic evaluation was ordered, so there was no decision about competency.

**Scenario 9:**

A man, age 20, African American, with severe mental retardation and a diagnosis of Impulse Control Disorder. He attacked his father after being told he could not turn on the television, "or else". Police were called; he was charged with assault and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The man was only classified as mentally ill and had not received an assessment for his mental retardation. The man lost his TennCare coverage and his SSI benefits, because he had been in jail several months until bonded out by his family.

## Handout 3-12i: Instructor Version

### ***Response***

### **Service Linkage for People with Co-Occurring Disorders**

Individuals who have mental illness in addition to other disabilities present challenges to the criminal justice system. Few community agencies are prepared to offer effective services and supports. Linkages that are successful are often forged through networking and creative approaches to meeting the individual's needs. The following are scenarios of actual individuals. Names have been changed to protect identity.

- Brainstorm with the group about services and supports in your area that could meet the individual's needs;
- After your discussion, the instructor will read what actually happened;
- Discuss your reaction.

#### **Scenario 1:**

A woman, age 35, African American, homeless, with Schizoaffective disorder, cocaine dependency and mild mental retardation has been arrested 43 times for charges such as possession of drug paraphernalia, criminal trespassing, pedestrian solicitation and assault charges. Most of the charges over the years have been misdemeanors. Several years ago she and her children were in a house fire in which one of her children died.

She was recently arrested on robbery charges after accosting a woman on the street. The most recent forensic evaluation found that she was competent to stand trial. Upon returning from the evaluation, she struck her public defender and was sent back to the jail cell where she punched a pregnant inmate. Six weeks passed until the preliminary hearing where charges were dismissed because the victim did not come to court.

#### **Solution 1:**

The criminal justice/ mental health liaison learned that the woman was to be released that day. When the liaison attempted to interview the woman, she was aggressive and violent. She attempted to strike and kick the liaison through the small hole in the cell door.

The liaison took the following steps:

- Called the crisis response team, who assessed the woman as dangerous to others and sent her to the regional mental health institute (RMHI) directly from jail.
- Contacted the RMHI attorney to initiate a mandatory outpatient treatment (MOT) order.
- Contacted the Tennessee Division of Mental Retardation services who conducted a psychological evaluation. The evaluator's opinion was that the woman required one-on-one care if she were to live in the community. Those resources were not available.
- The woman remained in the RMHI for six weeks receiving regular medication and care, and eventually stabilized.
- Upon release, she was linked to specialized residential housing and intensive outpatient treatment.

**Sad Ending:** The arrangement lasted four days. The woman has been in and out of jail for the past four months. The treatment provider has not filed an affidavit to revoke the MOT order and send her back to the mental health institute.

**Scenario 2:**

A man, age 40, Native American, homeless, with Schizoaffective disorder, posttraumatic stress disorder (PTSD) and alcohol dependence. He has been arrested numerous times mostly for public disturbance and disorderly conduct, and is constantly in an out of jail. He has been referred to case management several times, but because he does not arrive at appointments and the case manager cannot find him, he is dropped from the caseload.

He was recently arrested for disorderly conduct when he jumped off the bridge into the river in a suicide attempt. Once in the river he decided he didn't want to die and began throwing things at passing cars to attract attention.

The court offered him the options of doing 41 days in jail, or going before the mental health court. He was hearing voices and the mental health court would not see him until he was stabilized.

**Solution 2:**

The criminal justice/ mental health liaison knew this man from previous episodes and developed trust with him by:

- Listening to his perspective,
- Making recommendations he could be expected to achieve, and
- Following through on her commitments to him,
- Continuing to work with him whether or not he followed through on her referrals.

The liaison met with the man at the conclusion of the court hearing and convinced him to go back to the jail cell. She arranged medication management to help him stabilize and become eligible for the mental health court. He was initially reluctant, but the liaison reminded him that she had always followed through in the past and she would help him now. The man stabilized and was allowed to appear before the mental health court.

- The man was allowed to return to a motel where he felt comfortable.
- He was referred to case management.
- He was referred to an intensive outpatient program that offered integrated treatment.
- The case manager was charged with responsibility for monitoring his participation in treatment.
- The man telephoned the case manager and the intensive outpatient program himself to arrange initial appointments.
- He arrived at both initial appointments.

**Happy ending:** The liaison rewarded the man with a bus pass for following through on the referrals. She reminded him that she was always there as a point of contact if he needed help.

**Scenario 3:**

A man, age 50, African American, with bipolar disorder and alcohol dependence. He has a history of violence and was imprisoned for attempted murder ten years ago when he found his wife with another man. He always appears drunk and has been arrested repeatedly for nuisance crimes such as public intoxication and disorderly conduct. He suffered a stroke several years ago due to toxicity from an accidental overdose of lithium. He is partially paralyzed and has spasmodic movements. His landlady nursed him back to health and continues to care for him. When he was placed in intensive integrated community treatment, arrests slowed to once a month.

Recently he was incarcerated on charges of assaulting an officer during an arrest for public intoxication. He was accused of reaching for the officer's gun, but witnesses thought he might have made a spasmodic movement that was misinterpreted. Preparation of his case was not proceeding well because he was not able to communicate with his defense attorney and was not able to sign papers due to tremors.

**Solution 3:** The criminal justice/ mental health liaison knew the man and understood his speech. The liaison:

- Listened carefully to the man's account of events surrounding the arrest;
- Interpreted for the attorney who was then able to build the case;
- Testified on his behalf in court;
- Arranged for his return to integrated community treatment;
- Arranged with the landlady to accept him back; and
- Referred him to a psychosocial center to participate in social and vocational activities during the day.

**Happy ending:** The man got 5 years probation with participation in treatment as a condition of probation. The man comes in to visit with the liaison after his treatment appointments. Has not been re-arrested for several months.

**Scenario 4:**

A man, age 23, Caucasian, with moderate mental retardation, pervasive developmental disorder (autism spectrum disorder) and Impulse Control Disorder. He had a history of impulse control and violence dating from childhood and was frequently delusional.

He lived with his family home until he attacked his mother. She called the police and pressed charges of assault in an effort to get services for him. He was arrested and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The family was willing to drop charges if the individual were placed in an appropriate setting. The judge did not want to release him to the streets and required that he remain in jail until a suitable residential placement was arranged. The Howard Jordan Center in Nashville is the only facility in the state equipped to house individuals with mental retardation who are found incompetent to stand trial. Three beds were available, but there were a number of individuals from various regions of the state who needed those beds.

**Solution 4:**

- The judge appointed a guardian ad litem for the man to enable the criminal justice/ mental health liaison to obtain the consents to release information that would move the transfer forward,
- The liaison, the defense attorney and the judge worked together to resolve funding difficulties,
- The family, the judge and the criminal justice/ mental health liaison contacted the Jordan Center repeatedly to advocate for expedited admission of this man. He was admitted after three months.

**Happy ending:** The man was placed at the Howard Jordan Center, has stabilized and will continue to reside there as long as it is necessary.

**Scenario 5:**

A woman, age 43, Caucasian, with moderate mental retardation (I.Q. 53), Impulse Control Disorder and Mood Disorder NOS. She had a history of impulsive behaviors including vandalism and self-mutilation and has been banned from local mental health facilities due to her behavior.

She recently threw a tantrum at her group home, and broke several windows. This was the latest in a series of episodes of vandalism. She was arrested, given a felony charge of unlawful destruction of property and probation violation from a previous charge. She has been detained in the county jail for the past 60 days. A forensic evaluation found her incompetent to stand trial and stated that she would probably never gain competency. The judge would only release her to a suitable residential facility. Her family would not and could not take her. There is no facility for women in Tennessee that corresponds to the Howard Jordan Center.

**Solution 5:**

- The judge appointed a guardian ad litem for the woman.
- The criminal justice/ mental health liaison tried to find placement in an assisted living facility or a nursing home, but few facilities had lock-downs or behavioral programs,
- Those facilities that did have behavioral programs would not admit until her TennCare and SSI was reinstated,
- The TennCare Bureau estimated that reinstatement could take six months or more, because of the complexities of the case,
- The Tennessee Division of Developmental Disabilities or the Division of Mental Health were unable to find a placement that would take her once her SSI was reinstated,
- The family assisted with arrangements for a placement in a neighboring state,
- The liaison arranged for the woman to be escorted to the necessary appointments for her SSI to be reinstated, and filed the applications.
- The liaison arranged funding for a psychological evaluation that confirmed the woman's mental retardation and IQ, and stated that the condition was "indefinite" due to its severity.

**Sad Ending:** The woman was placed in a secure facility in another state. Her family must drive a considerable distance to visit her, which is hard for them due to their financial and health problems. The woman is self-mutilating on a regular basis and the facility is indicating that she may have to be sent back to Tennessee.

**Scenario 6:**

A man, 48 years old, Caucasian, a homeless veteran with schizophrenia and alcohol dependence. He was recently hit by a car, broke his leg, and has a cast and a walker. When stable, he is intelligent and sweet. He has a fixed delusion of being unworthy and frequently argues with a voice that he identifies as the devil. He is habitually arrested several times a week for public intoxication or criminal trespassing, but is usually released on his own recognizance. Sometimes the judge puts him in jail for 30 days where he becomes stable on Haldol, an antipsychotic medication.

**Solution 6:**

Upon release, the following arrangements are usually made:

- He is either placed with his sister, who is willing to house him,
  - Or a halfway house for recovering alcoholics.
- His veteran's benefit check goes to a representative payee at the downtown clinic.
- He receives his medication at the downtown clinic.

**Sad ending:** Invariably, the man is back on the streets drinking within a week. When the weather turns rainy he begins to drink. He reports that the medication does not make him feel good and does not make the voices go away. He states, "At least with beer, I get a buzz." He gets beat up by another homeless person or gets arrested for a nuisance crime and the cycle begins again.

**Hope for the future:** The local homeless program has applied for a large grant for assisted living rooms for chronically homeless people. He is on the list of intended residents. When the program is in operational he will get a room, assistance taking his medications, and other supports.

**Scenario 7:**

A woman, age 48, African American, educated, formerly homeless, who has schizophrenia, polysubstance abuse and AIDS with symptoms of dementia. She has been arrested multiple times for criminal trespassing due to her delusional system. She frequently knocked on doors and announced that she was married to the man of the house. When incarcerated at the county jail she became aggressive, bit herself, and tried to spit blood at others.

Most recently she was arrested for criminal trespassing several times in a row. Three times in three weeks, law enforcement officers transported her a considerable distance to the Regional Mental Health Institute. Institute admissions staff stated that they would not accept her because they did not deem that she met commitment criteria of imminent likelihood of danger to self or others.

**Solution 7:**

- On the third trip the police officer asked Institute personnel to sign a document stating that they would bear responsibility if the woman injured or killed someone in the community;
- The Institute accepted her for evaluation,
- The evaluation concluded that she needed to stay at the Institute for a considerable period of time and would probable never be discharged to the community,
- The plan is to discharge her to a secure nursing home eventually when she is stabilized.

**Scenario 8:**

A man, age 80, Caucasian, a veteran with posttraumatic stress disorder and Alzheimer's disease. He lives with his ex-wife, but claims he does not know her and has no family. He is often belligerent and has been arrested on public disturbance or disorderly conduct charges about twice a year for the past several years.

He was recently arrested for causing an accident with property damage when he drove his car into the wall of a gas station. He was released on his own recognizance. Because he was not detained and would not be appearing before the court, no forensic evaluation was ordered, so there was no decision about competency.

**Solution 8:**

- The family obtain legal guardianship following an evaluation conducted at the local mental health center,
- The man's driver's license was removed,
- He was enrolled in the local Veteran's administration day program,
- He continued to behave belligerently at home and was admitted to the Veteran's nursing home.

**Happy ending:** The man has stabilized on antipsychotic medication. He has peers to socialize with at the nursing home. They spend time trading stories about the Korean War.

**Scenario 9:**

A man, age 20, African American, with severe mental retardation and a diagnosis of Impulse Control Disorder. He attacked his father after being told he could not turn on the television, "or else". Police were called; he was charged with assault and detained in the county jail. A forensic evaluation found him incompetent to stand trial. The man was only classified as mentally ill and had not received an assessment for his mental retardation. The man lost his TennCare coverage and his SSI benefits, because he had been in jail several months until bonded out by his family.

**Solution 9:**

The criminal justice/ mental health liaison arranged for a psychological evaluation that found him to have severe mental retardation,

- Because he was under 22, the educational system was responsible to fund services for him under the Individuals with Disabilities Education Act.

**Happy ending:** The man is living with his family and is participating daily in vocational and educational training. Things are going well in the home because the family has respite while he is at the day programs. The young man is calmer at home after returning from his daily activities.