

Recovery: Latino Incarceration & Mental Illness

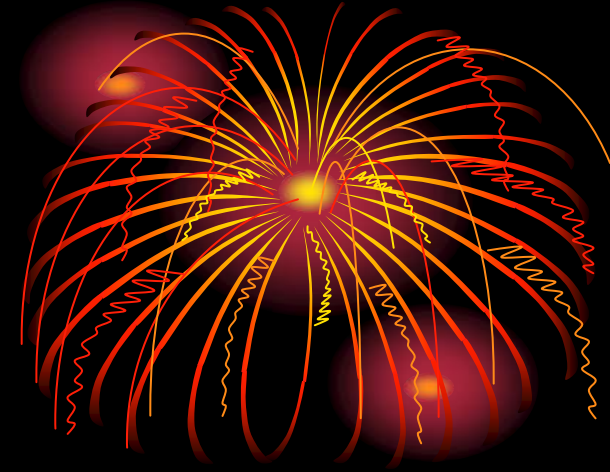
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Objectives:

- To ID treatment barriers for Latinos.
- To ID cultural Specific Issues.
- To Explore Promising Approaches to Treatment.
- To recognize drug seeking behaviors.
- To ID risk for self-harm.



Prison Expansion



- Began in the 1980's.
- Resulted in: *the highest incarceration rate in the world.*
- Today, over 2.0 million people are in prison.
- 50% of them (1.0 million) are African-American
- 75% (1.5 Million) are people of color.
- Women: (3/4 of color) expanded dramatically.

(Rohdes, 2004)

ODOC Inmate Statistics



- Total Oregon Prison Population: 13,405
- Men: 12,384 = 92.4%
- Age 31-45: 5,522 = 41.2%
- 'Person' Crimes: 9,196 = 68.6%
- Mental Health Needs: 5,821 = 43.4%
- Substance Abuse Problems: 74.0%
- Recidivism Rate: 31.3%
- *Nation wide: more than 300,000 prisoners were in need of intensive MH services (Kupers, 1999).*



Issues for the Latino Population

Treatment Considerations

Issues & Considerations:



- Underutilization of services:
 - Historical Issues:
 - Minority oppression & social control (Slave Psychologists, Ventura Morales & Triki Indian)
 - Legal & Immigration Issues
 - Formal & Informal help-giving networks
 - \$\$ Costs: survival -vs- good health
 - Lack of effective cross-cultural staff training
 - Accessibility & Availability of services

Issues ... continue:



- Sensitivity to medication:
 - “Indian” people from Mexico and Latin-America have shown to be more sensitive to medication.
 - More likely to experience side effects.
 - More willing to use “natural” remedies.
 - Stopping Meds with out Medical Advice: “I feel better” or “It makes me feel worst”.

Issues ... continue:



- Lack of culturally appropriate “help-giving” methods:
 - Cognitive Models
 - Trust and rapport
 - Culturally specific illnesses
 - Non-tangible services
 - Cultural axiologies:
 - Person to object -vs- Person to Person

Issues ... continue:



- Language Barriers:
 - Lack of bilingual program materials
 - Lack of bilingual staff: prescribers/CSW/Case Managers/Counselors/Nurses/etc.
 - Translation services and issues
 - Not trained in MH, client -vs- interpreter
 - Nearly 40% of "Hispanic/Latinos" have Spanish as their second language:
 - Over 150 Indian languages are spoken today just in Mexico, and many more in L.A.

Issues ... continue:



- Social/Cultural stigma of Mental Illness:
 - "Locura" as a Label
 - Shame and Guilt ("Vergüenza & Culpa")
 - Family Cover up
 - Moral Views & God's Punishment

Issues ... continue:



- Peer-Pressure:
 - The "Doctors & Lawyers" in the yard.
 - Are you mental?
 - (Homies, friends, cellies, staff, other inmates)
 - Weakness & Victimization
 - Exploitation: "Pay Rent" & "Bring me your meds"
- Lack of Psycho-education:
 - Brain Chemistry
 - Common Causes, Effects, & Symptoms
 - The Fear of "Locura"
 - Permanent state -vs- Illness (transient state)



Cultural Specificity

For
Latinos

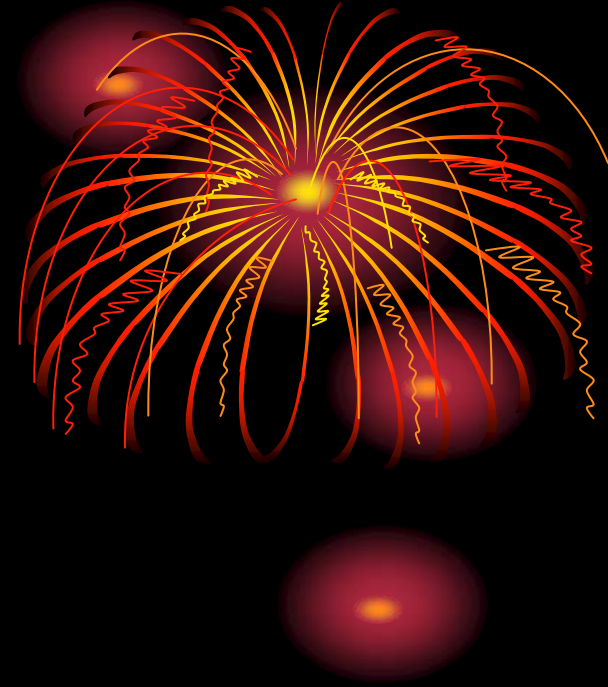
Culture, Illness, & Recovery



- It is well documented in the literature at large that in many cultures people suffer from culturally specific illnesses.
- Illnesses and disorders are, some times, specific to a place and time.
- Manifestation of Symptoms & Treatment may look different in different cultures.
- Cultures have formal and informal "help giving" systems, and sometimes they are NOT in tune with western medicine.

Culturally Specific Illnesses for Latinos

- To name a few:
 - "Mal de Ojo"
 - "Empacho"
 - "Susto"
 - "Se me carga el muerto"
 - "Caida de Mollera"
 - "Envidia"
 - "Embrujo"
 - "Nervios"
 - "Tristesa"
 - "Estoy Margaro"



Promising Approaches for Latinos:



- The following interventions have been used with various degrees of success, but seem to work better in combination:
 - Special need groups for DD, A/D, MH.
 - Work, school, church, etc.
 - Substance Abuse Treatment
 - “Tangible” help with Case Management.
 - Art Groups – music
 - Some DBT: Emotional Regulation, IPC, etc.
 - “Skills for Better Living” – great for drug seekers and Axis II.
 - Nutritional Education & Use of Supplements.
 - Exercise & Self-Help Programs of Recovery.
 - Cultural Support, Sx Management, Case Management.
 - Did I said: Medication?



Isolation & Mental Illness

More than 70,000 of the nearly 1.5 million inmates in state and federal prisons are placed in isolation for 23 hours a day.

Inmate suicides linked to solitary confinement,
By Kevin Johnson, USA TODAY 12/27/06

Suicide Behavior



- "Study after study has confirmed that the presence of a major mood disorder is a significant risk factor for suicide"
- *Depression ---> Suicidal Ideas ---> + Anxiety/Agitation, Poor Impulse Control, Substance Use ---> Suicidal Plans/Attempts*
 - Correctional Mental Health Report, January/February 2010, by James Konoll, M.D.

In custody: 3 Key Ingredients for SI & SA



- Social isolation:
 - DSU/IMU & Lack of Group Affiliations..
- Hopelessness:
 - (perceive no alternatives to SA)
- Poor problem solving abilities:
 - note the poor problem solving with DD population in prisons and increased risk for this population.

An individual is at greater risk when:



- Stopped taking psychiatric meds
- Suffered major loss: loved one, beloved pet, loss of job, custody issues, divorce, religious faith, family ties.
- Increased health care problems
- Sudden increase in anxiety level
- Change in housing: especially DSU placement.
- At greater risk when coming out of protective/restrictive units into GPs.

Other risk factors for Incarcerated Males:



- Hx inpatient psychiatric hospitalization
- Hx of chemical dependence
- Incarcerated for sexual and/or violent crimes & expresses remorse/guilt associated with offence.
- Expresses anxiety about transferring, appeals, parole requests.
- Background of early abuse (learned violence early in life)
- Expresses despair about the future
- Fearful about being murdered/attacked in prison
- Views incarceration as disgraceful
- High anxiety about family situation due to incarceration
- Complains of financial problems (including extortion)

Stages of Risk



- Stage 1 = no SI or SIB
- Stage 2 = Mild (complains of some distress without reported SI).
- Stage 3 = Moderate (may have active MH dx and/or health illness, makes vague comments regarding death, but denies plan or intent for self-harm) compromised support system, engaging in some risky behaviors.
- Stage 4 = Advanced (SI present, hopeless, depressed mood, gives things away, writes goodbye letters, no support system, perceived option less, plans suicide and selects method, may engage in SIB).
- Stage 5 = Severe (may or may not admit to SI, plan, and intent). May have Hx of SAs, increase in energy, ignores sources of support, using alcohol/drugs maybe, exhibiting risky behaviors beyond baseline, perceives no other options than suicide, during psychotic episode if applies, decreased verbalization.

Some Protective Factors:

- Developed Support Networks (family, friends, coworkers, religious services affiliation, etc).
- Hopeful about future plans.
- Married/ children.
- Communicating about suicidal ideation.
- Working and engaging in daily routines and social activities.
- Routine exercise decreases risk for depression related suicidal ideation.
- Appropriate housing placement.



Suicide Prevention:



- ❖ **Suggest other courses of action that would be appropriate to the situation**
- ❖ **Emphasize hope and positive accomplishments of the individual**
- ❖ **Keep talking and encourage the person to talk**
- ❖ **Report the information you have gathered immediately**
- ❖ **If the risk is immediate, don't leave the person alone**

Prevention Cont....



- **Ask the individual directly if they are thinking of killing themselves:**
 - ❖ **Determine the specificity of plan**
 - ❖ **Assess lethality of method**
 - ❖ **Recognize the availability of method**
 - ❖ **Consider the proximity of staff**



"Mad -vs- Bad"

(Axis I & Axis II)

"MAD" -VS- "BAD"

(Axis I -vs- Axis II)



- *Diagnostic and Statistical Manual of Mental Disorders:*
 - Help us separate the "Mad" from the "Bad".
 - Axis I: Clinical syndromes & Major Mental Illnesses for which, in general, a pharmacological treatment exist.
 - Schizophrenia, depression, bipolar, etc.
 - They respond well to medication, group treatment, and case management.
 - Axis II: Personality Disorders (and some developmental D/O).
 - Those whose traits emerge from and result in "conflicts between the individual and society".
 - Generally, no susceptible to change with medication or other kind of treatment – their issues are considered to be "behavioral" in nature.
 - May be difficult to: like, trust, or want (like ASPD or BPD).
 - Custody and DBT may be the treatments of choice.



Drug Seeking Behaviors

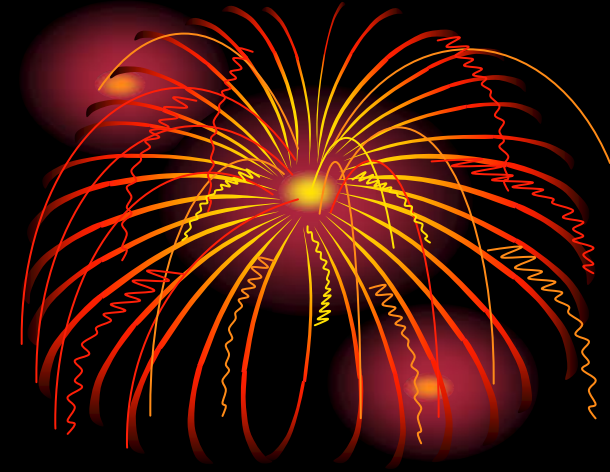
&
Malingering

Drug Seeking & Malingering:

- Please, remember that:
 - 74% of people in custody have “substance abuse” problems.
 - Many of them are:
 - Clean and sober for the first time in a long time.
 - Not clean and sober by choice.
 - Have num their feelings for a long time.
 - Beginning to “feel something”.
 - People with severe & chronic substance abuse Hx.
 - In some cases, facing long sentences.
 - Shopping for a “legal high”.



Drug Seeking & Malingering:



- They victimize:
 - Themselves by feeding their addiction and criminal behavior.
 - Unable to remain clean and sober in a controlled environment.
 - May end up “doing” more time, DSU, \$ sanctions.
 - Other patients & MH staff/prescribers.
 - Extorting other patients for their medication.
 - Pressuring staff and acting up behaviorally.
 - Tax payers – higher costs for medication, Tx services, extended custody.

Drug Seeking & Malingering:



- They fail to improve their level of functioning:
 - psychologically, vocationally, socially, etc.
- They are “informed” people.
 - Know preferred medication by name, strength, color, cost, & manufacturer (at times better than MH workers).
- Some are “professional” patients.
 - Exploit chronic conditions to “secure” and gain access to medications.
 - Know DSM criteria.
- Some are “business” people or “yard doctors”.
 - Seek medications that can be sold to others.

What to do?



- On going assessment:
 - Consultation with other professionals.
 - Refer to A/D specialists.
 - Reevaluate.
- Put responsibility on them to manage their own symptoms
 - Provide hand outs, exercises, DBT information.
- Have them articulate exactly what they "want or need":
 - TV, single cell, type of medication, etc.
- Offer alternative treatments:
 - Groups, individual counseling, journaling, etc