The Perfect Storm: The Prevalence of Co-Occurring Mental Disorders in a Sample of Heroin Users Participating in a Rural Family Drug Court

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Abstract
Family drug courts (FDCs) have shown a great deal of promise in dealing with parental substance abuse and the problems it creates for the child welfare system. However, the current opioid epidemic presents special challenges for FDCs. This paper reports on the prevalence of symptoms of co-occurring mental disorders among a sample of forty-nine parents with a history of heroin use who are participating in a FDC in a rural Ohio county, as well as the challenges these specific individuals present. Assessment results indicate that three-fourths of the sample have the symptoms of at least one mental health problem. The most common condition, experienced by over two-thirds of the sample was mood disorders (including depression). Other common disorders included ADD/ADHD, general anxiety disorder and traumatic stress disorder. More than forty percent of the sample experienced symptoms of both an internalizing and an externalizing disorder. Implications of these co-occurring mental disorders among heroin using parents for FDCs in general are discussed and directions for future research are considered.

Key Words: Family Drug Courts, Opioid Epidemic, Heroin Use, Co-occurring Mental Disorders, Child Welfare.

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Introduction

The abuse of opioids constitutes an unprecedented public health crisis in the United States, resulting in increasing numbers of deaths and emergency room visits from drug overdoses annually. Between 2000 and 2014 there was a 157% increase in drug poisoning deaths nationwide (Ruhm, 2017). Opioids were responsible for the vast majority of the approximately 64,000 overdose deaths recorded in 2016 (Aliprantis & Chen, 2017). Drug overdoses are now the leading cause of accidental death in the United States, accounting for a greater number of fatalities than either suicides, traffic accidents, or gun violence (Aliprantis & Chen, 2017; Ciccarone, 2017). However, the current demographic trends in opioid abuse differ from well-established historical trends. In the past, addicts tended to live in urban areas and were often minorities. Today the typical opioid addict is white and resides in a non-urban, often rural, area (Bowser, Fullilove, & Word, 2017; Cicero, Ellis, Surratt, & Kurtz, 2014).

The state of Ohio, which is at the epicenter of this epidemic, has experienced an unprecedented loss of life because of drug overdoses, with the number of deaths increasing 98% between 2010 and 2015 (Daniuśaitė et al., 2017). In 2015, Ohio had the highest death rate from heroin overdoses in the country (Drug Enforcement Administration, 2017). In 2016, drug overdoses (86.3% involved opioids) resulted in the deaths of 4,050 Ohio residents, representing a 52.8% increase from 2015 (Ohio Department of Health, 2017). In Ohio, drug overdoses now kill more than 2.5 times as many people as automobile accidents (Rembert, Betz, Feng, & Partridge, 2017). Unfortunately, this tragic trend is likely to accelerate in the future due to the widespread presence of the synthetic opioid fentanyl, which is at least 50 times more potent than heroin (Ciccarone, 2017). A recent examination of unintentional drug overdose deaths from 24 Ohio counties that occurred in January and February of 2017 revealed that approximately 90% involved fentanyl, its analogs, or both (Daniuśaitė et al., 2017).

Besides the horrific loss of life associated with opioid abuse, this epidemic is taking a severe toll on families. Substance abuse often leads to unstable households, as well as child abuse and neglect. The recent epidemic of opioid abuse has resulted in an increase in drug-related parental referrals to social service agencies and placement of children in foster care (Lloyd, Akin, & Brook, 2017; Mirick & Steenrod, 2016). In fact, veteran child welfare professionals have characterized the growing problem of opioid abuse as having the worst impact on the system that they have ever witnessed (Young, 2016). Opioid abusers often have co-occurring mental disorders which complicate the treatment process and negatively impact child welfare outcomes. The purpose of this paper is to examine the prevalence of mental health problems among individuals with a history of heroin use, who are participating in a rural family drug court, located in an area profoundly impacted by the opioid epidemic.

Hardin County is a rural community in Northwest Ohio. According to the United States Census Bureau (2016), there are approximately 31,500 residents, the vast majority of whom (97.5%) are white. The economy is a mix of light industrial and agriculture. Although Hardin County is not geographically classified as Appalachia, it shares some cultural characteristics. Many county residents are descendants of residents of rural areas of Kentucky. Their ancestors came to Hardin County to tenant farm the local swamp lands. Unfortunately, poverty and economic deprivation are widespread problems in this community. According to data from the Ohio Department of Job and Family Services
(2013), the per capita income for Hardin County is 74% of the state and 65% of the national averages respectively.

**Substance Abuse, Mental Illness, and Child Welfare**

The detrimental impacts of drug abuse extend to the children of substance abusers. These children are much more likely than their peers to be the victims of neglect and abuse (Solis, Shadur, Burns, & Hussong, 2012; Steenrod & Mirick, 2017). In general, children whose parents abuse substances have higher rates of mental health problems (e.g., depression, anxiety disorders, hyperactivity, and conduct disorder) than other children (Geschiere, Spijkerman, & de Glopper, 2017). Parental substance abuse is also linked to educational problems in these children including low grades, higher rates of absenteeism, and increased rates of suspension and expulsion (Canfield, Radcliffe, Marlow, Boreham, & Gilchrist, 2017; Smith & Wilson, 2016; Mirick & Steenrod, 2016). Finally, these children are at an elevated risk for behavioral problems including juvenile delinquency and substance abuse (Gifford, Eldred, Evans, & Sloan, 2016; Solis et al., 2012).

Consequently, many of the children of substance abusing parents are placed in foster care. According to recent studies, as many as 80% of the families involved in the child welfare system have problems that are related to parental substance abuse (Bruns, Pullmann, Weathers, Wirschem, & Murphy, 2012; Meyer, McWey, McKendrick, & Henderson, 2010). However, families characterized by parental substance abuse are among the most challenging child welfare populations (Brook, Akin, Lloyd, & Yan, 2015). These families have notoriously poor outcomes in the child welfare system. The majority of substance abusing parents fail to comply with the treatment conditions set by the dependency court, and more than 80% don’t complete the mandated treatment (Marlowe & Carey, 2012). Compared to other families, the children of parents who are substance abusers stay in foster care longer and the family has a lower likelihood of eventual reunification (Brook et al., 2015; Bruns et al., 2012; Burris, Mackin, & Finigan, 2011; Green, Furrer, Worcel, Burris, & Finigan, 2007).

Of particular concern is the fact that opioid abusers probably have the worst outcomes of any category of substance abuser in terms of child welfare system involvement. Parents who abuse opioids are less likely to reunify with their children and are more likely to have their parental rights terminated than parents who abuse other substances (Canifield et al., 2017; Mirick & Steenrod, 2016). Grella, Needell, Shi, and Hser (2009) found that the likelihood of eventual reunification with children for mothers whose primary drug was opioids was about 60% lower than for mothers who primary drug was alcohol. Opioid abusers are also a difficult population for drug courts, since they are significantly less likely to complete treatment than people who abuse alcohol or other drugs (Choi & Ryan, 2006).

Furthermore, there are extremely high rates of co-occurring mental disorders among substance abusers (Smith & Wilson, 2016; York et al., 2012). People who are experiencing the symptoms of mental illness may turn to substances of abuse for self-medication (Edwards & Ray, 2005). Co-morbidity with other mental illness is exceptionally common in individuals who abuse opioids (Pihkala & Sandlund, 2015). For example, research has consistently indicated that about three-quarters of heroin users fit the criteria for at least one co-morbid diagnosis (Darke, 2013). A new study estimated that about 25% of heroin users fit the criteria for a diagnosis of major depressive disorder,
about one-third met the criteria for an anxiety disorder, and at least half fit the criteria for post-traumatic stress disorder (Darke, Torok, & Ross, 2017). Research also indicates that mental illness increases the probability of negative treatment outcomes among substance abusers (Choi & Ryan, 2006). Evidence suggests participants with a co-occurring mental illnesses are more likely to drop out of drug court (Powell, Stevens, Dolce, Sinclair, & Swenson-Smith, 2012). Untreated mental illness can lead to a relapse among substance abusers. When the mental health problems they were trying to avoid reoccur, this can pressure the person to resume substance abuse (Meyer et al., 2010).

Finally, research indicates that these co-occurring mental disorders are also significant in terms of child welfare. First, having a co-occurring psychiatric disorder further increases the likelihood of child maltreatment among substance abusers (Meyer et al., 2010; Solis et al., 2012). Second, co-occurring mental disorders are linked to negative child welfare outcomes. Substance abusing parents who also have a mental illness are less likely than other parents to be reunified with their children after the children are removed from the home (Grella et al., 2009; Powell et al., 2012). Finally, substance abusing mothers who are also taking psychiatric medications are more likely than their peers to have parental rights terminated (Canfield et al., 2017).

**Family Drug Courts**

Family Drug Courts (FDCs) are specialized courts charged with addressing instances of child abuse and neglect involving parents with substance abuse disorders. Originating in the mid-1990s, FDCs were an attempt to reduce the number of child abuse and neglect claims attributable to substance abuse by a parent or guardian (Marlowe & Carey, 2012). The popularity of FDCs increased when Congress passed the Adoption and Safe Families Act (ASFA) of 1997 which was designed to reduce the amount of time children spent in the child welfare system by requiring a permanency decision within twelve months of a child’s placement into foster care. Some observers expressed concerns that the expedited process for permanently terminating parental rights was essentially setting up families with substance abuse problems for failure since many communities lacked the necessary resources to provide adequate treatment to parents dealing with substance abuse disorders (O’Flynn, 2000). While financial limitations can be an obstacle for many jurisdictions, the adoption of FDCs may be a critical step towards limiting the potential negative effects of ASFA.

FDCs show some variation in the way they are designed and operate from one jurisdiction to the next. Common areas of divergence include the types of cases to be handled, the target population, the specific court which will exercise jurisdiction, and the infrastructure of the local judicial jurisdiction (Bureau of Justice Assistance, 2004). Although the structure and scope of FDCs may differ by jurisdiction, at their very core, they generally share some common elements that often have a foundational basis in the “key components” of drug courts as defined by the National Association of Drug Court Professionals Drug Court Standards Committee (Bureau of Justice Assistance, 1997). These include the identification and selection of program participants, the integration of treatment and case processing, development of an interdisciplinary approach to treatment, as well as the importance of continued interaction between the judge and the treatment court participant.

The research on FDCs indicates these entities produce positive outcomes in three key domains. First, there are positive treatment outcomes for the substance abusing parents
who participate in FDCs. These parents tend to enter treatment sooner and stay in
treatment longer than parents who don’t participate in a FDC (Bruns et al., 2012; Burrus
et al., 2011: Green et al., 2007; Worcel, Furrer, Green, Burrus, & Finigan, 2008). Also,
the FDC parents are more likely to complete treatment (Bruns et al., 2012; Burrus et al.,
2011; Green, Furrer, Worcel, Burrus, & Finigan, 2009; Marlowe & Carey, 2012; Worcel
et al., 2008). Second, the child welfare outcomes associated with FDCs are positive.
Children from FDC families spend less time in the child welfare system waiting for
permanent placement than other children (Brook et al., 2015; Edwards & Ray, 2005;
Green et al., 2007). Furthermore, FDC families have higher rates of reunification than
similar families who do not participate in a FDC (Brook et al., 2015; Green et al., 2007;
Green et al., 2009; Worcel et al., 2008; Marlowe & Carey, 2012). Moreover, FDC
participants are less likely than other substance abusing parents to have their parental rights
terminated (Edwards, 2013). Third, FDCs have economic advantages for society since
they produce costs savings that are far superior to other child welfare models (Edwards

The Hardin County Family Recovery Court (HCFRC) is certified by the Supreme
Court of Ohio as a specialized docket under the jurisdiction of the Juvenile Division of
the Hardin County Common Pleas Court in Kenton, Ohio. The mission of the HCFRC
is to provide collaborative evaluation and treatment services for substance abusing parents
who have either lost, or are at risk of losing, custody of their children due to neglect,
abuse, or dependency. The HCFRC is treatment based, non-adversarial, and eligible
participants must agree to partake in the program. Structurally, the HCFRC is an
“integrated” FDC, where the same judge monitors the child welfare case, as well as
ensuring that the parent or guardian complies with the substance abuse treatment order
(Brook et al., 2015).

Participants in the HCFRC are typically referred from Hardin County Job & Family
Services (HCJFS) and are screened within seven days to determine eligibility for the
program. Eligibility requirements include: 1) Must be an adult resident of Hardin County;
2) Must be a parent/guardian of a child or children whom Hardin County Children
Services has filed a complaint of abuse, neglect, or recovery; 3) Clinically assessed as being
drug and/or alcohol dependent and because of this dependency, cannot safely and
effectively serve as a parent; 4) Cognitively able to participate in evaluation, treatment
recommendations, and other required program activities; 5) No assessment findings of
family violence or sex offenses with an alleged dependent child; and 6) Agrees to fully
cooperate and comply with program requirements.

During the screening process, a series of assessments are made to aid in developing an
individualized treatment plan for each program participant. The broad range of services
that are available include: relapse prevention plans; aftercare plans; gender specific
programming; programming for those diagnosed with co-occurring disorders; family
therapy; educational and vocational training; employment and transportation assistance;
and mental health treatment. To support the mission of the HCFRC, and to ensure
participant success, a multidisciplinary “treatment team” has been created. Members of
the treatment team include the Judge, defense counsel, assistant prosecutor, guardian ad
litem, Director of Court Programs, Family Recovery Court Coordinator, HCJFS Social Services
Supervisor, HCJFS Caseworker, as well as any number of licensed treatment providers.
The treatment program has multiple phases, with participants progressing to the next phase upon successful completion of previous phase requirements. While phase progression is based on individual performance, each generally lasts from eight to twelve weeks. The four phases utilized by the HCFRC are: 1) Stabilization; 2) Growth and Development; 3) Early Recovery; and 4) Life-long Recovery. Each phase has its own goals, expectations, and achievements. Common expectations of program participants include making scheduled appearances before the HCFRC, participation in regular drug/alcohol screenings, and adhering to the treatment programming schedule. The program also uses a system of rewards (incentives) and punishments (sanctions) to help ensure program participants compliance. Incentives vary, and may include verbal praise from the bench, gift cards, movie passes, or expanded privileges. Sanctions for non-compliant behavior also vary, and may include a verbal reprimand from the bench, homework assignments, increased drug screening, community service, or termination from treatment court.

To date, approximately 29 of the 69 participants have successfully completed the program. Upon successful completion of all program phases, the participant “graduates” from the program. Graduation consists of a ceremony in open court which is designed to recognize the participant’s successful completion of the program, acknowledge their hard work, and to support their future endeavors. In addition, upon program completion, participants are expected to remain sober, keep their child or children free from abuse and/or neglect, and participate in HCFRC follow up contacts and surveys.

Methods
The current study involved a secondary analysis of data that were previously collected by the court and provided to the research team as part of the larger evaluation process. Specifically, it used pooled data from the Global Appraisal of Individual Needs (GAIN) (see Ives, Funk, Ihnes, Feeney, & Dennis, 2012), which is administered to all of the court participants as part of the standard intake procedures. The GAIN was administered by court staff trained by Chestnut Health Systems and was done in strict accordance with HIPAA rules (45 CFR Parts 160 and 164, Subparts A and E). Use of this data for this secondary analysis is allowed by the Chestnut Health Systems as it is conducted with general consent under federal guidelines (42 CFR Part 2) that allow record abstraction for the purpose of program evaluation and development as long as the data is de-identified and kept confidential. The pooled data provided by Chestnut Health Systems for this study contained absolutely no identifying information of any court participant. Furthermore, the study was determined to fall under IRB exempted status of the respective university since it involved the secondary analysis of existing data and information is recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. From the population of court participants, a sample of 49 subjects who admitted to using heroin was selected for the current analysis.

The GAIN is a standardized comprehensive biopsychosocial assessment battery of measures designed to integrate clinical decisions and research into a single interview (Titus, Dennis, Lennox, & Scott, 2008). It is used to support diagnosis, treatment planning, placement, and service utilization. The GAIN has eight core sections including substance use and mental health indicators. These items are combined into more than 100 indexes, scales, and subscales. The GAIN scales have been developed using Rasch measurement analysis and they have been normed to with over 100,000 subjects (Scott,
Dennis, & Lurigio, 2015). The main mental health scales have outstanding internal consistency (Alpha of .9 or greater) and subscales have very strong internal consistency (Alpha of .7 or higher) (Chan, Dennis, & Funk, 2008; Titus et al., 2008). The diagnostic impressions produced by the GAIN are strongly correlated with blind psychiatric diagnoses, treatment records, and collateral reports (Ives et al., 2012). The GAIN provides a count of various symptoms experienced by a respondent over the course of the last twelve months that are consistent with a variety of common psychological disorders. The specific items are based in large part on various DSM-IV criteria (Conrad, Conrad, Dennis, Riley, & Funk, 2009a; Conrad, Conrad, Dennis, Riley, & Funk, 2009b).

The presence of an internalizing disorder was indicated by a respondent reporting a substantial number of symptoms consistent with a major internalizing problem (i.e., anxiety, mood disorder, suicidal ideation/behavior, and trauma). Past year general anxiety disorder was characterized by indicating at least three general symptoms plus two required symptoms. For past year mood disorder (including depression), the endorsement of five or more symptoms, including three compulsory ones, was required. Past year traumatic stress disorder was categorized by endorsing at least five symptoms. The existence of an externalizing disorder was indicated by a respondent reporting a substantial number of symptoms consistent with a major externalizing problem (i.e., ADHD/ADD and conduct disorder). Past year ADHD/ADD was classified by the endorsement of at least six symptoms related to hyperactivity/impulsivity type, inattention type, or both. For past year conduct disorder, the endorsement of at least three symptoms was required.

Results

Table 1 shows the demographic and background characteristics of the 49 subjects in this sample. The majority of the sample is white (89.8%), female (69.4%), and has never been married (61.2%). Approximately three-quarters are 30 years of age or younger. Eighty percent are unemployed, and a notable proportion (34.0%) did not complete high school. The vast majority of the sample (81.6%) has multiple children under 21 years old. Collectively, the sample has a total of 117 children under the age of 21. The supra majority (83.9%) reported an opioid was their drug of choice, with heroin (71.4%) being the most popular.

The estimated prevalence of various psychological problems is reported in Table 2. Overall, 77.6% of HCFRC participants with a history of heroin use reported problems that were consistent with some type of mental disorder. Internalizing disorders were more common, including mood disorder (69.4%), generalized anxiety disorder (40.8%) and traumatic stress disorder (39.6%). The respective externalizing problems were reported by between one-quarter and one-half of the sample. ADD/ADHD problems were experienced by 42.9%, while one-quarter experienced a conduct disorder. Finally, 40.8% of the sample experienced symptoms that were consistent with both an internalizing and an externalizing problem.
Table 1. Characteristics of the Sample (n = 49)

<table>
<thead>
<tr>
<th>Gender</th>
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</thead>
<tbody>
<tr>
<td>Female</td>
<td>69.4%</td>
</tr>
<tr>
<td>Male</td>
<td>30.6%</td>
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<table>
<thead>
<tr>
<th>Age</th>
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<tbody>
<tr>
<td>21–25 years old</td>
<td>34.8%</td>
</tr>
<tr>
<td>26–30 years old</td>
<td>40.7%</td>
</tr>
<tr>
<td>31–35 years old</td>
<td>18.4%</td>
</tr>
<tr>
<td>36 years and older</td>
<td>6.1%</td>
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<thead>
<tr>
<th>Race</th>
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<tbody>
<tr>
<td>White</td>
<td>89.8%</td>
</tr>
<tr>
<td>Bi-racial</td>
<td>10.2%</td>
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<thead>
<tr>
<th>Relationship Status</th>
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<tbody>
<tr>
<td>Never Married</td>
<td>61.2%</td>
</tr>
<tr>
<td>Married</td>
<td>14.3%</td>
</tr>
<tr>
<td>Cohabitating</td>
<td>10.2%</td>
</tr>
<tr>
<td>Separated</td>
<td>8.2%</td>
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<tr>
<td>Divorced</td>
<td>6.1%</td>
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<table>
<thead>
<tr>
<th>Number of Children Under 21</th>
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<tbody>
<tr>
<td>1</td>
<td>18.4%</td>
</tr>
<tr>
<td>2</td>
<td>40.8%</td>
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<tr>
<td>3</td>
<td>32.7%</td>
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<tr>
<td>4 or more</td>
<td>8.1%</td>
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<tr>
<th>Employment Status</th>
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<tbody>
<tr>
<td>Unemployed</td>
<td>80.0%</td>
</tr>
<tr>
<td>Working Full-Time</td>
<td>11.1%</td>
</tr>
<tr>
<td>Disabled</td>
<td>6.7%</td>
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<tr>
<td>Working Part-Time</td>
<td>2.2%</td>
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<table>
<thead>
<tr>
<th>High School Graduate</th>
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<tbody>
<tr>
<td>Yes</td>
<td>66.0%</td>
</tr>
<tr>
<td>No</td>
<td>34.0%</td>
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<table>
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<tr>
<th>Drug of Choice</th>
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<tbody>
<tr>
<td>Heroin</td>
<td>71.4%</td>
</tr>
<tr>
<td>Other Opioid</td>
<td>12.5%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>12.5%</td>
</tr>
<tr>
<td>Other</td>
<td>3.6%</td>
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Discussion

The purpose of the current undertaking was to explore the prevalence of mental health problems among a sample of adult participants in a family drug court who reported using heroin. The court is located in a rural Ohio county heavily impacted by the current opioid epidemic. Data from the GAIN indicates psychological disorders are extremely common in this sample, with nearly 80% reporting symptoms consistent with some type of mental disorder. Three-quarters of the sample reported signs of some type of internalizing disorder (i.e., mood disorder, generalized anxiety disorder, traumatic stress disorder). Slightly more than 40% experienced symptoms of some type of externalizing disorder (i.e., ADD/ADHD, conduct disorder), and a similar percentage reported symptoms of both internalizing and externalizing disorders. The findings of the current inquiry are consistent with those of previous studies indicating that substance abusers generally have high rates of co-occurring psychological disorders (Smith & Wilson, 2016; York et al., 2012). More specifically, co-occurring mental disorders are extremely common in opioid abusers (Pihkala & Sandlund, 2015). Our estimates that three-quarters of the heroin users in the HCFRC sample fit the criteria for at least one co-morbid diagnosis is identical to the estimate reported by Darke (2013) in his review of previous studies on heroin using adults.

Table 2. Prevalence of Mental Health Problems

<table>
<thead>
<tr>
<th>Mental Health Disorder</th>
<th>Prevalence</th>
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<tbody>
<tr>
<td><strong>Any Type of Disorder</strong></td>
<td>77.6%</td>
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<tr>
<td><strong>Any Internalizing Disorder</strong></td>
<td>75.5%</td>
</tr>
<tr>
<td>Mood Disorder (Including Depression)</td>
<td>69.4%</td>
</tr>
<tr>
<td>General Anxiety Disorder</td>
<td>40.8%</td>
</tr>
<tr>
<td>Traumatic Stress Disorder</td>
<td>39.6%</td>
</tr>
<tr>
<td><strong>Any Externalizing Disorder</strong></td>
<td>42.9%</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>42.9%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Both Internalizing and Externalizing Disorder</strong></td>
<td>40.8%</td>
</tr>
</tbody>
</table>

The extremely high rate of co-occurring mental disorders in the current sample is particularly concerning in terms of both child welfare and drug treatment outcomes. First, the mental health disorders are problematic because opioid abusers generally have poorer child welfare system outcomes than other types of substance abusers (Canifiled et al., 2017; Mirick & Steenrod, 2016). It is well established that having a co-occurring psychiatric disorder further increases the likelihood of child maltreatment (Meyer et al., 2010; Solis et al., 2012) and decreases the likelihood of eventual family reunification (Grella et al., 2009; Powell et al., 2012). These co-occurring psychological disorders also hinder the treatment prospects for these heroin using parents. Previous research indicates that mental illness increases the likelihood of negative treatment outcomes for substance abusers, and substance abusers with co-occurring mental disorders are more likely than other
participants to drop out of drug courts (Choi & Ryan, 2006; Powell et al., 2012). This is not surprising since untreated mental illness often triggers relapse (Meyer et al., 2010).

These co-occurring mental disorders are not the only challenge facing FDCs who are dealing with opioid abusers. While one would hope that the prospect of keeping custody of their kids would motivate FDC participants to embrace recovery, opioid addiction is so remarkably powerful that it is generally prioritized over family responsibilities (Mirick & Steenrod, 2016). The staff of the HCFRC has found heroin users to be particularly difficult to manage. For example, they often try to manipulate or tamper with the required urinalysis tests so they can circumvent program expectations and continue to abuse opioids. Furthermore, they sometimes skip the medication-assisted therapies (i.e., Naltrexone, Methadone, Buprenorphine) included in the program for the sole reason of wanting to experience an opioid high.

Another obstacle facing FDCs is the time limitations put in place by the Adoption and Safe Families Act (ASFA) of 1997. The legislation requires a permanency hearing to be held no later than 12 months after the child has been placed in foster care. Since recovery from opioid addiction is often a lengthy process, and relapse common, the temporal requirements of the ASFA may serve as a barrier to family reunification. The stringent time requirements imposed by ASFA may dissuade some parents from even attempting recovery. Further, those parents who do attempt recovery, but take longer to overcome their addiction, may be at risk for having their parental rights terminated. For FDCs to successfully address the challenges presented by parents who abuse opioids within the time frame mandated by the ASFA, it is essential that any co-occurring psychological problems be addressed (Goldner, Lusted, Roerecke, Rehn, & Fischer, 2014). Consequently, an integrated approach that simultaneously deals with those co-occurring substance and mental health issues is strongly recommended (Schuler, Vasilenko, & Lanza, 2015). Neglecting to treat the co-occurring mental health issues is setting the opioid abuser up for failure since the distressing symptoms of the mental health problem can pressure them to relapse (Meyer et al., 2010).

Limitations

There are three limitations associated with this study that need to be acknowledged. First, the data were collected from a single court in one rural Ohio county. Accordingly, the generalizability of these findings is unknown. However, the purpose of the current undertaking was to report on the prevalence of symptoms of mental disorders among our sample of heroin users, not to make generalizations regarding this phenomenon in the wider population. Second, we used a cross-sectional research design. Therefore, we are unable to establish any sort of causal relationship between mental disorders and heroin use, or mental illness and treatment success for heroin users. Finally, GAIN-I data on mental illness are not diagnoses, but rather a measure of the extent to which various diagnostic criteria are or are not met (Chan et al., 2008; Rush, Dennis, Scott, Castel, & Funk, 2008). However, the respective diagnostic impressions produced by the GAIN are strongly correlated with blind psychiatric diagnoses, collateral reports and treatment records (Ives et al., 2012).

Future Directions

The research reported in this paper was exploratory in nature and arose out of the evaluation of a rural FDC in Hardin County, Ohio. It was designed in response to reports
from HCFRC staff about apparent widespread mental health symptoms among parents with a history of heroin use, as well as the difficulties this phenomenon presents. Our intention was to document this phenomenon and its associated problems. The logical next step for research would be to investigate the relationship between specific mental health problems and treatment outcomes for heroin abusers. The identification of specific disorders that are linked to poor program performance would be extremely valuable. However, one obstacle facing such a prospective analysis is that the sheer number of mental health conditions relative to the number of heroin abusers in any single FDC, especially a rural one, would prohibit the use of most statistical techniques. Accordingly, it appears that it will be necessary to pool data from a number of FDCs to obtain a sufficiently large enough sample to utilize the more sophisticated types of statistical analyses.

One logical strategy to prevent these problems in the future is to attempt to identify youths who are at high risk for heroin use. In this regard, the Hardin County Juvenile Court is actively seeking to identify juveniles who are involved in the nonmedical use of prescription opioids. Research has clearly established that young people who abuse these prescription opioids are several times more likely to become heroin users than those who don’t (see Vosburg et al., 2016). A recent analysis of youths participating in the various Hardin County Juvenile Court dockets revealed that 95% of the juveniles who have abused prescription opioids have the symptoms of a at least one mental disorder (Durkin & Melton, 2017). Since there is such a strong link between mental health problems and heroin use among FDC participants, trying to more effectively identify and treat these mental health problems in juvenile prescription opioid abusers seems to be an excellent investment of resources.

References


Young, Nancy K. (2016). *Examining the opioid epidemic: Challenges and opportunities*. Written Testimony before the United States Senate Committee on Finance.