# Co-Occurring Disorders and Specialty Courts

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## Abstract

A growing number of persons with co-occurring mental and substance use disorders are involved in the criminal justice system, with an associated rise in the number of these individuals appearing before the court. Increasingly, "problem-solving courts" or "specialty courts" (e.g., drug courts, mental health courts, domestic violence courts, community courts, re-entry courts) have been implemented to move beyond case processing to address the underlying issues that brought the defendant to court in the first place. In linking participants with co-occurring disorders to treatment alternatives, judges are testing the ways in which the specialty courts can serve as a therapeutic agent. This source document is intended to provide specialty court staff an overview of the characteristics and needs of individuals with co-occurring disorders, as well as to describe best practices associated with positive outcomes both in treatment settings and the court.

# Section 1
## Background

A growing number of persons with co-occurring mental and substance use disorders are involved in the criminal justice system, with an associated increase in the number of these individuals appearing before the court. In most cases, the co-occurring disorders either directly resulted in their arrest (e.g., drug possession or sales) or contributed to it (e.g., severe disability, homelessness).

Mental disorders include DSM IV Axis I disorders (e.g., major depressive disorder, bipolar disorder, schizophrenia) that are often accompanied by one or more Axis II (personality) disorders. Substance abuse refers to substance use disorders, both abuse of and dependence on psychoactive substances, including alcohol. It is critical that court staff understands, identifies, and accommodates the court process to the unique features of defendants with co-occurring disorders. The effective handling of individuals with co-occurring disorders will improve both public safety and public health outcomes.

Research provides compelling reasons for the importance of this issue. On any given day, there are over two million adults in U.S. jails and prisons, and the cost of housing these inmates exceeds $40 billion per year (Justice Policy Institute, 2000). Persons with mental illnesses are arrested at disproportionately higher rates than persons without such disorders (Lamb & Weinberger, 1998). Over 11 million adults are booked into U.S. jails each year (Stephen, 2001). The prevalence of serious mental illness (SMI) among jail inmates is estimated at over 7 percent (Steadman et al., 1999), which is two to three times higher than rates found in the general population (Lamb & Weinberger, 1998). The majority of these individuals—approximately 75 percent—have co-occurring substance use disorders (National GAINS Center, 2001).

Traditionally, cases involving persons with co-occurring disorders in court settings have included competency evaluations, pleas of "not guilty by reason of insanity," and "guilty but mentally ill." These outcomes are employed in a relatively few cases. Increasingly, "problem-solving courts" or "specialty courts" (e.g., drug courts, mental health courts, domestic violence courts, community courts, re-entry courts) have been implemented to move beyond case processing to address the underlying issues that brought the defendant to court in the first place. In linking participants with co-occurring disorders to treatment alternatives, judges are testing the ways in which the specialty courts can serve as a therapeutic agent. Individuals

*Persons with mental illnesses are arrested at disproportionately higher rates than persons without such disorders.*

*The majority of these individuals—approximately 75 percent—have co-occurring substance use disorders.*

with co-occurring mental and substance use disorders pose unique challenges for specialty courts, in particular, as these courts must develop their own strategies for addressing public safety while engaging participants in programs outside of jail. For example, drug court judges have found that participants with co-occurring disorders are harder to place in treatment than other participants (Denckla & Berman, 2001).

This source document is intended to provide specialty court staff an overview of the characteristics and needs of individuals with co-occurring disorders, as well as to describe best practices associated with positive outcomes both in treatment settings and the court. Section 1 of the document will highlight the potential negative outcomes associated with co-occurring disorders, the need for screening and assessment, the heterogeneity of the population, evidence-based practices and treatment principles associated with positive outcomes, barriers to service delivery, and implications for specialty court programs addressing the needs of participants with co-occurring disorders. Subsequent sections will address: (1) eligibility considerations for specialty courts; (2) evidence-based treatment and management approaches and related "principles of care"; (3) modified services that should be provided by all specialty court programs; and (4) enhancements to treatment, judicial and supervision strategies for specialty court participants with co-occurring disorders.

*Specialty courts must develop their own strategies for addressing public safety while engaging participants in programs outside of jail.*

## Overview of Clinical Issues

The mental health and substance abuse fields have had a growing awareness of the prevalence of co-occurring disorders and the challenges presented by this population. The lack of success within traditional treatment settings for individuals with co-occurring disorders is well documented and has stimulated innovative and specialized service approaches. Despite increasing evidence that outcomes for persons with co-occurring mental and substance use disorders improve when care is provided in a comprehensive and integrated fashion (Drake et al., 2001; Drake et al., 1998), access to effective service remains elusive to most individuals with these conditions (U.S. DHHS, 1999). It is estimated that up to 10 million people in the United States meet criteria for co-occurring disorders in any given year (CMHS, 1997). Without adequate treatment we can predict a continuation of significant disability, poor adjustment, suboptimal quality of life, and increased court appearances among persons with co-occurring disorders (Osher & Kofoed, 1989).

Clinicians, health care administrators, families, and consumers articulate a sense of frustration that not enough is being done to address the needs of persons with co-occurring disorders. More recently judges and court advocates have shared concerns that new court processing approaches are required. These groups witness the way these individuals cycle in and out of costly and inappropriate treatment settings, such as emergency rooms and jails, and are consistently over-represented in surveys of homeless populations. Many of these individuals become the "revolving-door" defendants within the court.

## Negative Outcomes

Substance abuse among persons with mental illness has been associated with negative outcomes including increased vulnerability to relapse and rehospitalization (Caton et. al, 1993; Haywood et al., 1995; Seibel et al., 1993); more psychotic symptoms (Carey et al.; 1991; Drake et al., 1989; Osher et al., 1994); greater depression and suicidality (Bartels et al., 1992); violence (Cuffel et al., 1994); incarceration (Abram & Teplin, 1991; Bureau of Justice Statistics, 1999); inability to manage finances and daily needs (Drake & Wallach, 1989); housing instability and homelessness (Caton et al., 1994; Drake & Wallach, 1989; Osher et al., 1994); noncompliance with medications and other treatments (Drake et al., 1989; Owen et al., 1996); increased risk behavior and vulnerability to HIV infection (Cournos & McKinnon, 1997; Cournos et al., 1991) and hepatitis (Rosenberg et al., 2000); lower satisfaction with familial relationships (Dixon et al., 1995); increased family burden (Clark, 1994); and higher service utilization and costs (Bartels et al., 1993; Dickey & Azeni, 1996).

## The Relationship Between Substance Use and Mental Disorders and the Role of Assessment

It is important to recognize the complex interaction of substance use and psychiatric disorders. Sorting out the interaction is a sophisticated assessment task that may lead to classification as outlined by Lehman et al. (1989) in which six possible relationships were identified:

1. **Acute and chronic substance abuse may produce psychiatric symptoms**. Smoking a stimulant such

***Negative outcomes associated with co-occurring disorders may include:***

- *relapse and hospitalization*
- *increase in psychotic symptoms*
- *greater depression and suicidality*
- *episodic violence*
- *contact with the criminal justice system*
- *diminished functioning*
- *housing instability/ homelessness*
- *noncompliance with medication and treatment*
- *increased risk behavior and vulnerability to HIV/ hepatitis infection*
- *familial disfunction/strain*
- *increased service utilization/costs*

as crack cocaine will cause paranoid symptoms in a significant percentage of users. Prolonged alcohol use and its negative effects on sleep and nutrition can produce profound depressive symptoms.

2. **Substance withdrawal can cause psychiatric symptoms**. A person who is physically dependant on heroin will demonstrate extreme anxiety if they lose access to the drug for over a day.

3. **Substance use can mask psychiatric symptoms.** A person with social anxiety and an inability to interact with others, might be capable of completing a job interview after using minor tranquilizers.

4. **Psychiatric disorders can mimic symptoms associated with substance use**. A college student with schizophrenia may have hallucinations that seem similar to those of their friends who use LSD.

5. **Acute and chronic substance abuse can exacerbate psychiatric disorders**. A person with schizophrenia who regularly smokes marijuana may not get relief from auditory hallucinations despite taking medication.

6. **Acute and chronic psychiatric disorders can exacerbate the recovery process from substance use disorders**. A person with cocaine addiction and depression may not be able to get to treatment/ support groups or understand the lessons being taught.

In this classification scheme, the first two relationships do not qualify as co-occurring disorders but will require substance abuse interventions. These are individuals for whom abstinence will allow for an elimination of psychiatric symptoms. The third and fourth relationships do not represent bona fide examples of co-occurring disorders either. Individuals with psychiatric illnesses can be effectively treated with existing forms of mental health treatment. It is only the last two categories that qualify as co-occurring disorders. Persons within these categories require integrated treatment strategies. Accurate classification of persons with co-occurring disorders is somewhat difficult, especially at, or near, the time of arrest. In many cases, the most effective strategy is to assume that co-occurring disorders exist. In clinical terms, this approach is often represented as a notation to "rule/out" the co-occurring condition.

*The interaction of substance use and psychiatric disorders is complex ... two reciprocal relationships qualify as co-occurring disorders:*

- *Acute and chronic substance abuse can exacerbate psychiatric disorders.*
- *Acute and chronic psychiatric disorders can exacerbate the recovery process from substance use disorders.*

For the courts, further efforts are required to establish the relationship between these clinical disorders and the criminal charges.

- Did these conditions affect the defendants understanding of the crime?
- Did the conditions influence the commission of the crime?
- Do these conditions affect the defendant's capacity to participate in their own defense?

Determining the nature of the relationship between substance use, mental illness, and abnormalities in mood, thinking, and behavior is a complex, yet critical, task. It is predicated on the expectation that clinicians, supervision staff, or court personnel actively search for the relationship. This is not a routine practice in most behavioral health treatment settings or in pre-trial evaluation services. Specialized staff available to the court for assessment purposes must be familiar with the interactions between mental and substance use disorders.

## Heterogeneity of the Population with Co-Occurring Disorders

Court orders and treatment planning require an accurate description of the problems to be addressed. Despite considerable progress in assessment tools and strategies, the identification and characterization of persons with co-occurring disorders remains a difficult task (Lehman et al., 1996). While the assessment process is complex and can be protracted, the identification of individuals with co-occurring disorders is simply a preliminary step in designing an appropriate response to their needs. Having determined that the defendant has two simultaneous, interacting conditions—a mental illness and a substance use disorder—does not allow a simple template or formula for court processing. It is critical that the *heterogeneity* of the population be acknowledged. Some defendants will have thought disorders like schizophrenia, while others will have mood disorders such as major depression or bipolar disorder. Their treatment and court needs will be very different. Any substance of abuse can be combined with any mental disorder to meet criteria under the umbrella term of co-occurring disorder. These two dimensions—mental illness and substance abuse—can be crossed with any set of demographic variables (age, gender, and/or culture) to create additional subgroups with special needs. Add the frequent presence of other medical co-morbidities, and the classification of co-occurring disorders gains additional complexity. Lastly, the nature of the crime and criminal history will vary substantially. These interacting variables underline the importance of the adage: *if you've seen one person with co-occurring disorders, you've seen one person with co-occurring disorders.*

For clinical and organizational purposes, the separation of persons with co-occurring disorders into subgroups based solely on diagnosis or demographics will not lead to effective matching to treatment and supervision services. Arguably the most important dimension to consider is the degree of disfunction the two disorders produce in an individual. One useful model was developed in New York and endorsed by both the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors (NASMHPD & NASADAD, 1999). (See Figure 1.)

Rather than focus on diagnoses, the model uses two dimensions—the severity of the mental illness and the severity of the substance abuse problem—to define four sub-groups of individuals with co-occurring disorders in a two-by-two matrix. The advantages of this model are that it encompasses the heterogeneity of the population with co-occurring disorders, it assigns responsibility for providing some degree of care to these individuals to every system, and it is flexible enough to be adapted to most service settings. Significant overlap between systems is inherent in the model, and it more realistically corresponds to the multiple pathways used by persons with co-occurring disorders to access care. With this conceptual framework, court personnel do not need to be as facile with technical behavioral health terms nor understand subtle differences in differential diagnostics. These differences in severity are important in deciding conditions of release as is discussed later in this document.

Using this type of organizational model, individuals who are assessed as having high severity of mental

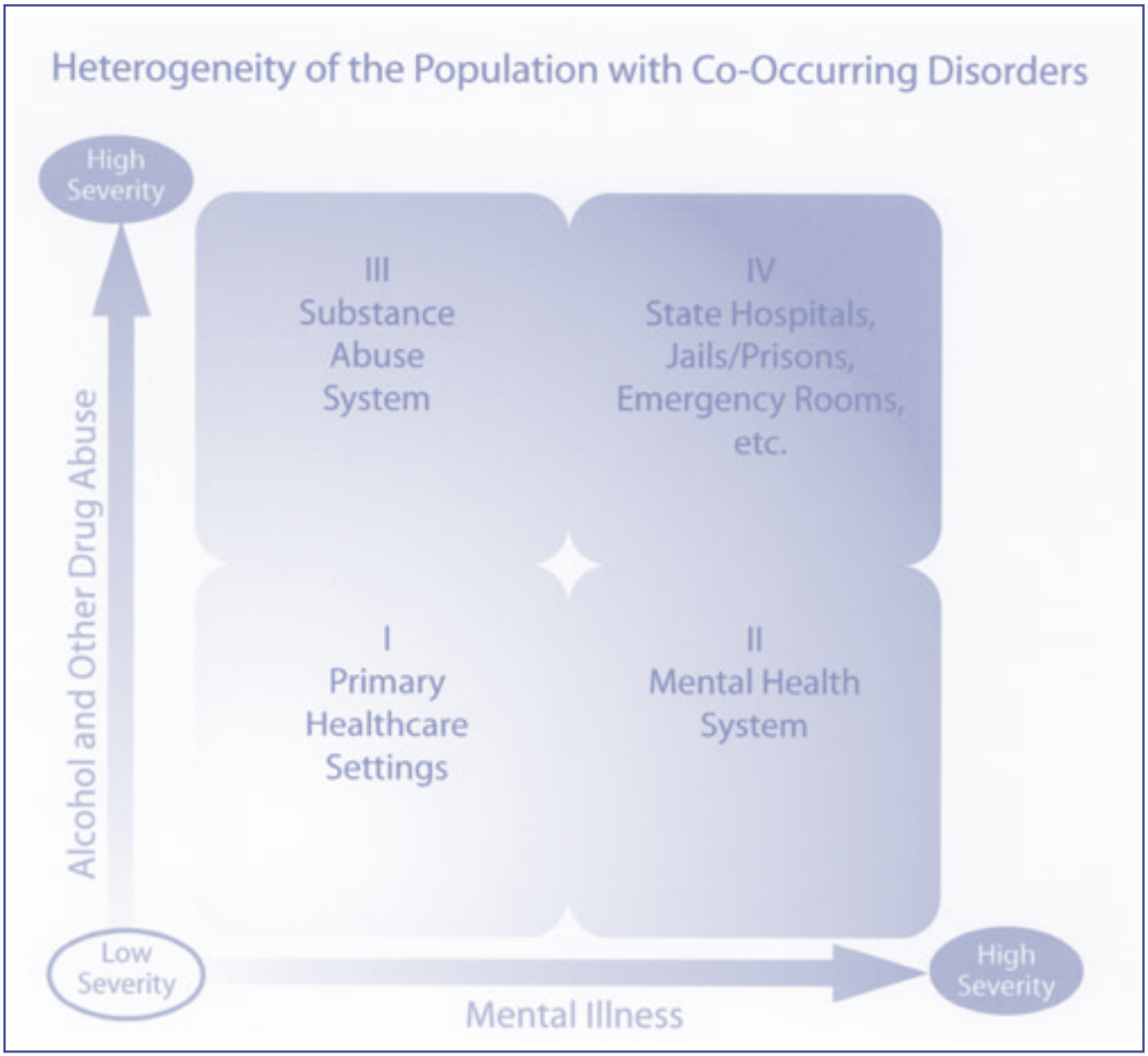


Figure 1.

health problems and low substance abuse problems may be most productively placed in mental health court programs or similar diversion programs. Individuals who have high severity of substance abuse problems and low mental health problems may be matched most effectively to drug court programs. Individuals who have high severity of both co-occurring disorders would be good candidates for specialized court-supervised co-occurring disorder treatment programs, or enhancement of existing specialty court programs to create unique "tracks" or components that address co-occurring disorders. Individuals who have low severity of both co-occurring disorders may be best suited for traditional diversion programs that do not include intensive treatment programming. This treatment matching approach assumes that individuals assessed for treatment have low public safety risk, and meet other program eligibility criteria.

Section 2

# Specialty Courts and Individuals with Co-Occurring Disorders

*Overview of Court Issues* Courts will need to determine which defendants are eligible for specialty services. Specialty courts have sometimes attempted to screen out individuals with co-occurring mental disorders during the admission process. For example, in some drug courts, participants have been discharged due to their use of psychotropic medication, and several of the more recently developed mental health courts have indicated a reluctance to provide services to defendants with severe substance abuse problems. However, most specialty courts have successfully involved participants with both mental and substance use disorders, and have adapted relationships with community behavioral health agencies to accommodate participants' broad range of need. Even in programs that attempt to exclude individuals with co-occurring disorders, there are many successful graduates with co-occurring disorders who were not detected at the time of admission.

*Specialty courts have sometimes attempted to screen out individuals with co-occurring mental disorders during the admission process.*

Clearly, some participants with co-occurring disorders may not ultimately complete the specialty court program, just as many other problems (e.g., health conditions, housing, employment, transportation) experienced by participants may interfere with, or slow their progress in the program. Specialty courts can anticipate a pattern of variability in functioning and symptom severity among many participants with co-occurring disorders and need to adapt a flexible approach in working with these individuals. Some programs may not have the resources to work effectively with participants who have co-occurring disorders, and may choose not to work with this population. However, exclusion of these individuals is clearly not a satisfactory solution. Given the high frequency of co-occurring disorders among criminal defendants, this approach would exclude a large number of potential specialty court participants, and would deprive those with the greatest needs from receiving effective services.

Specialty courts should not restrict admission solely on the basis of co-occurring disorders, past mental health or substance abuse diagnoses, or a history of treatment for behavioral disorders, but should instead consider the degree to which these disorders lead to functional impairment that inhibits effective program participation (see Figure 1). In many cases, the precise nature and effects of functional impairment (e.g., difficulties in attention/concentration) are difficult to gauge until an individual is placed in a specialty court treatment setting and it can be determined how they respond to staff

directives, group treatment experiences, and supports that are provided by the program. Separate specialty court tracks for persons with co-occurring disorders may not be required unless participants exhibit significant impairment in psychological or social functioning. The symptom picture and functioning level of specialty court participants who have mental disorders can be expected to change over time and is influenced by use of medication, stress at home or work, and use of drugs and alcohol. Specialty court staff should follow-up on any observations of even small changes in mental health symptoms or functioning level to determine if there are issues related to treatment and supervision that need to be addressed.

## Five Critical Domains that Affect Specialty Court Participation

1 *critical domain*

**Severity of Mental Illness** The severity and associated level of psychosocial impairment of mental disorders varies significantly across individuals. Those seen in specialty courts vary between having few strengths and major mental health symptoms to being self-sufficient with few mental health symptoms. Specialty court programs should carefully assess the level of severity of mental disorders and areas of functioning that are affected, in addition to the mental health diagnosis.

Evidence of delusions, hallucinations, or paranoia may make it difficult for the individual to participate in certain types of treatment (e.g., group counseling), although other approaches (e.g., individual counseling) may be available to address these mental health needs. It is particularly important to identify periods of relatively high functioning and to assess whether adherence to prescribed medications, involvement in structured treatment programs, social and family supports, or other factors contributed to these outcomes.

The impact of substance abuse on mental disorders should be examined to determine if these disorders improve substantially during periods of abstinence. Recovery potential related to mental disorders should also be assessed. Specialized training related to co-occurring disorders and reduced staff caseloads should be considered, particularly when there are a significant number of participants who have major mental disorders and who have personality disorders.

*Critical Domains that Affect Specialty Court Participation:*

- *Severity of mental illness*
- *Severity of substance use disorder*
- *Severity of criminal charges and criminal history*
- *Motivation for recovery and stages of change*
- *Program resources*

### Mental Health Indicators that Affect Specialty Court Participation

Key *mental health indicators* that suggest potential difficulties in traditional community treatment (Peters & Hills, 1997) such as specialty court programs, include the following:

- Delusions, hallucinations, severe depression, paranoia, or mania (i.e., hyperactivity and agitation) that occurs frequently, is obvious to others, is disruptive to status hearings or group treatment activities, or that otherwise prevents constructive interaction with specialty court staff or participants. Many participants with unusual thoughts and odd or eccentric behaviors can be tolerated within specialty court programs and may be responsive to community treatment. In order to manage these persons effectively, it is often useful to provide staff training and education to specialty court participants regarding the nature and cause of mental health symptoms.
- A historical lack of stabilization on psychotropic medication, or failure to adhere to medication. It is important to note that use of medications is not a violation of abstinence policies and does not conflict with other principles of substance abuse treatment. Orders that improve treatment compliance may be sufficient to allow for participation in court ordered programs.
- Presence of suicidal thoughts or other dangerous behavior.
- Inability to handle stress in group treatment settings.
- Impaired cognitive functioning. This includes difficulties in attention, concentration, memory, and abstract thinking that impair an individual's ability to communicate his or her needs and understand treatment-related materials.
- Inability to interact effectively with specialty court staff without excessive anxiety, agitation, or aggressive behavior. In some cases, anxiety and agitation can result from withdrawal from alcohol, cocaine, methamphetamine, or other drugs.
- The presence of a co-occurring personality disorder. A significant number of individuals with substance abuse problems have an Axis II (personality) disorder, and may be noncompliant with program directives or guidelines. Personality disorders that may be particularly problematic in specialty courts include Borderline Personality Disorder with associated suicidal and manipulative behaviors, and Antisocial Personality Disorder with associated features of psychopathy such as callousness towards others and inability to develop reciprocal interpersonal relationships.

2 *critical domain*

### Severity of Substance Abuse Disorder

Even small to moderate levels of alcohol and drug use can produce significant difficulties—including enhanced stress, return of major mental health symptoms, loss of housing and social supports, and unemployment—for specialty court participants who have mental disorders. It is particularly problematic in specialty courts when these individuals are unable to achieve sustained abstinence from drugs or alcohol, even when involved in progressively more intensive treatment services. For some individuals who do not have a history of sustained abstinence, more intensive services (e.g., residential treatment) may be needed prior to placement in a specialty court program. Specialty court programs should examine the severity of substance abuse problems, and determine whether current use patterns are aggravating mental health problems. Assessment should also consider whether use of psychotropic medications (e.g., antidepressants, mood stabilizers, anti-psychotic medications)

concurrently with alcohol or illicit drug use present a threat to the participant's physical well-being.

The general recovery potential related to substance use disorders should be considered in reviewing admissions to specialty court programs. Factors such as the level of family and peer support, stable housing, medication adherence, and availability of crisis services and other ancillary mental health services should be considered in this process.

Participants who have co-occurring disorders may not be fully aware of the interdependent nature of their mental health and substance abuse problems, and even with this knowledge, may not be motivated to make lifestyle changes related to their substance abuse. Treatment options other than specialty courts may be needed for those individuals who are unable or unwilling to reduce their substance abuse in light of adverse health consequences.

3 critical domain

**Severity of Criminal Charges and Criminal History** Criminal history and current charges are key factors in determining eligibility for specialty courts, and may also affect the conditions of community release and supervision. Most programs do not accept participants who have a history of violent offenses or multiple prior felonies. The elaboration of this domain is beyond the scope of this monograph and is best handled by court personnel. Additional information regarding this domain and related screening and assessment approaches is available in a monograph published by the U.S. Department of Justice (Peters & Peyton, 1998).

4 critical domain

**Motivation for Recovery and Stages of Change** Initially, motivation for involvement in specialty court services is typically low for persons with co-occurring disorders; it may vary considerably over time. Substance abuse issues may not be perceived as significant problems, given the range of other problems (e.g., homelessness, HIV/AIDS, unemployment) that may be present. The nature and severity of the mental illness may be disputed. Individuals with co-occurring disorders may need different sets of incentives to engage them in specialty court services. These may include low-cost housing, food assistance, and vocational training opportunities. Often the most important and powerful incentives are not obvious and need to be explored with the specialty court participant.

The motivation level of participants with co-occurring disorders can be expected to fluctuate considerably over time. This fluctuation is normal for clients in both mental health and substance abuse programs, and is particularly evident among individuals who have substance use disorders and who are faced with giving up their drug(s) "of choice" and making major lifestyle changes (e.g., related to peers, jobs, and old habits).

Individuals progress through various "stages of change" as they enter and move through recovery from co-occurring disorders. Most new specialty court participants will be in very early stages of motivation for treatment, in which they are unconvinced that they have a problem and may be thinking about changes without taking any major action. As they progress through treatment (often over the course of several years), specialty court participants are likely to develop greater internal motivation for treatment, as indicated by their recognition of the need to make lifestyle change and to take steps towards recovery goals.

In early stages of recovery, key tasks of specialty court staff will include engagement of participants in a working relationship and persuasion to help the participant view co-occurring disorders as problems that should be worked on, and that they have a reasonable chance of overcoming. Staff often misattribute participants' behavior in early stages of recovery as "resistance" and "denial," when in fact their ambivalence is a normal consequence of facing uncertainties related to making major behavioral and lifestyle change.

A variety of brief screening approaches are available to identify levels of participant motivation and commitment related to treatment. Specialized treatment interventions such as Motivational Interviewing (MI) and the related Motivational Enhancement Therapy (MET) are also available to help engage participants in

specialty court programs, and described in more detail later in this document.

5 critical domain

**Ancillary Program Resources and Other Relevant Domains** The availability of additional resources will affect whether individuals with co-occurring disorders can participate effectively in specialty courts:

- Access to psychiatric consultation and medications
- Access to other mental health services
- Detoxification services
- Outreach and crisis services
- Case management

Other factors may affect an individual's ability to participate effectively in specialty court:

- the willingness of family to participate in community follow-up
- need for child care
- physical health
- access to transportation and
- stable living situations.

### Guidelines for Specialty Court Programs

The following general guidelines should be considered regarding *specialty court programs* for individuals with co-occurring disorders:

- Specialty courts should strive to be inclusive in admitting individuals with co-occurring disorders and other potentially disabling conditions (e.g., physical handicaps). Many individuals with mental health and substance abuse problems have successfully participated in specialty courts in the past, including a significant number in drug courts who were not diagnosed with mental disorders until after admission to these programs.
- A mission statement should be developed that describes how the specialty court intends to deal with mental health and substance abuse issues and related confidentiality concerns.
- Each specialty court program should evaluate its capacity to work with individuals who have co-occurring mental disorders. This should include identification of the number of program participants who have mental disorders, the type of disorders, and the level of functional capacity of these participants. Courts should examine existing program resources and procedures for participants who have mental disorders and whether mental health screening/assessment is being conducted, Courts should ascertain which other community mental health and specialized co-occurring disorder services are available for referral, review which requirements of the specialty court program may create special hardships for those with mental disorders, and clarify the levels of functioning needed to participate effectively in the specialty court program.
- To the extent possible, each previously described "critical domain" should be assessed to determine the functional status and risk level of candidates considered for placement in specialty courts.
- Programs should prioritize how to use existing resources to address participants who have co-occurring mental disorders.
- Partnerships should be established with family members and other care providers to assist in developing treatment plans and in coordinating services related to housing, transportation, child care, financial support, and involvement in treatment.

Section 3

# Evidence-Based Practices and Principles of Care

**Evidence-Based Practices:** Services with demonstrated positive outcomes in multiple research studies are called "evidence-based practices." Mental health and substance abuse research has demonstrated that "treatment works." However, this is not true of all treatments as delivered by all providers. Given the high prevalence rates and negative outcomes associated with co-occurring disorders, the identification of effective interventions has gained both immediacy and a growing database. For the past 15 years, extensive efforts have been made to develop integrated models of care that bring together mental health and substance abuse treatment. Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help persons with co-occurring disorders reduce substance use and attain remission (Drake et al., 1998). Positive outcomes associated with integrated approaches include a reduction in hospital utilization, psychiatric symptomatology, substance use, and other problematic negative outcomes.

Other evidence-based practices have been identified for persons with serious mental illnesses. These include

- pharmacologic treatment
- illness self-management and recovery skills
- supported employment
- family psychoeducation and
- Assertive Community Treatment.

Most states face revenue shortages and are having to make critical decision about the allocation of scarce resources. So too, courts are finding community systems with diminished capacity to take on new clients. It is incumbent on decision-makers to ensure that available resources are spent in a way likely to achieve the desired outcomes. As key decision-makers, judges and other court personnel should be engaged in the process of building and sustaining resources for specialty courts.

Toward the goal of effective resource management, it is useful to understand what research has proved to work and to ensure, at a minimum, that these services are available to specialty court participants. This research base has allowed the development of treatment principles associated with positive outcomes for the general population with co-occurring disorders. On a cautionary

*As key decision-makers, judges and other court personnel should be engaged in the process of building and sustaining resources for specialty courts.*

note, the generalization of these principles to court-involved populations has not been fully established.

**Ten Principles of Care:** While historically mental health and substance abuse treatment approaches have been somewhat different, principles of care within the two fields converge on respect for the individual, reaching out to engage those who cannot yet trust, and the importance of community, family, and peers to recovery. These principles emerge from research and practice experience in providing services to persons with co-occurring disorders. They serve to bridge the gap between the service orientations and characterize an effective system of care for persons with co-occurring disorders. They can be used for both planning court orders and evaluating the quality of community providers.

1 principle of care

***Integration*** An integrated conceptual framework is needed to design an effective service system for persons with co-occurring disorders. For example, the court should recognize, and treatment should address, the interwoven nature of the disorders. This can be achieved by implementing the following procedures:

- Develop a common language for describing the target population;
- Develop a common methodology for describing categories of integrated services in the system based on the severity of disability;
- Assure that each disorder receives specific and appropriately intensive primary treatment that takes into account the complications resulting from the co-occurring disorders; and
- Identify a primary clinician, or team of practitioners, for each individual who has the responsibility of coordinating ongoing treatment interventions for both disorders.

While no specific model should assume to be generalizable across systems, the common goal should be for individuals with co-occurring disorders to get their needs comprehensively addressed within one setting, by one set of providers. Successful integrated efforts reduce conflicts between providers, eliminate administrative barriers to care, and assist the consumer by providing a consistent message about recovery principles (Minkoff, 1989).

2 principle of care

***Individualized Planning*** Any psychiatric disorder with any substance use disorder may occur in any person, regardless of age, gender, or socio-economic status. Effective responses must be tailored to the needs of the specialty court participant, instead of participants needing to fit the specifications of the program. Integrated continuous treatment relationships should be developed to support the participant with a balance of appropriate case management and care. The system should be created utilizing existing services and programs as much as possible, with matching of program to individual needs. Specialty courts should develop an implementation plan that identifies priorities for and barriers to change, and that recommends strategies to overcome barriers. This plan should be derived from:

- Identification of existing services for persons with co-occurring disorders and specification of the role of those services in the court orders;
- Identification of significant gaps in existing services that require new services, programs, and/or funding to address those gaps;
- Development of a process to modify conditions, procedures, regulations, or laws in order to create flexible programs; and
- Creation of an infrastructure empowered to oversee and direct the implementation process.

3 principle of care

***Assertiveness*** Successful programs recognize that co-occurring disorders are an expectation and not an exception. As such, efforts by specialty courts to assess and incorporate clinical conditions into treatment and release planning are

expected. It is often necessary to provide outreach services to engage individuals in treatment and assure compliance with release plans. Successful community programs use active interventions, such as mobile treatment so that "going wherever the client is" shapes the nature of the counseling relationship.

Intensive case management gives caseworkers smaller caseloads needed to devote considerable time to working with each client. One evidence-based program useful in work with the most disabled individuals is Assertive Community Treatment. This is ideally suited to addressing needs of homeless persons with co-occurring disorders. If available, this is likely to be a limited resource in most communities.

4 principle of care

***Close Monitoring*** This principle of care is well suited to court-based interventions where monitoring can be built in to conditions of supervision. Close monitoring refers to intensive supervision, usually with the participants' consent, but sometimes involuntarily, that follows compliance with treatment and court orders. Monitoring may already be a part of the participants' daily routine. For example, when accessing public entitlements, participants with substance-related disability payments might be required to have a representative payee. This person receives the monthly disability payment and helps the individual manage his or her funds to ensure that important bills (e.g., rent) are prioritized. Drug tests can be mandated and supervised by staff. Protocols for drug testing are in widespread use by drug courts throughout the country. While participants often express ambivalence or disdain about monitoring in the beginning, as they recover from substance abuse, they typically need less supervision.

5 principle of care

***Longitudinal Perspective*** Co-occurring disorders can be chronic conditions characterized by slips and relapse. The language of substance abuse treatment refers to "recovering," not "recovered" to convey the long-term process. Effective treatment occurs continuously over years and progress can be measured over that time. The court must determine what part it plays in this longitudinal course. Some would argue that conditions of release or probation sentences should not be in excess of what typical sanctions for defendants withouth mental illness would be. If the court can play a role in effectively linking participants to quality programs, it may well

*Effective treatment occurs continuously over years and . . . the court must determine [its role] in this longitudinal course.*

be necessary for this treatment relationship to continue after the court monitoring has ended.

6 principle of care

***Staged Interventions*** Persons with co-occurring disorders are typically in various stages of recovery with different levels of, and capacity for, motivation. Effective programs assess individuals with co-occurring disorders and design interventions for their stages in recovery. Osher & Kofoed (1987) provide a model with four stages of treatment:

- engagement
- persuasion
- active treatment
- relapse prevention.

*Engagement* is the process of forming a trusting relationship with the client. *Persuasion* is the process of helping the client develop motivation to participate in recovery-oriented programs. *Active treatment* provides skills training and other services that are necessary to achieve abstinence and medication compliance. *Relapse prevention* provides a set of strategies for maintaining recovery. Other models of treatment evaluate the individual's motivation for change and gear interventions to the assessed stage of change. Specialty courts can play an important role in motivating participants to engage in treatment, although long-term changes in motivation will need to be internalized.

*Specialty courts can play an important role in motivating participants to engage in treatment, although long-term changes in motivation will need to be internalized.*

7 principle of care

***Harm Reduction*** Harm reduction is a philosophy derived from clinical experience. It is based on the assumption that behaviors exist on a continuum—for example, that substance use runs from abstinence through problematic use to abuse and dependence. Central to this approach to care is a belief that if the quantity, frequency, or type of use is reduced, the likelihood of negative consequences will go down.

Harm reduction provides an alternative to the traditional "abstinence only" philosophies and is more likely to engage persons who at the onset cannot embrace abstinence, or the use of medication, as a goal. Harm reduction is the theoretical underpinning to needle exchange programs that use the delivery of clean intravenous equipment as an opportunity to engage the substance abuser in alternative behavior.

8 principle of care

***Stable Living Situation*** To address the needs of persons with co-occurring disorders, it is necessary to confront the affordable housing crisis in the United States. It is estimated that 15–20 percent of the homeless population has co-occurring disorders. Homeless persons are very visible in our communities, and are arrested frequently for vagrancy, panhandling, loitering, and public intoxication. "Mercy bookings" by law enforcement bring homeless persons to the shelter of jail when winter temperatures might otherwise kill them. Participants' homelessness will make any specialty court intervention very difficult to implement.

The absence of reliable transportation is also an important issue for many specialty court participants with co-occurring disorders and may prevent regular participation in treatment and court activities. Successful efforts to provide housing and to divert individuals who have co-occurring disorders from jails and prisons will require the participation and coordination of representatives from mental health and substance abuse administrators, criminal justice officials, and family and consumer advocates. Coordinated and integrated programs have been found to enhance continuity of care, improve clinical outcomes, and to reduce criminal recidivism (CMHS, 1995).

9 principle of care

***Cultural Competency*** Inadequate consideration of culture and ethnicity, as well as frequent misdiagnosis of behavioral disorders, are common phenomena experienced by persons of color in the justice system. In a consumer/family-oriented system for persons with co-occurring disorders, the service goal is to ensure that each clinical contact is welcoming, empathic, hopeful, culturally sensitive, and consumer-centered. Special efforts should be made to engage persons who may be unwilling to accept or participate in recommended services, or who do not fit into the available program models. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2000) within the Department of Health and Human Services has defined cultural competency as:

> *An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.*

*Specialty courts and their health care partners should implement strategies to recruit, retain, and promote . . . a diverse staff and leadership that are representative of the demographic characteristics of the service area.*

Specialty courts and their health care partners should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. They should also ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

10 principle of care

***Optimism for Change*** Growing evidence indicates that persons with co-occurring disorders who receive services based on the aforementioned principles have positive outcomes. This is in contrast to the attitudes among many court personnel, providers, families, and consumers, which can undermine the goals of specialty courts and treatment systems. In its application of therapeutic jurisprudence, the specialty court can advance optimism by sharing the belief that because the participants' problems are severe, they deserve help and by creating a vision of what a hopeful outcome might be. Every specialty court participant, regardless of the severity and disability associated with his or her co-occurring disorders, is entitled to experience the promise and hope of recovery.

*Key areas for specialty court modification:*

- *Screening and assessment*
- *Education*
- *Monitoring*
- *Graduated sanctions*
- *Community treatment providers*
- *Crisis response*

## Section 4
# Modification and Enhancement of Specialty Courts for Co-Occurring Disorders

The ability of specialty courts to address mental health and substance abuse issues will vary according to the functioning level of participants with co-occurring disorders and the level of program resources. However, all specialty courts should provide several "core" modifications to services for participants with co-occurring disorders that address their unique needs. A number of evidence-based practices have been established that can help guide specialty courts in designing program modifications to provide these basic services. Key areas for specialty court modification include the following:

- Screening and assessment approaches that examine both mental health and substance abuse content.
- Education regarding mental and substance use disorders.

- Medication monitoring and drug testing.
- Flexible application of graduated sanctions to accommodate the effects of mental disorders and other individual needs of program participants.
- Liaison with other community mental health and substance abuse treatment providers.
- Court hearings and judicial monitoring approaches that provide a rapid response to potential crises and
- Specific court-ordered requirements for mental health and substance abuse services.

Depending on the level of program services available, some specialty courts will be able to provide further enhancements to services to include integrated treatment components (e.g., co-occurring disorder groups or "tracks") designed to address the unique needs of participants who have co-occurring disorders. Specialty courts that provide more intensive program enhancements may choose to implement a number of structural and clinical approaches that have been used effectively in justice settings. Many of these enhancements do not require new program resources, and can be accomplished through reorganizing existing services.

Enhanced supervision and treatment approaches are generally longer, more intensive, slower paced, more flexible, and accommodate various cognitive impairments in implementing sanctions, treatment groups, and other services.

***Modified Drug Courts*** Several drug courts have successfully implemented separate program "tracks" for participants who have co-occurring disorders, or have developed separate programs for this population. These enhanced programs provide a blended set of mental health and substance abuse services, and use a "phased" approach that includes sequenced interventions focusing on orientation, intensive treatment, and relapse prevention and transition. Other major program enhancements for specialty courts include enriched motivational interventions, greater use of individual counseling, on-site psychiatric consultation, intensive case management and outreach services, and community supervision teams that include smaller case loads and staff who are trained in co-occurring disorders. The following section describes several modified services that should be provided by all specialty courts working with individuals who have co-occurring disorders. Subsequent sections describe enhancements to specialty courts beyond this "core" set of modified services, and implementation strategies for developing program enhancements.

*Several drug courts have . . . separate "tracks" for participants with co-occurring disorders ... [with] programs [that] provide a blended set of mental health and substance abuse services . . .*

## Modified Services for Co-Occurring Disorders in Specialty Courts

*Screening and Assessment* Mental health and substance abuse screening should be conducted prior to all specialty court program admissions. Routine screening for both disorders is warranted due to the high rates of co-occurring disorders among specialty court participants, and to the negative consequences for non-detection of these disorders. Screening for mental health and substance abuse problems should be completed at the earliest possible point, so that impairment in functioning and suitability for the program can be determined, and timely referrals made for mental health services. Early detection of behavioral health problems also increases the likelihood of stabilization of symptoms, and for placement in community treatment settings.

Acute effects of drugs and alcohol often are indistinguishable from mental health symptoms, and may cloud the true extent of mental health problems until a period of abstinence has been achieved. Ideally, to obtain the most valid results, screening for co-occurring disorders should be delayed until an individual reaches sobriety. However, this approach is impractical in many cases, and some information is needed quickly to make a determination regarding specialty court eligibility. In most cases, important

### How Drug Courts Can Modify Screening for Co-Occurring Disorders

In addition to substance abuse information routinely collected by drug courts, mental health information that should be gathered during *screening* includes the following (Peters & Bartoi, 1997):

- Acute mental health symptoms (e.g., depression, hallucinations, delusions).
- Suicidal thoughts and behavior.
- Age at which mental health symptoms began.
- History of mental health treatment and use of psychotropic medication.
- History of trauma such as sexual/physical abuse.
- Family history of mental illness.
- Chronology of mental and substance use disorders.
- Motivation for treatment of mental and substance use disorders.

### How Drug Courts Can Modify Assessment for Co-Occurring Disorders

In addition to substance abuse information routinely collected by drug courts, mental health information gathered during *assessment* includes the following (Peters & Bartoi, 1997):

- Chronology of mental and substance use disorders.
- Interactive effects of substance abuse and mental disorders (e.g., exacerbation of symptoms, masking symptoms).
- Cognitive impairment (e.g., ability to process information and to communicate an understanding of concepts related to treatment).
- Impairment in abilities to handle stress, and to interact with staff and other participants in treatment activities.
- Perceived level of mental health problems.
- Results from previous court-ordered evaluations related to mental health issues.

screening and assessment information can be obtained even if an individual has recently used drugs or alcohol.

In some jurisdictions, specialty courts may be able to obtain information regarding prior involvement in community mental health treatment services through cooperative arrangements developed by the jail, court services, or between treatment providers. Efforts should also be made to acquire as much information as possible from previous court cases and court-ordered evaluations (e.g., related to the medication history, history of violence, significant others who can serve as resources). Release forms should be routinely signed by specialty court participants in order to obtain this type of information.

Behavioral health screening and assessment should focus on areas of functional impairment that would prevent effective participation in the specialty court program and should not focus on ascertaining precise diagnoses or specific symptoms in the absence of attempts to understand their relation to specialty court functioning. Key functional areas to be examined include

- ability to process information from homework
- ability to process information from counseling
- ability to process information from other treatment activities
- ability to communicate difficulties in comprehending information to staff
- ability to communicate effectively with treatment staff and other program participants
- ability to handle stress (e.g., criticism, confrontation)
- reading skills
- ability to interact effectively in group settings (e.g., process groups, community meetings)

Similar or standardized screening and assessment instruments for co-occurring disorders should be used across different justice settings, including specialty courts. This approach will promote greater awareness of co-occurring disorders and needed treatment interventions, and can reduce unnecessary repetition of screening for individuals identified as having co-occurring disorders. Several recommended instruments for screening and assessment of co-occurring disorders are described in a monograph developed by the National GAINS Center (Peters & Bartoi, 1997).

*Judges, supervision staff, treatment staff, and other specialty court staff must be aware of changes in the participant's living arrangements, treatment plan, medications, and in other treatment services.*

*Unless there are significant public safety risks, incarceration should be used sparingly as a specialty court sanction for participants with co-occurring disorders.*

Although specialty court programs will certainly benefit from careful screening and assessment of participants who have co-occurring disorders, and matching these individuals to appropriate levels of services, identification of co-occurring disorders can potentially lead to stigmatization and reluctance to participate in program activities. Caution should be used in labeling specialty court participants as "mentally ill," or with other diagnostic labels (e.g., "schizophrenic"). Although mental health diagnoses are inevitably used in the assessment and treatment planning process, they often inaccurately imply a level of functional impairment that may not be present. In addition, these diagnoses are often interpreted incorrectly as evidence of a permanent condition, when in fact mental health symptoms are frequently controlled quite effectively by medication. Use of mental health labels can augment the stigma and shame experienced by participants who have already been identified as substance abusers and offenders.

***Education Regarding Co-Occurring Disorders*** Education should be provided to all specialty court participants regarding mental and substance use disorders. This can be provided in psychoeducational groups, individual counseling sessions, and/or through assigned homework that may include reading and exercises. Educational content may address the interactive nature of co-occurring disorders; symptoms and diagnoses related to mental and substance use disorders; the prevalence, course, and treatment of these disorders; medications used to treat mental and substance use disorders; side effects of medications; interaction of medications and alcohol/illicit drugs; and available community treatment resources, including peer support groups. Several psychoeducational modules are available that have been used effectively in community treatment settings (Mueser, et al., 2003; Mueser & Fox, 1998; Peters et al., 2002).

***Medication Monitoring and Drug Testing*** For specialty court participants with co-occurring disorders who are not currently receiving mental health services, an initial psychiatric consultation and assessment should be provided to review the need for medication. Ongoing psychiatric services are needed to evaluate and monitor the use of prescribed medications, to provide education regarding the interactive effects of medication with alcohol and illicit drugs, and to discuss side effects and medication adherence issues.

Psychiatrists also can provide support for the continued use of medication while participants are involved in peer support groups. Routine and random drug testing

**Judicial Orders Related to Specialty Court Participation**

The following types of *court-ordered conditions* have been found to be useful for individuals with co-occurring disorders who are supervised in judicial settings:

- Complete a psychological evaluation to determine the extent of mental health problems.
- Comply with recommendations for treatment described in the psychological evaluation.
- See a psychiatrist, if recommended in the psychological evaluation.
- Take medications, if prescribed by the psychiatrist.
- Complete a substance abuse evaluation.
- Attend substance abuse treatment as recommended in the evaluation.
- Abstain from use of alcoholic beverages and illegal drugs.
- Refrain from visiting businesses whose major source of income is the sale of alcoholic beverages.
- Report to the community supervision staff as ordered.
- Abide by standard orders of curfew.
- Comply with other community supervision orders (e.g., fees, victim restitution).
- Sign a release/waiver of information form to allow access to records describing prior treatment and medication use.
- Attend the next scheduled case review/hearing.

is warranted for all specialty court participants. This is typically provided twice weekly during early, more intensive phases of treatment, and once weekly or biweekly during later stages of treatment.

***Graduated Sanctions*** As is the case among other specialty court participants, those with co-occurring disorders will benefit from implementation of graduated sanctions that are imposed swiftly, that establish a clear and measured connection between the behavioral infraction and the response, and that are applied consistently over time. It is generally useful to employ a team approach in developing effective sanctions for specialty court participants with co-occurring disorders, with staff included on the team who are trained in both mental health and substance abuse issues.

Flexibility is needed in responding to behaviors that may be affected by the co-occurring disorders, such as missed appointments due to the sedative effects of psychotropic medications or agitation due to withdrawal from street drugs. Thus, judges, supervision staff, treatment staff, and other specialty court staff must be aware of changes in the participant's living arrangements, treatment plan, medications, and in other treatment services. Incarceration should be used sparingly as a specialty court sanction for participants with co-occurring disorders. Unless there are major public safety risks present, these participants should be incarcerated for only brief periods, and should be rapidly involved in jail mental health and other related services to insure adequate continuity of medication and to address other treatment needs.

***Liaison with Community Treatment Agencies*** In many cases, specialty courts will not be able to provide a full set of on-site integrated mental health and substance abuse services for participants who have co-occurring disorders, and these services will be provided by other community treatment agencies or individual practitioners. Specialty courts will need to establish contact with these agencies and practitioners to routinely obtain results of assessment and court evaluations, and to monitor progress in treatment. Specialty courts have often found it useful to include these ancillary treatment providers in treatment team meetings. Memoranda of agreement and other affiliation arrangements can be developed between specialty courts and other community treatment providers to facilitate open communication and information exchange.

***Court Hearings and Judicial Monitoring*** Specialty court status hearings and related treatment team meetings may need to be conducted more frequently for participants who have co-occurring disorders, in order to respond quickly to changes in mental health symptoms and in patterns of medication adherence and involvement in treatment. Following an initial hearing to establish conditions of specialty court participation, another hearing may be needed to impose more specific components of the treatment plan, such as requirements to obtain mental health services. Court hearings provide a good opportunity to recognize and reward even small positive changes in behavior, such as attendance at treatment activities, improvements in personal hygiene, increased periods of abstinence, and involvement in work or vocational training. With the consent of the specialty court participant, family members should be engaged in the treatment process and encouraged to assist the court in monitoring the participant's behavior. Family members may also be recognized during hearings for their contributions to assist specialty court participants.

Conditions of participation in specialty court programs are useful in defining program expectations and promoting successful completion of co-occurring disorders treatment services. These conditions optimally provide a blend of specific requirements (e.g., drug testing twice weekly) and more general guidelines (e.g., complete a mental health and/or substance abuse assessment and enroll in treatment as required by the treatment provider), to enhance the flexibility of community treatment agencies and supervision staff in developing recommendations based on information that may not be available at the time of matriculation to the program. Conditions of specialty court involvement should specify that participants regularly report to supervision staff and/or the court, who can monitor their progress and "flag" any problems that occur.

### Structural Enhancements to Co-Occurring Disorders Services

Specific *structural program enhancements* for individuals with co-occurring disorders include the following:

- A higher staff-to-client ratio is used, with more mental health staff integrated into treatment groups. Treatment staff have smaller caseloads.
- Staff provide significant monitoring and coordination of treatment activities.
- All staff are cross-trained, with mental health staff trained in self-help approaches and stages of recovery, and reoriented to the role of staff as guides or facilitators rather than "treatment" providers. Substance abuse staff are trained in mental disorders and diagnoses, pharmacotherapy, and in adjusting their treatment approaches to accommodate slower rates of behavior change, lower motivation and commitment to treatment, and reduced responsivity to interventions.
- At least one year of treatment services is provided, with the potential for ongoing involvement in treatment.
- Movement through the program and specific treatment activities is more individualized.
- Rewards (e.g., verbal praise, privileges) are delivered more frequently. The pace of treatment activities is slower.
- Treatment groups and other activities are of shorter duration, and more breaks are provided.
- Information is provided more gradually, and supplemental group or individual sessions are used to consolidate information.
- There is more overlap in activities, with planned repetition of material both within and between groups.

### Clinical Enhancements to Co-Occurring Disorders Services

Specific *clinical program enhancements* for individuals with co-occurring disorders include the following:[2]

- More emphasis is placed on psychoeducational and supportive approaches than on confrontation and compliance. However, as the court is ultimately responsible to protect the public safety, the specialty court participant is informed that he or she has the primary responsibility for compliance with program requirements.
- Groups that include significant confrontation are replaced by conflict resolution or "community" groups, with more emphasis on affirmation of progress and individual change efforts.
- More individual counseling is provided.
- Exercises, skills training, and didactic activities tend to minimize the need for abstraction and are presented using basic concepts and terminology.
- Outlines are used for all treatment sessions and include explicit learning objectives.
- Instructions provided to guide homework, exercises, and other activities are brief.
- Frequent testing is provided to assess knowledge acquisition.
- Participants engage in "role preparation" to help prepare for unexpected circumstances.
- Participants demonstrate the ability to perform skills during staff-supervised sessions.
- Role-play activities are typically brief and focused on specific situations or scenarios.
- Staff provide specific feedback regarding how to apply treatment principles and techniques.
- Audiovisual aids are used frequently in groups, including illustrations and "concept mapping."
- Memory enhancement strategies are provided, including use of notes, tapes, and mnemonic devices.

## Enhancements to Specialty Courts for Co-Occurring Disorders

Specialty courts interested in a more active service role can consider the following program enhancements to supplement the "core" set of modified services described in the previous section. These changes do not always require additional staff or financial resources. For example, specialty courts may consider redirecting resources to more efficiently address the treatment needs of participants with co-occurring disorders through implementation of co-occurring disorder groups, case management services, or other types of interventions. Alternatively, specialty courts may elect to augment existing services to provide additional "tracks," "groups," psychiatric consultation, case management, or counseling services. The following section describes several different approaches to enhance or modify specialty courts to better address the needs of participants with co-occurring disorders.

Several program enhancements have been developed for individuals with co-occurring disorders who are participating in specialty courts and other types of forensic/justice services. These enhancements are quite consistent with principles of effective correctional treatment programs (Gendreau & Ross, 1984; Gendreau, 1996), and have been applied successfully with individuals who have co-occurring disorders in various treatment settings.

***Treatment Services*** Specialty court programs for participants who have co-occurring disorders may require more than a year of involvement in services. This extended period may be needed to provide for adequate engagement in treatment, stabilization on medications, linkage with ancillary community services, and to achieve sustained abstinence.

Specialty courts may need to be flexible in the amount of time allowed participants to progress to different phases of treatment and in criteria for graduation to different phases. Specialty courts that are not able to provide extended program involvement for individuals with co-occurring disorders may elect to provide extended tracking and case monitoring (e.g., through specialized case management services) to insure that participants are engaged in community services, are taking prescribed medication, and remain abstinent. Specialty courts may also need to provide some flexibility to allow participants with co-occurring disorders to exit the program and re-enter as needed, following periods of more intensive mental health treatment or hospitalization.

*Specialty courts may need to be flexible in the amount of time allowed . . . [and] to allow participants with co-occurring disorders to exit the program and re-enter as needed*

Where supplemental services are available for participants with co-occurring disorders, specialty courts should, at minimum, accommodate the needs of these individuals through modifying existing services, as described in the previous section. Depending on the level of symptom severity, it may not be necessary for participants to leave the specialty court treatment setting to receive these services. For example, if cross-program consultation services are provided, supplemental needs (e.g., mental health counseling) may be addressed effectively within the specialty court setting. Similar collaborative arrangements can be made for individuals who are identified during the course of mental health treatment as having a serious substance abuse problem.

***Group Treatment Components*** Group treatment components for specialty court participants with co-occurring disorders include education about their diagnoses and disorders, including review of biological, risk, and protective factors related to these disorders; discussion of key psychotropic medications, side effects, and interactions with the use of alcohol and illicit drugs; review of the interdependent nature of mental and substance use disorders; motives and consequences related to substance abuse; and relapse prevention approaches and techniques.

A range of cognitive and behavioral skills are also commonly taught in group treatment settings, including problem solving skills, communication skills, anger management, stress management, drug coping skills (e.g., dealing with active users, drug refusal skills), and effective strategies for collaborating with mental health professionals. Relapse prevention approaches that have been developed within substance abuse treatment settings can be readily adapted for treatment of co-occurring disorders. Strategies include identification of "red flags" for substance abuse relapse and recurrence of mental health symptoms and strategies to respond to these relapse warning signs.

More intensive specialty court programs for co-occurring disorders are likely to include several phases, or stages of treatment. The scope, frequency, and duration of these program phases will vary according to available resources, although most existing programs provide the following general sequence of phased activities:

- Orientation
- Intensive treatment
- Relapse prevention and transition

*More intensive specialty court programs for co-occurring disorders are likely to include several phases, or stages of treatment. Most programs provide the following:*

- *Orientation*
- *Intensive treatment*
- *Relapse prevention and transition*

### Key Features of Group Treatment

Group treatment for co-occurring disorders tend to share the following substantive features:

- A *highly structured therapeutic approach* is used, that includes significant staff supervision and involvement, and a highly organized and focused daily schedule of activities.
- Attempts are made throughout treatment activities to *destigmatize mental illness*. Mental and substance use disorders are presented as manageable life problems that are experienced by many individuals. Biological, emotional/ psychological, and behavioral aspects of the disorders are reviewed to "demystify" mental disorders.
- Treatment groups *focus on symptom management versus "cure,"* presenting recovery as a long-term process. Relapse prevention approaches provide a useful model to conceptualize management of the co-occurring disorders, similar to approaches used with other health disorders (e.g., diabetes, heart disease).
- *Education* is provided regarding participant's mental disorders, diagnoses, and the interactive effects of co-occurring disorders. Attempts are made to "normalize" the fact that participants have a mental disorder, and key information is provided about medications and medication side effects, and effects of substance use on medications and mental disorders.
- For participants with ingrained criminal belief systems, some programs have offered *"criminal thinking" groups* that are useful to assist participants in identifying maladaptive "criminogenic" beliefs and to learn cognitive strategies to modify these beliefs and associated behaviors.
- Basic *life management and problem-solving skills* are provided to address a range of psychosocial deficits in areas of social skills and communications skills, anger management, assertiveness, leisure skills, stress management, nutrition, and managing personal finances.

An assumption underlying orientation activities is that specialty court participants have not yet committed themselves to making major lifestyle change. As a result, the orientation phase should include a comprehensive assessment of co-occurring disorders and other related psychosocial areas (including motivation and commitment to the recovery process) and a focus on persuasion and engagement interventions, development of a treatment plan or contract, introduction to the recovery process, and frequent appearances before the court.

Intensive treatment phases include individual and group activities that use a supportive and psychoeducational approach and that have a focus on life skills and other important coping and self-management skills. Participants in this phase are expected to take "action steps" towards lifestyle change and recovery goals. In the final phase of program activities, participants receive advanced skills in relapse prevention and often help to develop a relapse prevention plan (or "contingency" or "emergency" plan). A transition plan is also developed to help guide linkages to community treatment, engagement with the self-help community, and to mobilize resources to assist with housing, employment, and economic support. Case managers or transition coordinators are often actively involved in these activities, and work closely with community supervision staff in developing the transition plan.

***Families and Treatment*** Family members often welcome the leverage provided by the court in engaging participants in structured treatment and supervision activities. Specialty courts can provide counseling and support services to family members to assist them in monitoring participant's medication use and signs of relapse, and in managing crisis situations.

Group and individual treatment interventions should reflect the unique styles and concerns of cultural and ethnic groups that participate in the specialty court, particularly as the styles and concerns relate to mental health treatment; involvement of the family in treatment; and issues related to shame, guilt,

and self-disclosure of mental health and substance abuse symptoms. Specialty courts can also provide education for family members about co-occurring mental and substance use disorders, and should, with the participant's consent, attempt to involve family members or significant others (e.g., those residing with the participant) in treatment planning and monitoring. Group dynamics may be disrupted if participants with co-occurring disorders are perceived as receiving "favored" treatment by the court. For this reason, all participants should be advised of the unique needs of their peers who have co-occurring disorders and the unique treatment, supervision, or sanction approaches that have been developed by the specialty court for use with individuals who have these disorders.

***Co-Occurring Disorder Groups and Program Tracks*** Although some specialty courts have attempted to exclude those with co-occurring disorders, in reality, a large proportion of specialty court participants have co-occurring disorders that may often go undetected and that may not be addressed in treatment. In order to best meet the needs of this population, specialty courts would optimally develop focused co-occurring disorder services or "tracks," requiring additional planning, staff resources, training, supervision, and space, in many cases. These tracks may include several variations: 1) mental health services that are provided concurrently with other specialty court services; 2) "parallel" sets of services, or "transition" tracks, in which participants receive specialized mental health services for a period of time, and then are "mainstreamed" with other specialty court participants; and 3) supplemental or "booster" services that include individual counseling, psychiatric consultation, and other mental health supports to participants. These tracks have been developed in both mental health courts and drug courts. In some cases, freestanding specialty court programs have been developed for individuals with co-occurring disorders. For specialty courts that contract with community agencies to provide treatment services, co-occurring disorder tracks can be embedded in existing mental health or substance abuse programs.

***Motivational Interventions*** Research indicates that persons with co-occurring disorders experience considerable fluctuation in their motivation and commitment to lifestyle and behavior change, particularly during early phases of treatment. Despite their attendance in treatment, specialty court participants and others with co-occurring disorders are often not fully committed to the idea of becoming abstinent during early stages of treatment (Drake, Rosenberg, & Mueser, 1996), and require involvement in ongoing activities to promote motivation. If unaddressed, these issues are likely to lead to non-adherence to treatment and dropout from specialty court programs.

Early phases of specialty court treatment should be designed to enhance motivation for treatment, and motivation levels should be monitored periodically over an extended period of time. The provision of adjunctive services (e.g., economic assistance, housing, employment, child care), the removal of other barriers to participation in treatment, and leveraging involvement in treatment through the courts, where appropriate, can all serve to encourage participant's engagement in specialty court programs. During initial phases of specialty court programs, strategies to address motivation and engagement will often be the primary focus of treatment, particularly for participants with co-occurring disorders. These include Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) approaches or groups, and "persuasion groups" that examine the interactions between co-occurring disorders and promote motivation to address substance use disorders (Mueser, et al., 2003). Several MET curricula are described in the resource section of this monograph.

Contingency contracting and related "voucher" approaches have been used successfully to engage and retain individuals in treatment who are at high risk for dropout (Onken, Blaine, & Boren, 1993). These approaches often use non-cash items of value to reward specific treatment-related behaviors, such as maintaining clean drug test or attending treatment groups. Rewards can be tapered off as individual treatment goals are met.

***Individual Counseling*** Specialty court participants who have co-occurring disorders may need more frequent involvement in individual counseling to address negative moods, personal stressors, and recurrence of mental health or substance abuse

symptoms. Individual counseling may also provide an opportunity to explore in more detail issues that were originally addressed in group treatment, such as "high risk situations" for relapse, and development of life skills or cognitive-behavioral skills. Individual sessions can also provide a useful forum to discuss progress and participation in specialized services (e.g., use of medications, involvement in peer recovery groups).

***Medication Monitoring and Drug Testing*** Psychotherapeutic medications are quite effective in reducing the symptoms of major mental disorders such as depression, bipolar disorder, and schizophrenia. Most of the currently prescribed medications have few serious side effects when combined with alcohol or drug use, and generally do not affect drug test results. Use of psychotherapeutic medication does not violate abstinence-based treatment policies, and self-help groups such as AA/NA have explicit policies that support the use of such medication by those in recovery.

Psychiatric consultation should be provided during the initial assessment to examine the need for psychotropic medication and to determine if the effects of medication may be compromised by current or recent patterns of substance abuse or if medications may be contraindicated by these potential interactions. Specialty court participants who have co-occurring mental disorders often require periodic evaluation by a psychiatrist to examine adherence to medication, to determine whether their medication should be continued, and if so, to determine whether the dosage should be modified. Peer support and counseling services may also be quite useful in managing medication adherence.

Over the course of treatment, specialty court participants should be educated about their need for medication, the rationale for being prescribed specific medications, potential side effects, and about the effects of continued substance abuse on their use of medication. Education and training is also needed for specialty court staff and participants regarding:

- the nature of co-occurring disorders
- mental health diagnoses and symptoms
- the purpose and use of psychotherapeutic medication
- the difference between medication and street drugs
- the need to preserve confidentiality, and
- strategies for handling confrontation related to medication use that may occur within community self-help groups.

Information is also needed regarding the effects (e.g., addictive) of psychotropic medications prescribed for specialty court participants, differences between psychotherapeutic medications and narcotics/illicit drugs, and the effects of prescribed medication on drug test results.

Frequent and random drug testing is an important component of treatment for specialty court participants who have co-occurring disorders and can provide early detection of substance abuse problems before they result in a full-blown relapse. Specialty courts frequently provide testing through either the collaborating treatment or supervision agency, and some courts have on-site testing labs or other testing capability (e.g., via quick screens) in the courtroom. Specialty court participants often report that the presence of drug testing enhances their motivation to remain abstinent and provides tangible evidence to the court of their continuing sobriety.

***Case Management and Outreach Services*** Case management services are particularly useful in working with specialty court participants who have co-occurring disorders and other individuals who are at "high risk" for homelessness, unemployment, chronic health problems, and criminal recidivism. Case managers often negotiate contact across various service systems and link together services that are not addressed in other treatments, including housing, vocational rehabilitation, community mental health services, and evaluation of eligibility for Medicaid/SSI or other financial entitlements.

Case managers are also well positioned to coordinate and monitor scheduled appointments and provide important linkages with the court and community supervision. Another important responsibility is coordination with family members or other

care providers to ensure that basic needs (e.g., housing, transportation) are met and to monitor medication use, symptoms of co-occurring disorders, and other behavior problems.

TASC (Treatment Alternatives for Special Clients) programs have provided offender case management and linkage services in many jurisdictions and have worked effectively with specialty courts and offenders. Case managers working with participants with co-occurring disorders generally are assigned smaller caseloads and have the capability of tracking participants through different phases of the specialty court program and during the transition to follow-up community services.

***Community Supervision:*** Supervision of specialty court participants with co-occurring disorders involves monitoring active symptoms and high risk situations related to both disorders, responding to infractions and violations, referral to treatment, and monitoring involvement in treatment and other services. In general, supervision of specialty court participants who have mental health problems is likely to require smaller caseloads and more intensive services. This will include more frequent monitoring of their functional status, mental health symptoms, motivation and commitment to treatment, and adherence to medications and other treatment requirements. This intensive monitoring will need to include frequent contact with family members, friends, and other collaterals, particularly those who live and work with the specialty court participant. Consent should always be obtained from the specialty court participant prior to contacting any supports.

Supervision staff should carefully monitor even moderate levels of alcohol or drug use, which may trigger recurrence of mental health symptoms and behavior problems (e.g., criminal behavior) among individuals who have co-occurring disorders. Supervision staff should also be familiar with co-occurring disorders treatment approaches, including integrated treatment models, cognitive-behavioral and skills-building approaches, and common psychotropic medications and their side effects. Supervision staff can play a pivotal role in monitoring medication compliance and communicating with both the participant and the psychiatrist about medication issues.

At the procedural level, outstanding or "fugitive" warrants issued for specialty court participants with mental disorders should receive priority for enforcement by local law enforcement officers. Warrants should be flagged to alert the arresting officer that participants have a history of co-occurring disorders, and of

*Conflicts sometimes arise between court, treatment, and supervision staff . . . that can be addressed through treatment teams and other regular meetings [with] representation from all participating agencies.*

### Summary of Effective Supervision Strategies

Effective supervision approaches with specialty court participants who have co-occurring disorders include the following:

- Dedicated specialty court supervision caseloads are provided that consist of participants who have mental and substance use disorders. Caseloads should be smaller than ordinary to accommodate the need for more intensive supervision, monitoring, and ongoing contact.
- Use of multidisciplinary teams to monitor progress towards supervision and treatment goals and to respond to infractions and other offenses.
- Ongoing monitoring is provided of mental health and substance abuse symptoms through observation, contact with the participant and collaterals (e.g., family members), and frequent drug testing.
- Ongoing monitoring is provided to assess adherence to prescribed medication. Liaison is provided with the psychiatrist and other mental health and treatment staff regarding symptoms and behaviors related to mental disorders, adherence to medication, and to assist in evaluating the effectiveness of medications and to request information regarding prescribed medication and changes in medication.
- Regular updates are provided to the specialty court regarding participant progress and deviation from program rules and guidelines.
- Participants are referred to a psychiatrist when undesirable behaviors, moods, or thought patterns are detected that may be responsive to medication.
- Supervision staff reinforces the importance of medication compliance with participants.
- Staff have the ability to schedule hearings before the court to address concerns related to treatment and supervision.
- A proactive role is taken in scheduling court and supervision appointments.
- Supervision staff promote the participant's involvement in a highly structured set of daily activities and development of planning skills to organize daily activities.
- Special service needs (e.g., individual counseling, transportation, housing, medical care, vocational support) are recognized and addressed.
- Clear and concrete directives are provided regarding specialty court guidelines, with frequent repetition and monitoring to determine the participant's level of understanding.
- A supportive rather than confrontative approach is used in addressing mental health and substance abuse problems, and in monitoring adherence to program guidelines. Verbal praise and other support is provided for small successes and indicators of progress.
- Expectations are adjusted regarding the response to supervision to reflect the potentially disruptive effects of mental health symptoms, with flexibility provided in responding to infractions (e.g., missed appointments).

the presence of related behavioral problems. This will allow the officer to take preventive steps (e.g., arranging for backup support), particularly if there is a history of violence related to the co-occurring disorders.

Specialty court participants with co-occurring disorders are likely to have some level of cognitive impairment (e.g., difficulties in attention and concentration, memory, abstract reasoning, problem solving, and planning ability) that affects their level of engagement in treatment and supervision. For example, these participants may not understand or remember critical information regarding their treatment requirements, or obligations related to their court and community supervision (e.g., dates of hearings or appointments), and may not recognize the full range of consequences resulting from violations and other criminal behavior. As a result, instructions may need to be repeated several times and regular written reminders provided of upcoming appointments and consequences of

### Key Training Issues Related to Co-Occurring Disorders

Key training issues related to co-occurring disorders that should be addressed for specialty court staff include the following:

- Identification of signs and symptoms of mental illness and substance abuse.
- Awareness of the range and scope of mental disorders (e.g., diagnostic categories and definitions, course of disorders, cognitive symptoms).
- Strategies for treating and managing participants who have personality disorders (e.g., Borderline Personality Disorder)
- Treatment and supervision approaches for participants with a history of trauma and physical, sexual, or emotional abuse.
- When and how to arrange for mental health evaluation.
- Characteristics of psychotropic medications (e.g., commonmedications for different disorders, side effects), interactive effects of medications with drugs and alcohol, and effects of medications on drug testing.
- Identification of existing community treatment resources and ancillary services.
- Strategies for accessing community treatment resources and ancillary services.
- Use of supportive rather than confrontative treatment and supervision approaches.
- Development and use of an integrated system of sanctions and treatment to respond to critical incidents.
- Adjusting expectations regarding outcomes of supervision (e.g., developing long-term goals of abstinence).
- Flexibility in responding to noncompliance with community supervision rules (e.g., missed appointments).
- Strategies to avoid staff burnout.

infractions and noncompliance with treatment requirements. Specialty court participants with co-occurring disorders are likely to be more disorganized than other participants and would benefit from considerable daily structure and external monitoring to insure adherence to rules and regulations.

Specialty court participants who have co-occurring disorders may not respond favorably to confrontation, and judicial, treatment, and supervision approaches should focus on goals of engagement rather than on punishment. In general, treatment and supervision requirements should reflect the participant's level of functioning, with flexibility provided to adjust these requirements according to demonstrated abilities to handle confrontation, group interaction, and to provide sustained attention during treatment and other required activities (Pepper & Hendrickson, 1996).

Conflicts sometimes arise between court, treatment, and supervision staff related to sharing of information, critical incidents, and progress in treatment. Specialty court participants who have personality disorders may attempt to augment these tensions and conflicts through their interaction with various staff to obtain less restrictive sanctions, privileges or special consideration, or other favorable disposition of incidents that may occur. These potential areas of conflict can be addressed productively through use of treatment teams and other regular meetings that include representation from all participating agencies.

These meetings provide a vehicle to share information about the participant's status, level of engagement in treatment, to review critical incidents, to develop appropriate sanctions, and to update the treatment and

supervision plan. Relapse prevention approaches often provide a unifying organizational structure, theme, and vocabulary for these treatment teams (Clear, Byrne, & Dvoskin, 1993; Peters, 1994), and are particularly helpful in developing strategies to address specialty court participants who have co-occurring disorders.

***Staff Training*** Treatment, court, and supervision staff working in specialty courts should receive training in issues related to co-occurring disorders, including issues related to medication management, abuse and trauma issues (particularly salient for female participants), community outreach and crisis stabilization services, and linkage to community treatment. In the absence of advanced training, staff may interpret unusual and unpredictable behaviors related to mental disorders as noncompliance with treatment or supervision rather than as indicating the need for mental health treatment.

Judicial training should address the types of questions related to mental health issues to ask participants at court hearings. Additional judicial training should be provided regarding the types of problems that are typically encountered by individuals with various types of mental disorders and how different levels of cognitive and physical functioning may influence behavior in treatment, supervision, and in status hearings. Supervision staff should have significant prior work experience with traditional probation caseloads to work effectively with participants who have co-occurring disorders.

Cross-training should be provided for community supervision staff, case managers, treatment staff, and others who provide services for specialty court participants with co-occurring disorders. Through this process, the different professional disciplines can advise each other of key strategies for supervision, management, and treatment of participants who have co-occurring disorders. For example, community supervision staff can review the type of information related to critical incidents (e.g., positive drug screens, recurrence of mental health symptoms) that should be reported to the court. Cross-training also provides an opportunity to understand the goals and missions of cooperating agencies, and to develop strategies for sharing information and accessing services. Whenever possible, training should also be provided to family members or other care providers who work with specialty court participants.

*All specialty courts will need to address critical issues related to the treatment, management, and supervision of participants with co-occurring disorders, whether these are addressed early and in a planned manner, or later, during periods of crisis.*

# Section5
# Conclusion

A significant number of individuals in the justice system have co-occurring mental and substance use disorders, including many participants in specialty court programs. Although some specialty courts attempt to exclude these individuals, co-occurring disorders are often undetected for a period of time before coming to the attention of court personnel. Mental health and substance abuse problems that are not initially addressed tend to worsen over time and require far greater program resources if dealt with during periods of acute crisis rather than as an integrated, ongoing part of specialty court programs. In reality, all specialty courts will need to address critical issues related to the treatment, management, and supervision of participants with co-occurring disorders, whether these are addressed early and in a planned manner, or later, during periods of crisis.

Although the ability of specialty courts to address these issues will vary according to the functioning level of participants with co-occurring disorders and the level of program resources, all specialty courts should provide several "core" services for this population that address their unique needs. A number of evidence-based practices have been established that can help guide specialty courts in designing program modifications to provide these basic services. Key areas for specialty court modification include the following:

- Screening and assessment approaches that examine both mental health and substance abuse content.
- Education regarding mental and substance use disorders.
- Medication monitoring and drug testing.
- Flexible application of graduated sanctions to accommodate the effects of mental disorders and other individual needs of program participants.
- Liaison with other community mental health and substance abuse treatment providers.
- Court hearings and judicial monitoring approaches that provide a rapid response to potential crises and specific court-ordered requirements for mental health and substance abuse services.

For specialty courts that elect to provide more intensive program enhancements to address the unique needs of participants with co-occurring disorders, a number of structural and clinical approaches are available that have been used effectively in justice settings. Many of these enhancements do not require new program resources and can be accomplished through reorganizing existing services.

In general, both supervision and treatment approaches are longer, more intensive, slower paced, more flexible, and accommodate various cognitive impairments in implementing sanctions, treatment groups, and other services.

Several specialty courts have successfully implemented separate program "tracks" for participants who have co-occurring disorders or have developed separate programs for this population. These enhanced programs provide a blended set of mental health and substance abuse services and use a "phased" approach that includes sequenced interventions focusing on orientation, intensive treatment, and relapse prevention and transition.

Other major program enhancements for specialty courts include enriched motivational interventions, greater use of individual counseling, on-site psychiatric consultation, intensive case management and outreach services, and community supervision teams that include smaller case loads and staff who are trained in co-occurring disorders.

Specialty courts have emerged in the past decade to provide significant national leadership in developing treatment and supervision approaches that reduce criminal recidivism, engage individuals in the recovery process, and that safely retain people in their communities rather than in jails or prison.

The spirit of innovation embodied by specialty courts and the unique coordination and partnership between courts, treatment, and supervision that has been applied so successfully to assist individuals with mental or substance use disorders can also be

effectively applied on behalf of those with co-occurring disorders. The National GAINS Center and federal agencies that support the Center are committed to assist the pioneering efforts of specialty courts in developing program modifications and enhancements for participants with co-occurring disorders, and look forward to collaborating with specialty courts in pursuit of these goals. Specialty courts are encouraged to contact the National GAINS Center and related federal agencies to obtain information, technical assistance, and other resources to assist in developing program services for participants who have co-occurring disorders.

## References


Abram, K.M., & Teplin L.A. (1991). Co-occurring disorders among mentally ill jail detainees: Implications for Public Policy. *American Psychologist*, 46(10): 1036-45.

Bartels, S.J., Drake, R.E., & McHugo, G.J. (1992). Alcohol abuse, depression, and suicidal behavior in schizophrenia. *American Journal of Psychiatry*, 149, 394-395.

Bartels, S.J., Teague, G.B., Drake, R.E., Clark, R.E., Bush, P., & Noordsy, D.L. (1993). Substance abuse in schizophrenia: Service utilization and costs. *Journal of Nervous and Mental Disease*, 181, 227-232.

Bellack, A.S., Bennett, M.E., Gearon, J.S., & Alexander, M.A. (2000). *Behavioral treatment for substance abuse in schizophrenia: A training manual for mental health professionals*. Baltimore, MD: University of Maryland.

Bureau of Justice Statistics (2000). *Prison and jail inmates at midyear 2000.* U.S. Department of Justice Statistics, Washington, D.C., NCJ-185989.

Carey, M.P., Carey, K.B., & Meisler, A.W. (1991). Psychiatric symptoms in mentally ill chemical abusers. *Journal of Nervous and Mental Disease*, 179, 136-138.

Caton, C.L.M., Wyatt, R.J., Felix, A., Grunberg, J., & Dominguez, B. (1993). Follow-up of chronically homeless mentally ill men. *American Journal of Psychiatry*, 150, 1639-1642.

Caton, C.L.M., Shrout, P.E., Eagle, P.F., Opler, L.A., Felix, A., & Dominguez, B. (1994). Risk factors for homelessness among schizophrenic men: A case-control study. *American Journal of Public Health*, 84, 265-270.

Center for Mental Health Services (1997). *Addressing the Needs of Homeless Persons with Co-Occurring Mental Illness and Substance Use Disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Clark, R.E. (1994). Family costs associated with severe mental illness and substance use: A comparison of families with and without dual disorders. *Hospital and Community Psychiatry*, 45, 808-813.

Clear, T.R., Byrne, J.M., & Dvoskin, J.A. (1993). The transition from being an inmate: Discharge planning, parole, and community-based services for offenders with mental illness. In Steadman, H.J., and Cocozza, J.J. (Eds.), *Providing services for offenders with mental illness and related disorders in prisons* (pp. 131-157). Washington, D.C.: The National Coalition for the Mentally Ill in the Criminal Justice System.

Cournos, F., Empfield, M., Horwath, E., McKinnon, K., Meyer, I., Schrage, H., Currie, C., & Agosin, B. (1991). HIV seroprevalence among patients admitted to two psychiatric hospitals. *American Journal of Psychiatry*, 148, 1225-1230.

Cournos, F., & McKinnon, K. (1997) HIV Seroprevalence among people with severe mental illness in the United States: A critical review. *Clinical Psychology Review*, 17, 259-269.

Cuffel, B.J., Shumway, M., & Chouljian, T.L. (1994). A longitudinal study of substance use and community violence in schizophrenia. *Journal of Nervous and Mental Disease*, 182, 342-348.

Denckla D, & Berman, G. (2001). Rethinking the Revolving Door: A Look at Mental Illness in the Courts. New York, NY, Center for Court Innovation.

Dickey, B., & Azeni, H. (1996). Persons with dual diagnosis of substance abuse and major mental illness: Their excess costs of psychiatric care. *American Journal of Public Health*, 86:973-977.

Dixon, L., McNary, S., & Lehman, A. (1995). Substance abuse and family relationships of persons with severe mental illness. *American Journal of Psychiatry*, 152, 456-458.

Drake, R.E., Essock, S., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., Lynde, L., Osher, F.C., Clark, R.E., & Rickards, L. (2001). Implementing Dual Diagnosis Services for Clients with Severe Mental Illness, *Psychiatric Services*, 4(52), 469–476.

Drake R.E., Mercer-McFadden, C., & Mueser, K.T. (1998). A review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, 24: 589-608.

Drake, R.E., Osher, F.C., & Wallach, M.A. (1989). Alcohol use and abuse in schizophrenia: A prospective community study. *Journal of Nervous and Mental Disease*, 177, 408-414.

Drake, R.E., Rosenberg, S.D., & Mueser, K.T. (1996). Assessing substance use disorder in persons with severe mental illness. In R.E. Drake and K.T. Mueser (Eds.), *Dual diagnosis of major mental illness and substance abuse*, Vol. 2: Recent Research and Clinical Implications (pp. 3-17). San Francisco: Jossey-Bass.

Drake, R.E., & Wallach, M.A. (1989). Substance abuse among the chronic mentally ill. *Hospital and Community Psychiatry*, 40, 1041-1046.

Edens, J.F., Peters, R.H., & Hills, H.A. (1997). Treating prison inmates with co-occurring disorders: An integrative review of existing programs. *Behavioral Sciences and the Law*, 15, 439-457.

Gendreau, P. (1996). The principles of effective intervention with offenders. In A. Harland (Ed.), *Choosing correctional options that work*. Newbury Park, CA: Sage Publications.

Gendreau, P., & Ross, R.R. (1984). Correctional treatment: Some recommendations for successful intervention. *Juvenile and Family Court Journal*, 34, 31-40.

Haywood, T.W., Kravitz, H.M., Gorssman, J.L., Davis, J.M., & Lewis, D.A. (1995). Predicting the "revolving door" phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. *American Journal of Psychiatry*, 152:856-861.

Justice Policy Institute (2000). U.S. Imprisoned Population May Hit 2 Million in 2000, Washington Post, A4, January, 1, 2000.

Lamb H.R., & Weinberger L.E. (1998). Persons with Severe Mental Illness in Jails and Prisons: A Review. *Psychiatric Services*, 49(4):483-492.

Lehman A.F., Myers C.P., & Corty E. (1989). Assessment and classification of patients with psychiatric and substance abuse syndromes. *Hospital and Community Psychiatry*, 40: 1019-30.

Mueser, K.T., & Fox, L. (1998). *Stagewise family treatment for dual disorders treatment manual*. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

NASMHPD & NASADAD (1999). National Dialogue on Co-occurring Mental Health and Substance Use Disorders, Washington, D.C..

National GAINS Center for People with Co-Occurring Disorders in the Justice System (2001). The Prevalence of Co-Occurring Mental Health and Substance Use Disorders in Jails, Fact Sheet Series: Delmar, NY: The National GAINS Center.

Onken, L.S., Blaine, J.D., & Boren, J.J. (Eds.) (1993). *Behavioral treatments for drug abuse and dependence*. National Institute on Drug Abuse Monograph Series #137. Rockville, MD: National Institutes of Health.

Osher, F.C., & Kofoed, L.L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry*, 40, 1025-1030.

Osher, F.C., Drake, R.E., Noordsy, D.L., Teague, G.B., Hurlbut, S.C., Biesanz, J.C., & Beaudett, M.S. (1994). Correlates and outcomes of alcohol use disorder among rural outpatients with schizophrenia. *Journal of Clinical Psychiatry*, 55, 109-113.

Owen, R.R., Fischer, EP, & Booth BM. (1996). Medication noncompliance and substance abuse among patients with schizophrenia. *Psychiatric Services*, 47:853-858.

Pepper, B., & Hendrickson, E. (1996). Working with seriously mentally ill substance abusers (pp. 78-93). In Lurigio, A.J. (Ed.), *Community corrections in America: New directions and sound investments for persons with mental illness and codisorders*. Seattle, WA: National Coalition for Mental and Substance Abuse Health Care in the Justice System.

Peters, R.H. (1994). Relapse prevention approaches in the criminal justice system. In Gorski, T.T., Kelly, J.M., Havens, L., & Peters, R.H. (Eds.), *Relapse prevention and the substance-abusing criminal offender: An executive briefing* (pp. 19-30). Rockville, MD: Center for Substance Abuse Treatment.

Peters, R.H., & Bartoi, M.G. (1997). *Screening and assessment of co-occurring disorders in the justice system*. Delmar N.Y: The National GAINS Center.

Peters, R.H., & Hills, H.A._(1997). *Intervention strategies for offenders with co-occurring disorders: What works?*_Delmar N.Y: The National GAINS Center.

Peters, R.H., Hills, H.A., Moore, K.A., Matthews, C.O., Hunt, W.M. (2002). *Co-occurring Disorders Treatment Manual*. Tampa, Florida: Louis de la Parte Florida Mental Health Institute.

Peters, R.H., & Peyton, E. (1998). *Guideline for drug courts on screening and assessment*. Washington, D.C: U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office.

Rosenberg S.D., Goodman L.A., Osher F.C., Swartz M., Essock S.M., Butterfield M.I., Constantine N., Wolford G.L., Salyers, M. (2001). Prevalence of HIV, Hepatitis B and Hepatitis C in People with Severe Mental Illness, *American Journal of Public Health*, 91(1), 31-36.

Seibel, J.P., Satel, S.L., Anthony, D., Southwick, S.M., Krystal, J.H., & Charney, D.S. (1993). Effects of cocaine on hospital course in schizophrenia. *Journal of Nervous and Mental Disease*, 181, 31-37.

Steadman, H.J., Deane M.W., Morrissey J.P., Westcott M.L., Salasin S., & Shapiro, S. A. (1999). SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons, *Psychiatric Services*, 50(12), 1630–1624.

Stephan, J.J. (2001). *Census of jails, 1999*. NCJ 186633. Washington D.C.: U.S. Department of Justice Programs, Bureau of Justice Statistics.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD. (1999). U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Rockville, MD: Author.