

Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?

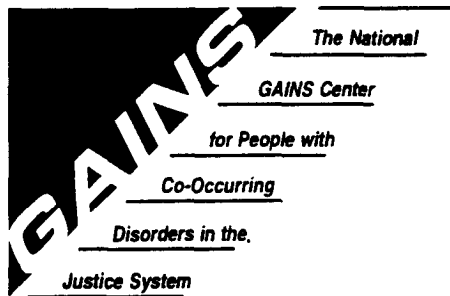
Prepared with support from the GAINS Center by

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INTRODUCTION

Criminal justice populations have risen dramatically in the last 15 years, and now include over a million prison inmates and 3.7 million individuals who are under probation or parole supervision (Bureau of Justice Statistics; 1996a,b). The most important factor contributing to the growth in criminal justice populations during this period is the large number of drug law violators who have been arrested and incarcerated. The number of federal inmates committed to prison for drug charges nearly doubled between 1986 and 1991 (Bureau of Justice Statistics, 1992). This trend has been accelerated by the availability of relatively inexpensive cocaine, intensified efforts by law enforcement to apprehend street drug users and sellers, increasingly punitive sentencing laws for drug offenses, and heightened levels of criminal behavior associated with drug use (Anglin & Speckart, 1988).

The growing population of substance abusers who are under criminal justice supervision have a range of psychosocial problems that often contribute to their involvement in the justice system (Abram & Teplin, 1991). For example, rates of both mental health disorders and substance use disorders are significantly higher among criminal justice populations in comparison to the general population (Robins & Regier, 1991). An estimated 7 percent of jail inmates and 3-11 percent of prisoners have co-occurring mental health and substance use disorders (National GAINS Center, 1997; Peters & Hills, 1993). Approximately one million mentally ill and/or substance abusing individuals are currently incarcerated in correctional institutions (Pepper & Massaro, 1992) - more than the number of clients who are receiving services in psychiatric hospitals throughout the country.

Co-occurring disorders are used to describe individuals who have a DSM-IV Axis I major mental disorder (e.g., psychotic, depressive, and bipolar disorders) and a substance use disorder. Mental retardation, personality disorders, or other less severe mental disorders will not be extensively reviewed in this paper, although these disorders are very common among justice populations, and frequently co-exist with substance use disorders. Given the increasing confluence of mentally ill and/or substance abusing individuals who are seen in courts and community

corrections settings, jails, and prisons, greater attention has been provided to the need for diversion and rehabilitation programs in these settings ((American Bar Association, 1992; Dvoskin, 1991; Inciardi, 1993; Leukefeld & Tims, 1992; National Institute of Corrections, 1991; Steadman, 1991; Steadman, McCarty, & Morrissey, 1989). Recent initiatives sponsored by the Center for Substance Abuse Treatment (CSAT), the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), the Center for Mental Health Services (CMHS), and the National Institute of Corrections (NIC) reflect the need to develop specialized treatment interventions for mentally disordered and substance abusing offenders.

One of the major challenges in designing screening and assessment approaches, treatment interventions, and supervision strategies for offenders with co-occurring disorders is the diversity of this population. This diversity is reflected in the choice of primary drugs, the etiology and history of the disorders and related treatment, symptoms and interactive effects of the disorders, history of criminal justice involvement and violent behavior, level of impairment in psychosocial functioning, and level of social support (Lehman, 1996). The latest formulation of the Diagnostic and Statistical Manual (DSM) of Mental Disorders (Fourth Edition; American Psychiatric Association, 1994), now differentiates between several types of co-occurring “substance-induced” mental health disorders.

Which Offenders are at Higher Risk for Co-Occurring Disorders?

The most important set of indicators for identifying co-occurring disorders among offenders is the presence of mental health symptoms, use of psychotropic medication, or a history of mental health symptoms and/or treatment. As noted previously, offenders with substance abuse problems also have a heightened risk for co-occurring mental disorders. In addition to evidence of mental health or substance use disorders, there are several other important characteristics or indicators that reflect a higher risk for the presence of co-occurring disorders¹ (Drake, Rosenberg, & Mueser, 1996; Lehman & Dixon, 1995; Mueser, Bennett, & Kushner, 1995). These include

¹ Research has not yet addressed the relative importance of these risk factors in predicting the presence of co-occurring disorders among offenders.

youthful offenders, males, and individuals who have a history of poor family relationships, unstable housing, homelessness, criminal justice involvement, suicide, or emergency room and other acute care visits. Other risk factors include peer or family substance abuse, and family history of mental health disorders. Many of these same characteristics are also associated with aggressive and violent behavior, criminal recidivism, poor treatment outcomes, and other undesirable behaviors. Offenders who have several of these characteristics should be carefully screened for co-occurring disorders, and reexamined over time for both mental health and substance abuse symptoms. As these characteristics converge, there is a greater likelihood of co-occurring disorders and a corresponding need for more detailed mental health and substance abuse screening.

Challenges in the Treatment and Supervision of Offenders with Co-Occurring Disorders

The presence of co-occurring mental health and substance abuse disorders generally indicates a poor prognosis for involvement in treatment (McLellan, 1986; Weiss, 1992) and compliance with medication (Drake, Osher, & Wallach, 1989), and is associated with greater rates of hospitalization (Safer, 1987), more frequent suicidal behavior (Caton, 1981), and difficulties in social functioning (Evans & Sullivan, 1990). In one recent study (Peters, Keams, Murrin, & Dolente, 1992), inmates referred for substance abuse treatment who manifested psychopathology were found to have more pronounced difficulties in employment, family and social relationships, and had more serious medical problems, in comparison to other inmates. Individuals with co-occurring disorders frequently do not have a support network, or identifiable family members who are willing to provide shelter and supervision of the offender. The vast majority of individuals with co-occurring disorders are not involved in treatment (Grant, 1997).

Accurate assessment of co-existing disorders also presents difficult challenges, due to the residual effects of addictive substances (e.g. withdrawal effects) that may mask or mimic psychiatric symptoms such as depression. Dually diagnosed individuals may also present acute psychiatric symptoms such as anxiety and depression that may interfere with traditional forms of

substance abuse treatment, and more often require hospitalization or participation in intensive mental health services (Evans & Sullivan, 1990; Pensker, 1983). Involvement and retention of offenders with co-occurring disorders in treatment is often difficult, due to rationalization and blaming others for their difficulties, distrust of service providers, and sudden changes in psychiatric symptoms.

This population is also thought to be at greater risk for relapse following release from custody (Weiss, 1992). One reason for this is the likelihood of medicating uncomfortable emotional states (e.g. depression, mania) through use of drugs. Mental illness may also impair the dually diagnosed offender from understanding the negative effects of drugs or alcohol on his/her behavior. Even small amounts of alcohol or drugs may precipitate recurrence of mental health symptoms among individuals with co-occurring disorders (Drake, Mueser, Clark, & Wallach, 1996) and reinvolvement in the criminal justice system (Pepper & Hendrickson, 1996).

Another potential barrier in accessing services for this population is the absence of coordinated mental health and substance abuse services in jails and in community corrections settings. For example, jail treatment programs often have inadequate community linkage and aftercare services (Peters, May, & Keams, 1992). There are also considerable difficulties in coordinating services for offenders with co-occurring disorders within community settings (Clear, Byrne, & Dvoskin, 1993). This is often due to lack of awareness of existing dual diagnosis programs, confidentiality issues, and waiting lists for treatment services. Dually diagnosed offenders are frequently excluded from some community treatment programs due to severe mental health and substance abuse problems, use of psychotropic medication, and to their criminal justice history. Lack of health insurance may also hinder involvement in community treatment services.

SCREENING AND ASSESSMENT OF CO-OCCURRING DISORDERS

In the past, mental health, substance abuse, and criminal justice systems have often conducted independent screening and assessment activities. This has resulted in inadequate sharing of information, poor communication regarding overlapping areas of interest, non-detection of mental health and substance use disorders, and fragmented service goals. Non-detection of mental health and substance use disorders often leads to misdiagnosis, misattribution of the causes of mental health symptoms, neglect of appropriate interventions, inappropriate treatment planning and referral, and poor treatment outcomes (Drake, Alterman, & Rosenberg, 1993; Peters & Bartoi, 1997; Teague, Schwab, & Drake, 1990). Other factors have also contributed to non-detection of mental health and substance use disorders. These include negative consequences associated with disclosure of symptoms, lack of staff training, and cognitive and perceptual difficulties associated with severe mental illness or toxic effects of recent alcohol or drug use.

Integrated screening, diagnosis, and assessment approaches should be developed in criminal justice settings that consider critical indicators of mental health and substance abuse problems, and that also examine key criminal justice information. Integrated screening and assessment approaches are associated with more favorable outcomes (Kofoed, Dania, Walsh, & Atkinson, 1986). To date, single integrated instruments have not been developed to screen or assess for co-occurring disorders. As a result, it may be useful to combine specialized mental health and substance abuse instruments for purposes of screening and assessment.

Screening

The primary purpose of screenings conducted in criminal justice settings is to detect mental health and substance use symptoms, to identify related problem areas that reflect the need for treatment or ancillary services, and to identify individuals with a history of violence, severe medical problems, severe cognitive deficits, or who are not eligible or amenable for treatment of co-occurring disorders. A series of screenings are usually conducted in jail, and at the point of release to community supervision, or transfer between points in the criminal justice system. These

screenings focus on diverse areas such as health problems, mental health problems, substance abuse problems, vocational and educational needs, and other areas of service needs. In community corrections settings, presentence or postsentence investigations (PSI's) provide screening in a number of areas, including mental health and substance abuse. PSI's are frequently completed by local community corrections staff to assist in determining the judicial disposition or in case planning.

Most criminal justice screenings are quite brief, reflecting the large volume of offenders, limited staff resources, and the need for relatively quick processing or classification of offenders. Since screenings are often conducted by staff who do not have considerable experience in diagnosis or assessment of mental health or substance use disorders, and who may be unfamiliar with treatment services, specialized training should be provided in the following areas: (1) detecting co-occurring disorders, (2) use of screening instruments, (3) developing collaborative screening approaches, and (4) initiating referral to assessment and treatment services. Evidence of substance abuse or mental health problems that is detected through screening is typically used to 'flag' cases that need more extensive assessment of treatment needs.

Key considerations in screening for co-occurring disorders.

- All individuals who are placed under community supervision should be screened for mental health and substance use disorders. This can be accomplished in a short amount of time through some combination of brief self-report screens, symptom checklists completed by the supervision officer, and structured interviews that examine both sets of disorders. Key symptoms that should be examined include agitation, depression, hallucinations, delusions, suicidal thoughts, and evidence of recent drug or alcohol use. Universal screenings are warranted due to the high rates of co-occurring disorders among offenders and due 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 after involvement in the criminal justice system, and placement on probation, parole, or other form of community supervision. For example, identification of these problems among pretrial defendants will assist the judge to establish conditions of release (e.g. drug testing, involvement in treatment) that will increase the likelihood of stabilization in the community and of the individual's return for additional court hearings.

- Screening for co-occurring disorders should be provided at different stages in the community corrections system in which referrals for treatment are made, such as diversion, admission to jail, pretrial hearings, presentencing, sentencing, probation, parole, or revocation hearings. Ongoing opportunities for screening will help to identify individuals who are initially reluctant to discuss mental health or substance abuse problems, but who may become more receptive to involvement in treatment services over time.
- Similar or standardized screening instruments for co-occurring disorders should be used across different community corrections settings. 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.
- To obtain the most accurate results, screening for co-occurring disorders should be delayed until an individual reaches sobriety. This will allow for mental health symptoms to clarify, pursuant to diagnosis and potential referral for mental health services.
- Information from previously conducted screening and assessment should be communicated across different points in the criminal justice system.
- Drug testing is an important component of screening and assessment of co-occurring disorders in the justice system. Drug testing should begin immediately after an arrest or other triggering event that brings the individual into contact with the justice system, and should be administered at random intervals during the course of treatment and supervision.
- Whenever possible, interview and test results should be supplemented by collateral information obtained from family members, friends, arresting officers, and other informants (Drake, Alterman, & Rosenberg, 1993). Observation by family members, friends, or direct care staff may also provide important collateral information that is as accurate as that obtained from interviews or standardized instruments (Comtois, Ries, & Armstrong, 1994).

Components of screening. Screening for co-occurring disorders should examine the presence of mental health and substance use disorders, and relevant criminal justice information. Key symptoms to be examined are described in the section to follow. because of the high rates of co-occurring disorders in community corrections and other justice settings, detection of a single disorder (i.e., either mental health or substance use) should immediately ‘trigger’ screening for the other type of disorder. In general, the presence of mental health symptoms is more likely to signal a substance use disorder than the reverse.

Screening often includes a brief interview, use of self-report instruments, and review of archival records. Drake et al. (1993) recommend using a short self-report instrument to document the frequency of use of drugs and alcohol over the past 30 days and over a longer interval. A range of similar instruments are also available to detect mental health symptoms. A mental status examination is usually provided during screening for co-occurring disorders (Kosten & Kleber, 1988).

Key components that should be reviewed in screening for co-occurring disorders include the following:

- **Mental health information**, including acute mental health symptoms (e.g., agitation, depression, hallucinations, delusions), suicidal thoughts and behavior, prior involvement in mental health treatment, and use of psychotropic medication, cognitive impairment, and family history of mental illness.
- **Substance abuse information**, including acute signs of drug or alcohol intoxication, withdrawal or tolerance effects, self-reported substance abuse, negative consequences associated with substance use, prior involvement in treatment, and family history of substance abuse.
- **Interaction effects of co-occurring disorders**, including the effects of one disorder on the other, and patterns of symptom expression.
- **Motivation and readiness for treatment**, including the perceived level of mental health and substance abuse problems.
- **Criminal justice information**, including the criminal history, history of aggressive or violent behavior, and the most recent offense of record.
- **Infectious disease.**

Suicide screening should be provided for all offenders who are placed under community supervision. This is particularly important for individuals with mental health or substance use disorders, who have higher rates of suicidal behavior. Examination of suicide potential should also be conducted when there is a major change in supervision status (e.g., to more restrictive levels of supervision, placement in jail) or other significant life event (e.g. loss of job or important relationship). Ongoing suicide screening should be provided for offenders with co-occurring disorders. Screening for suicide risk is particularly important for individuals who have severe

depression, schizophrenia, or who are suffering from stimulant withdrawal. All suicidal behavior (including threats and attempts) should be taken seriously. An immediate referral should be made for mental health assessment to determine the type of follow-up interventions that are needed. Suicide screening should address current levels of agitation and depression, current suicidal thoughts, previous suicide attempts and their seriousness, any suicide plans, and availability of potential suicide instruments.

Screening in community corrections settings should also examine motivation and readiness for treatment, which have been found to predict treatment compliance, dropout, and outcome (Lehman, 1996; Ries & Ellingson, 1990). In these settings, motivation to participate in treatment is affected by perceived sanctions and incentives (e.g. court orders to complete treatment, probation revocation), and increases when continued substance abuse threatens current housing, involvement in mental health treatment, vocational rehabilitation, family, marriage, or may lead to incarceration in jail (Ziedones & Fisher, 1994). Individuals often cycle through several predictable “stages” of motivation during the treatment and recovery process (Prochaska, DiClemente, & Norcross, 1992). Due to the chronic relapsing nature of substance abuse problems, movement through these stages is not a linear process, and individuals frequently return to previous stages before achieving sustained abstinence.

Treatment is likely to be ineffective until individuals accept the need for treatment of mental health and substance abuse problems (Kofoed, 1991). For this reason, supervision officers and case managers should understand the importance of matching individuals to treatment based on the offender’s current “stage” of motivation and readiness. Assessment of motivation is useful in treatment planning and in matching offenders to various different types of treatment. For offenders who are in the preliminary stages of motivation, placement in treatment that is too advanced and that does not address ambivalence regarding recovery may lead to drop out from treatment. Conversely, for offenders who are in the later stages of motivation, placement in services that focus primarily on early recovery issues may also lead to drop out from treatment.

Screening instruments. Given the absence of current instruments that address both mental health and substance abuse disorders, and include information relevant to community corrections settings, several independent instruments should be combined for use in screening. Standardized screening instruments should be used to identify co-occurring disorders in the justice system. Use of similar instruments across different justice settings (e.g. pre-trial screening, community supervision) will promote a shared understanding of co-occurring problems and treatment interventions that are needed. Instruments used in screening for co-occurring disorders differ significantly in their coverage of substance abuse symptoms, mental health symptoms, reliability (consistency of results), validity in detecting disorders, prior use within criminal justice settings, cost, scoring procedures, and training required for administration and scoring. These factors should be examined carefully before selecting a screening instrument for co-occurring disorders. Screening instruments are sometimes included in a larger assessment battery to provide focused information regarding substance abuse and dependence symptoms, and patterns of current use. Examples of selected instruments that address mental health and substance use disorders are described in the section to follow.

Few studies have examined the validity of different substance abuse screening instruments in criminal justice settings. In the most comprehensive study of this type (Peters & Greenbaum, 1996), three screening instruments were found to be the most effective in identifying prison inmates with substance dependence problems:

- ADS/ASI Drug (a combined instrument, consisting of the Alcohol Dependence Scale and the Addiction Severity Index - Drug Use section; Skinner & Horn, 1984; McLellan, Luborsky, O'Brien, & Woody, 1980).
- TCU Drug Dependence Screen (DDS; Simpson, Knight, & Broome, 1997).
- Simple Screening Instrument (SSI; Center for Substance Abuse Treatment, 1994).

These instruments outperformed several other substance abuse screens, including the Michigan Alcoholism Screening Test (MAST) - Short version, the ASI - Alcohol Use section, the Drug Abuse Screening Test (DAST-20), and the Substance Abuse Subtle Screening Inventory

(SASSI-2) on key validity measures. The three screening measures identified above appear to hold considerable promise for use in community corrections settings. Among non-criminal justice community populations, several other screening instruments have been found to have adequate validity for use with substance-abusing populations (McHugo, Paskus, & Drake, 1993; Peters & Greenbaum, 1996; Ross, Gavin, & Skinner, 1990; Staley & El Guebaly, 1990), including the Drug Abuse Screening Test (DAST; and DAST-20, a short version of the DAST), the Michigan Alcoholism Screening Test (MAST; and SMAST - a short version of the MAST), and the CAGE.

Several brief mental health screens are available that examine a broad range of mental health symptoms (e.g., BSI, RDS, SCL-90-R), while others focus on symptoms of a single disorder, such as depression (e.g., BDI). Several commonly used screening instruments that have been validated for use in detecting mental health symptoms² are described as follows:

- Beck Depression Inventory (BDI; Beck & Beamesderfer, 1974).
- Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983).
- Referral Decision Scale (RDS; Teplin & Schwartz, 1989).
- Symptom Checklist 90 - Revised (SCL-90-R; Derogatis, Lipman, & Rickels, 1974).

Several new instruments are available that examine motivation and readiness for treatment. These are designed primarily to identify individuals who are inappropriate for admission to substance abuse treatment. Instruments examining motivation and readiness for treatment include the following:

- Circumstances, Motivation, Readiness, and Suitability Scale (CMRS; DeLeon & Jainchill, 1986).
- Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller, 1994).
- University of Rhode Island Change Assessment Scale (URICA; McConaughy, Prochaska, & Velicer, 1983; DiClemente & Hughes, 1990).

² See also, Peters and Bartoi (1997) for a more complete description of mental health screening instruments used in criminal justice settings.

Assessment

Assessment of co-occurring disorders is usually accomplished after completion of screening and referral to treatment services, and provides the basis for development of an individualized treatment plan and a reentry/follow-up plan. Sufficient time should be provided prior to initial assessment to insure that an individual is detoxified, sober, and that any mental health symptoms exhibited are unrelated to withdrawal from substance use (Weiss & Mirin, 1989). Although the initial assessment is often conducted after the first point of involvement with the community treatment provider, assessment is an ongoing process, and must consider new issues that arise, and new information that is obtained over the course of treatment. For example, prior physical and sexual abuse are often not reported until an individual is comfortable in disclosing sensitive information with treatment counselors and other treatment participants. Relapses that occur in treatment, changes in living arrangements and employment, and other new issues are often reviewed by treatment staff, with modifications then made to the treatment plan to reflect new problem areas and related services to address these problems.

If there is a question regarding whether an offender is currently sober, screening and assessment should be delayed until an observable period of abstinence has been achieved. This will help to determine whether symptoms of co-occurring disorders will diminish, persist, or worsen (Weiss & Mirin, 1989). Several steps should be taken when considering use of an extended baseline for screening and assessment: (1) examine the significance and interactive nature of the mental health and substance use disorders, (2) determine the length of the current abstinence, with delay of diagnosis if abstinence has not been achieved, (3) reexamine mental health symptoms at the end of four to six weeks of abstinence, (4) if mental health symptoms have fully resolved, consider referral for substance abuse or specialized “dual diagnosis” services, and (5) provide ongoing reevaluation of mental health symptoms and appropriateness of treatment placement.

Components of assessment. Key components that should be reviewed in assessment of co-occurring disorders include the following:

- **Symptoms of co-occurring disorders**, including specific mental health and substance abuse symptoms, symptom severity, acute or chronic nature of symptoms, and duration of disorders.
- **Substance abuse history and patterns of current use**, including the drug of choice, other secondary drugs, misuse of prescription drugs, reasons for substance abuse, context of substance abuse, periods of abstinence and how they were attained, treatment history, age of onset, frequency, amount, and duration of use, and patterns of high and low use, and **types of treatment** and ancillary services that are needed.
- **Mental health history and current status**, including significant past and current symptoms (e.g. suicidality, depression, anxiety, psychosis, paranoia, stress, self-image, inattentiveness, impulsivity, hyperactivity), treatment history, the history of psychotropic medication and current use of medication, and patterns of denial and manipulation, and types of treatment and ancillary services that are needed.
- **Interaction between the co-occurring disorders**, including patterns of mental health symptoms and substance abuse, effects of mental health symptoms on substance abuse (and vice versa), and the chronology of mental health and substance use disorders.
- **Family and social relationships**, including social interactions and lifestyle, existing sources of social pressure to use drugs and alcohol, family history of mental health and substance use disorders, and evidence of current support systems. The stability of the home and social environment should be also be examined, including violence in the home and effects of the home/other relevant social environments (e.g. work, school) on abstinence from substance use.
- **Medical history and current health status**, including the history of injury and trauma, chronic disease, physical disabilities, substance toxicity and withdrawal, impaired cognition, neurological symptoms, and prior use of psychiatric medication. If a history of AD/HD is suspected, assessment should examine attention and concentration difficulties, hyperactivity and impulsivity, and the developmental history of childhood AD/HD symptoms.
- **Criminal justice history and current status**, including the record of prior juvenile and adult arrests and convictions, the history of incarceration in jail and prison, violent offenses, the most recent offense of record, and the history of community supervision (e.g., probation violations, absconding, compliance with fees and other requirements).

Other key **areas that should be addressed in an assessment of co-occurring disorders** include employment/vocational status, educational history and status, literacy levels, **IQ**, and developmental disabilities, interpersonal coping strategies, skills deficits (e.g., related to problem solving or communication).

Assessment instruments. Few instruments have been validated for use in assessing individuals with co-occurring disorders. Moreover, few studies have attempted to validate assessment instruments in community corrections settings. Given the heterogeneity of symptoms presented by individuals with co-occurring disorders, it is unlikely that a single instrument will be developed to assess the full range of co-occurring problems, or to distinguish between individuals who have mental health or substance use disorders (Osher & Kofoed, 1989).

An integrated approach should be developed for assessment of co-occurring disorders in the justice system. This integrated approach should include a comprehensive review of mental health and substance use disorders, and examination of criminal justice history and status. An independent assessment should be conducted of each disorder, in addition to an assessment of interactive effects of the disorders. Several previously described screening instruments are often used as part of the assessment battery to examine specialized areas (e.g. diagnostic symptoms of alcohol and/or drug abuse) related to co-occurring disorders.

Several self-report mental health instruments used in assessment include the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Millon Clinical Multiaxial Inventory-III (MCMI-III), and the Personality Assessment Inventory (PAI). The Addiction Severity Index (ASI) is the most commonly used substance abuse assessment instrument, and uses a structured interview approach. A combined battery that includes one of the mental health assessment instruments and one of the ASI would require approximately three hours to administer and score. Each of these instruments have been found to be reliable and valid for use in assessment, and have also been widely used in criminal justice settings. Several more intensive diagnostic instruments are also available to examine the presence of specific mental health and substance abuse disorders. The most common diagnostic instruments include the Diagnostic Interview Schedule (DIS), and the Structured Clinical Interview for DSM-IV - Patient Version (SCID-IV). Both the DIS and the SCID are structured interviews that require approximately one to two hours to administer. Case manager ratings, information from collateral informants (e.g. family members), and archival records (e.g. criminal history) should also be considered during assessment.

TREATMENT OF CO-OCCURRING DISORDERS

Offenders placed under community supervision who have co-occurring mental health and substance use disorders are quite diverse in symptom presentation, severity and chronicity of disorders, impairment in psychosocial functioning and cognitive abilities, drug(s) of choice, and other areas. These individuals often have several mental health disorders, and simultaneously use different types of drugs, presenting considerable challenges to treatment programs for this population. Many offenders with co-occurring disorders would benefit from specialized treatment services in the community.

Given the varying symptoms and functional skills of offenders with co-occurring disorders, flexibility must be provided in developing treatment program services and in treatment planning. For example, persons with psychotic-spectrum disorders often require a long-term treatment program, greater structure, and a less confrontational approach (Edens, Peters, & Hills, in press; Zweben, Smith, & Stewart, 1991). A range of different types of treatment settings, service configurations, and orientations to treatment must be considered with individuals who have co-occurring disorders. The complicated symptom profile among this group often leads to their exclusion from many treatment programs, and thus, more have found their way into the criminal justice system - with typically no better chance of receiving comprehensive care.

Why are Separate Mental Health and Substance Abuse Services Provided for Offenders with Co-Occurring Disorders?

The separation of substance abuse and mental health treatment services has a long and complicated history. The struggle over the medical-model versus community-based treatment of addiction has waxed and waned during the past century, fueled by different philosophical and economic forces (Osher & Drake, 19%). This separation is reflected in the establishment of separate research agencies (NIAAA and MDA) in the 1970's, the net effect of which was to formalize isolation and competition between the different agencies. Economic influences further limited treatment for persons with co-occurring disorders as utilization review efforts defined eligibility

for service. As demand for service increased but resources diminished, persons with co-occurring disorders were routinely excluded from eligibility. Another barrier to integrated services has been the independent monitoring and licensing systems that apply to mental health and substance abuse services, which have restricted co-mingling of funds (Ridgely & Dixon, 1995) and discouraged administrators from inviting oversight from multiple funding authorities.

Lack of professional training or treatment experience with co-occurring disorders has been a major impediment to integration of services. The mental health system in the U.S. comprises a variety of multidisciplinary mental health professionals who provide both public and private services. Many of these practitioners have distinct ideologies and methods of practice based on their training. Largely absent in this training has been a specific emphasis on the addiction process, substance abuse treatment perspectives, and information about relapse and recovery from substance abuse. The substance abuse service system also includes a broad range of treatment providers who are themselves unfamiliar with the process and evolution of many forms of mental illness. Because of their background, they are often uncomfortable with treatments that involve use of medication, which may place them in conflict with mental health service providers who view prescriptive medications as an integral part of the treatment of severe forms of mental illness.

Differing theoretical orientations have emerged from substance abuse and mental health treatment professions, which are reflected in the types of services provided (Evans & Sullivan, 1990). One key difference between the professions is the struggle over which disorder is “primary.” While many self-help programs in the substance abuse field emphasize the concept of “powerlessness,” many mental health interventions are based on “empowerment.” Similarly, many substance abuse programs focus on spirituality, which is not a major focus of mental health programs. As a result of these philosophical, systemic, and ultimately, geographic differences, offenders with co-occurring disorders are unlikely to receive the comprehensive services that they require.

What are the Advantages of an Integrated Treatment Approach?

Community treatment for offenders with co-occurring disorders has been traditionally accomplished through one of three approaches: 1) sequential treatment, in which individuals are referred from one to the “other” service system, 2) parallel treatment, in which there are attempts to coordinate between the two service systems, and 3) integrated treatment, in which a multidisciplinary cross-trained staff simultaneously provides services for both disorders in a single setting. Reviews of the treatment literature indicate that integrated approaches are generally more effective than sequential or parallel treatments (Drake, Rosenberg, & Mueser, 1996; Hills, in press). In general, the best chance for sustained symptom remission among offenders with co-occurring disorders is likely to be provided in a system that doesn’t require shifting back and forth between service settings and providers. Several desirable features of an integrated treatment approach include: 1) assertive outreach and intensive case management; 2) offering a comprehensive range of services to accommodate individuals with different levels of impairment and varying symptoms; 3) an emphasis on motivating and engaging people to commit to treatment; 4) conceptualizing people passing through different “phases” or “stages” of treatment; 5) modification of psychopharmacological approaches; and 6) ongoing reassessment and treatment plan modification.

What Modalities are Currently Used to Treat Co-Occurring Disorders?

Several different types of treatment modalities have been adapted for offenders with co-occurring disorders. Typically, these have involved use of integrated approaches through modification of traditional substance abuse or mental health approaches such as therapeutic communities, cognitive-behavioral interventions, relapse prevention, and supportive psychoeducational approaches that are combined with 12-step/AA models. Although these modalities appear to be distinctive, programs may blend two or more of these approaches in the same treatment setting. The following section reviews several of the more common modalities used for offenders with co-occurring disorders, and describes several ways in which these modalities have been adapted for this population.

Therapeutic communities. Therapeutic communities (TC's) are among the most common approaches used in residential substance abuse treatment. These are usually long-term programs (six to 24 months) that are highly intensive and regimented. Therapeutic communities are designed to restructure the lifestyles and personalities of program participants to help them to abstain from drug use, achieve employment, and behave in a prosocial manner. These goals are achieved through a variety of treatment approaches including encounter groups, community meetings, individual counseling, and performance of job duties (DeLeon, 1985). Therapeutic communities typically employ a predominance of recovering individuals.

Though TC's have always served persons with Axis I mental health disorders, the clinical and research findings indicate greater effectiveness with persons who have less severe (non-affective, non-psychotic) disorders (DeLeon, 1993). Several therapeutic community programs for persons with co-occurring disorders have been developed over the past several years (McLaughlin & Pepper, 1991; Sacks, DeLeon, Bemhardt, & Sacks, 1993), and research is underway in several community and institutional settings to examine the effectiveness of these programs (De Leon, 1993). Several modifications to TC approaches have been developed for individuals with co-occurring disorders. These modifications are quite consistent with principles of effective correctional treatment programs; as determined through empirical review and analysis of the correctional literature (Gendreau & Ross, 1984, Gendreau, 1996); and also have been applied successfully with dually diagnosed individuals in non-TC programs.

Specific modifications to TC's for individuals with co-occurring disorders include the following:

- At least one year of treatment services is provided, with the potential for ongoing treatment participation.
- Greater emphasis is placed on psychoeducational and supportive approaches than on confrontation and compliance.
- Movement through the program and specific tasks are more individualized.
- Rewards (e.g., verbal praise, privileges) are delivered more frequently.
- Treatment groups and other daily activities are of shorter duration.

- There is more overlap in activities, and the pace of treatment activities is slower.
- Information is provided gradually, and with significant repetition.
- More individual counseling is provided.
- “Encounter” groups are replaced by conflict resolution or “community” groups with more emphasis on affirmation of progress and individual change efforts.
- Resident job functions are more “horizontally” organized (i.e., there is less peer supervision and guidance in job duties).
- A higher staff-to-client ratio is used in the TC, with more mental health staff integrated into treatment groups. Staff have smaller caseloads.
- Staff provide more monitoring and coordination of treatment activities.
- All staff are cross-trained, with mental health staff trained in self-help approaches and reoriented to the roles of TC staff (i.e., use of staff as guides or facilitators rather than as “treatment” providers). Substance abuse staff are trained in mental health 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 responsiveness to interventions (DeLeon, 1993).

Peer support and 12-step programs. Although peer support interventions have long been included in substance abuse programs, they have only recently emerged in mental health treatment settings. Integration of persons with dual disorders into peer groups associated with one or the other discipline can be somewhat challenging. Though the 12step/AA literature clearly supports the individual’s right to take prescribed medication for psychiatric or other medical problems, many individual group members are intolerant of this choice. Persons referred to 12-step meetings should be prepared in advance to address concerns that group members may have about their use of medication and commitment to recovery. Role playing or other simulations can be used to rehearse for these encounters. Concepts such as powerlessness and a ‘higher power’ also can be difficult to integrate into mental health treatment, and need to be communicated in a way so as to reduce confusion and contradiction (Zweben, Smith, & Stewart, 1991).

Ambivalence regarding abstinence is more common among persons with co-occurring disorders, due to uncertainty about the relationship between their substance abuse and mental health symptoms, which may be implicitly reinforced by treatment providers who did not address their co-occurring disorders. As a result, accepting an abstinence orientation can be a difficult task,

as reflected in difficulties experienced among persons with co-occurring disorders in affiliating with AA groups (Noordsy, Schwab, Fox, & Drake, 1996).

Many dual diagnosis treatment programs are based on an AA orientation and 12-step principles. For example, the Combined Psychiatric and Addictive Disorders Program (COPAD; Rosenthal, Hellerstein, & Miner, 1992) combines attendance in 12-step and peer support activities with group therapy, education on interactive effects of co-occurring disorders, staff-moderated confrontation, medication management, and drug testing. Though abstinence is encouraged, absolute sobriety is not a required condition for treatment. Integrated services have been provided in residential settings that include 12-step groups, traditional substance abuse treatment, and case management services (Bartels, Drake, & Wallach, 1995).

Cognitive-behavioral or skill-building approaches. Cognitive-behavioral therapy (CBT) has been applied successfully with co-occurring disorders to develop self-control strategies related to problem solving, impulse control, anger management, often through identification of cues and cognitions associated with these problem areas (Najavits, Weiss, & Liese, 1996). CBT also works to develop latent skills that may not have developed fully due to the presence of mental health or substance abuse disorders. Skill-building strategies focus on planning daily activities, problem solving, and improving relationships through assertiveness, negotiation, asking for help, active listening, and use of positive self-statements. CBT programs for individuals with co-occurring disorders also provide a focus on relapse prevention techniques.

Several CBT strategies have been developed to promote engagement and knowledge acquisition for individuals with co-occurring disorders, including the following:

- Use of visual aids, including illustrations and “concept mapping.”
- Role preparation to help prepare for unexpected circumstances.
- Providing specific feedback on how to apply treatment principles and techniques.
- Use of outlines for all sessions, with explicit learning objectives.
- Testing for knowledge acquisition.
- Memory enhancement strategies, including use of notes, tapes, and mnemonic devices.

Jerrell and Ridgely (1995) modified the Social and Independent Living Skills program (SILS; Liberman, Massel, Mosk, & Wong, 1985; Liberman, Mueser, & DeRisi, 1989) to create a Behavioral Skills intervention for individuals with co-occurring disorders. Five skill modules provided in their program included symptom monitoring, medication management, relapse prevention, leisure activities, and social skills. Participants in this program were found to have more favorable outcomes than individuals who received intensive case management or 12-Step treatments (Jerrell & Ridgely, 1995).

Relapse prevention. Increasingly, treatment services for offenders with co-occurring disorders have included relapse prevention strategies, in recognition of the high rate of recurrence of mental health symptoms, substance abuse relapse, and return to criminal behavior. These approaches are often psychoeducational in nature and based on cognitive-behavioral models. Core features of relapse prevention programming include identification of antecedents to relapse, including warning signs and high risk situations, development of coping skills, development of new lifestyle behaviors, increasing self-efficacy, avoiding the Abstinence Violation Effect (AVE), and drug testing.

Psychoeducational techniques for persons with co-occurring disorders include helping participants to understand how neurochemistry and neurotransmitter systems are effected by mental health and substance use disorders. The role of conditioned cues and influences of craving on substance abuse are also explored. Specific drug and alcohol effects are reviewed to allow persons to understand how their symptoms may have been masked, mimicked, or exacerbated by their substance use. The evidence for intergenerational transmission of co-occurring disorders is explored, as well as risk factors for HIV+/AIDS.

High risk situations are thoroughly evaluated to determine all of the possible influences, stimuli, and decisions that may lead to relapse. Participants are asked to evaluate their former behavioral patterns including the time of day that they may have regularly used, the stimulus of having pocket money, risks inherent in having idle time, and the role of continuing to relate to drug using friends, or going to bars to socialize. Relapse prevention activities explore the role of

mental health symptoms and affective states in relation to substance abuse, as well as the effects of alcohol and drug use on recurrence of mental health symptoms.

Development of new coping skills is an important component of relapse prevention programs. This can be a very difficult task for individuals with co-occurring disorders, who often have a very limited repertoire of coping behaviors. New coping strategies may involve learning to resist offers of drugs or alcohol, or defending their need to take prescription medications to members of an AA group. New leisure, recreational, and employment skills are also provided. The net effect of relapse prevention skills development is to improve self-efficacy in abilities to cope with challenging situations.

Case management. Case management services may be seen as both an approach for organizing services and as an intervention. Case management services are also of vital importance for offenders with co-occurring disorders, and are complementary to the range of treatment approaches described in previous sections. ‘Case management is often provided by multidisciplinary teams with shared caseloads. Engagement to treatment is provided through outreach, culturally relevant programming and use of motivational approaches over an extended period of time. Overall case management goals for this population are to provide access to a broad range of mental health and substance abuse services. Preliminary research examining case management approaches indicates improvement in functional status and fewer hospitalizations during an extended follow-up period (Mueser, Drake, & Miles, 1997). Approximately half of individuals examined were able to achieve some period of sustained abstinence during follow-up.

Services provided by the case management team are often designed to reflect the stages of dual diagnosis treatment (Osher & Kofoed, 1989). This includes an early emphasis on **engaging** the person to commit to treatment, followed by **persuasion** to consider abstinence and active behavior change, application of cognitive-behavioral and social network interventions in the active **treatment** phase; and finally, focused awareness of **continued risks in the relapse prevention stage**. One example of case management approaches that have been modified for individuals with co-occurring disorders is the Program for Assertive Community Treatment (PACT; Drake, et al., 1991;

Stein & Test, 1980). Core components of this program include: Crisis intervention, supportive therapy, substance abuse counseling, skills training, medication monitoring, housing support, vocational rehabilitation, specialized dual diagnosis groups, family psychoeducational groups, and family outreach activities.

What Key Principles of Dual Diagnosis Treatment Have Emerged from the Literature?

Though much has been written about dual diagnosis in the past 20 years, it has only been in the past 5 years that results have been available from studies comparing different forms of dual diagnosis treatment services. There is an emerging consensus from these studies that treatment must focus on building cognitive and interpersonal skills. Whether these are refusal skills or prosocial skills to overcome boredom or aggressive impulses, treatment plans must address the individual's specific deficits.

The need for a broad range of services that are available over several years time also appears to offer the best hope for achieving symptom stabilization and early abstinence. Long periods of intensive services don't appear nearly as important as a range of services that are provided over a period of several years. While an understanding of the interaction between the co-occurring disorders may be an initial focus of treatment, later interventions are likely to deal with complex interpersonal skills and vocational difficulties.

From the clinical and research literature, several key principles have recently emerged to guide the design of treatment programs for individuals with co-occurring disorders in the justice system (Hills, in press). These include the following:

Dealing with both disorders as "primary." Mental health services for persons with co-occurring disorders have often been based on the concept that treatment of the "primary" (mental health) disorder would be sufficient to resolve the substance use disorder. This strategy has proved to be both simplistic and futile, with most persons with co-occurring disorders failing to make expected treatment gains or to achieve symptom remission due to their continued, therapeutically-unaddressed use of drugs or alcohol.

Treating disorders as “co-primary” does not mean that each will be given parallel emphasis at all times during service delivery. As noted, both disorders often have a cyclical course, with periods in which there is greater or lesser symptom intensity, and need for services. Nor does this approach preclude examination of substance use disorders that developed secondary to mental health symptoms; however the importance of determining the impact of substance abuse on mental health symptoms, psychosocial functioning, current symptom experience, and overall prognosis is not underestimated. Cross-training provides an important vehicle to develop this shared treatment emphasis within the multidisciplinary team and to communicate this emphasis to the offender, and increases the likelihood that both disorders are included in a comprehensive individualized service plan.

Integration of treatment services. Interventions provided for offenders with co-occurring disorders should address mental health and substance use disorders simultaneously. Accordingly, treatment services should address specific symptoms and behavior patterns associated with both sets of disorders. Treatment services should consider the interactive effects of co-occurring disorders and include treatment perspectives drawn from both mental health and substance abuse disciplines.

Parallel and sequential treatment approaches may be adequate in serving persons with less severe co-occurring disorders. Attempts to provide fully integrated treatment programming should be reserved for priority populations of individuals who have severe and persistent mental illness and substance use disorders, and who are at high risk for relapse, recurrence of mental health symptoms, and for rearrest and incarceration.

Individualized programming to address symptom severity and skill deficits. The multidisciplinary treatment team should meet prior to development of an individualized treatment plan to review different perspectives regarding diagnosis, onset of disorders, and interactive effects of disorders. The proposed treatment plan is then discussed with the offender to incorporate their impressions and to receive comments and suggestions for specific program services that are consistent with their own therapeutic goals. Even within homogeneous diagnostic groups,

individuals will present with different patterns of motivation for use, different levels of cognitive skills or deficits, and varying symptom intensity.

Treatment comprehensiveness and flexibility. Treatment services should be provided for individuals with different levels of symptom severity or dysfunction. These services should address a range of related psychosocial problems and different levels of commitment to treatment. Orientation and treatment activities should be flexibly designed for different diagnostic groups, individuals with different cognitive abilities, and different levels of motivation for treatment.

Though addressing the needs of persons with different diagnoses can be somewhat challenging, most treatment programs can begin by forming groups of individuals with similar diagnoses to address their unique issues. Persons with diminished cognitive skills may need additional group sessions to repeat and reinforce important concepts. When there are few treatment “slots” or services available, motivational groups may be designed to determine readiness for treatment. These groups may also address resistance among offenders who are reluctant to give up their substance use.

“Phased” treatment interventions should be of graduated intensity. Offenders with co-occurring disorders appear to achieve the greatest benefit from highly structured psychoeducational treatment approaches. Several program “phases” are often provided that include progressively less intensive services and supervision over time. Many programs provide three to four phases of treatment, with each phase lasting from two to six months. Aftercare/reentry phases may be somewhat longer in duration.

Early phases of treatment include an emphasis on orientation, assessment, development of a treatment plan, motivation, engagement, persuasion. Didactic approaches are particularly useful in early stages of treatment to help individuals understand their mental health disorder, and in understanding the biological aspects of mental illness and substance abuse. Secondary phases focus more on coping skills, life skills, lifestyle change issues, and cognitive-behavioral interventions. Later phases may include mentor activities, vocational training, and linkage with community peer support and treatment groups. Case management and relapse prevention

activities should be provided throughout the phases of treatment, with particular focus during pre-release and reentry phases, in which detailed relapse prevention and follow-up treatment plans should be developed. In jails, the relatively brief period of incarceration may prevent the use of a comprehensive phased treatment approach, and treatment services may need to focus on assessment, brief psychoeducational interventions, community “inreach” services, if available, and linkage to community services.

Treatment continuity. For offenders with co-occurring disorders, recovery and stabilization in the community sometimes require several years and multiple episodes in treatment. These individuals, may leave community-based treatment programs with little notice, and thus should be well informed of how to contact other available community services. Dual diagnosis programs should provide linkage with other treatment and ancillary services and develop an aftercare, transition, or post-release plan to insure continuity of services. Staff should also monitor the offender’s transition between different programs.

Recommendations for continued treatment services may come out of a “post-release” planning meeting, and may include referral to a halfway house or other adult congregate living facility, as a step-down to community care. Post-release plans are sometimes developed through use of a structured workbook format to help prioritize individual needs and to identify related services. Components of this plan may include living arrangements, reconnection with abstinence-oriented family members, vocational planning, continued participation in treatment, and self-help activities. A list describing the network of community service providers should be developed and provided at the time of treatment discharge. Whenever possible, case managers or service providers from agencies of subsequent referral should contact the offender prior to discharge and should assist in transition planning activities.

The transition from a jail setting back to the community may be more rapid and unpredictable than between community agencies, thus requiring a high level of coordination with community providers to insure that psychopharmacological and other treatment interventions are continued without interruption. Difficulties often emerge when prescriptions run out before

linkages have been established between the jail and community treatment providers. Forensic coordinators, or other mental health/dual disorders specialists (where available), can help to address difficulties in the transition from jail to community care.

Engagement in treatment. The research literature has shown that individuals with co-occurring disorders experience considerable fluctuation in their motivation and commitment to behavior change during early phases of treatment. Despite their attendance in treatment, offenders are not often initially committed to the idea of becoming abstinent (Drake, Rosenberg, & Mueser, 1996), and require ongoing work to promote motivation. If unaddressed, these issues are likely to lead to high rates of dropout and non-adherence to treatment regimens.

Early treatment interventions should address motivation to commit to treatment, and motivation levels should be subsequently monitored 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 (Griffin, Hills, & Peters, 1996) can all serve to enhance engagement in treatment. For short-term community programs, motivation and engagement activities should form the core of treatment for individuals with co-occurring disorders.

Psychopharmacological interventions should be used when appropriate. Psychiatric consultation should be provided during the initial assessment to examine the need for psychotropic medication, and to determine if the effects of medication might be compromised by current or recent patterns of substance abuse, or if medications may be contraindicated by these potential interactions. Over the course of treatment, offenders should be educated about their need for medication, why specific medications are prescribed for them, potential side effects, and how continued substance abuse would effect their use of medication. Medication needs and adherence to medication regimes should be closely monitored during treatment.

Physicians may have concerns about prescribing medications with addictive potential to individuals with co-occurring substance use disorders. Despite the addictive properties of some psychotropic medications, if used judiciously and with careful observation, these can be used with

significant benefit. Ideally, prescription neuroleptic medication should be delayed until four weeks of stable abstinence has been achieved. In practical application, severe symptoms should be immediately addressed whether or not stable abstinence has been established. Most of the currently prescribed medications have few serious side effects when combined with alcohol or drug use.

Involvement in peer support and self-help groups. Peer support and self-help organizations can play an important role in providing sustained attention and commitment to abstinence, in understanding how to cope with continued symptoms and pitfalls in the recovery process, and in providing support, encouragement, and reinforcement for progress towards recovery goals. The widespread availability and use of standardized formats enhance the utility of these services.

Difficulties have arisen in some areas when individuals with co-occurring disorders have been confronted regarding their use of psychotropic medications. Criticisms related to use of psychotropic medications are generally isolated to relatively few group members, and do not reflect written and stated policies of the parent organization (Alcoholics Anonymous/AA). However, instruction is needed in strategies to address these concerns, should they arise. Brochures are also available that describe official policies of the parent self-help organizations related to use of prescribed medications.

Modification of treatment services through reassessment. Given expected changes in symptoms over time that are related to the duration since the last period of substance abuse, the impact of treatment services, and response to medication; regular assessment is needed to examine which treatment goals have been accomplished, and which areas still require attention. As symptoms diminish, other psychosocial issues (e.g., vocational planning) may emerge which require additional services. Ongoing reassessment leads to needed diversity in treatment programming and planning (Griffin, Hills, & Peters, 1996). As some symptoms are addressed, symptoms of other disorders may be revealed such as characterological disturbances, eating disorders, problems with attentional deficits, or even previously unrecognized psychosis. As these symptoms are identified and evaluated, treatment services may need to be modified.

How are Community Treatment Approaches Modified According to the Mental Health Diagnosis?

As previously discussed, offenders with co-occurring disorders are characterized by significant diversity. Some offenders may use drugs to reduce apathy and withdrawal, whereas others may use to reduce the discomfort of tremors, muscle rigidity, and agitation. Still others may be motivated by peer or socialization concerns. Most substance use does not result in the effective reduction of targeted symptoms - contrary to popular beliefs regarding "self-medication." Differences in the range and intensity of mental health symptoms, cognitive abilities, and motivation for substance abuse necessitates that specialized treatment services are developed for offenders with different types of co-occurring disorders. This is often reflected in different types of orientation activities and specialized treatment groups. Treatment programs that provide dual diagnosis treatment of uniform scope and intensity are likely to experience considerable attrition and decompensation. Several different types of interactive effects between mental health and substance abuse disorders are discussed in the following section, with a review of treatment strategies that may be adapted for these individuals.

Major Depression. Though substance use is often intended to reduce symptoms, alcohol often acts to increase impulsivity and to increase suicidality. Women are more likely to have co-occurring depression and substance abuse, which frequently includes use of prescription drugs, stimulants, sedatives, tranquilizers and amphetamines (Peters, Strozier, Murrin, & Keams, 1997). High doses of either marijuana or hallucinogens can lead to anhedonia, chronic apathy, concentration difficulties and social withdrawal - all symptoms of major depression (Grant, 1995).

Treatment strategies for persons with co-occurring major depressive and substance use disorders often focus on the negative cognitions that lead to alcohol or drug use. Issues of loss and trauma can be addressed when an individual has achieved the ability to tolerate uncomfortable *mood* states without turning to substance abuse. Understanding how these issues are expressed emotionally, and how emotions are affected by drug and alcohol use are important needs to address in treatment.

Bipolar Disorder (Manic-Depressive Disorder). Use of even minor stimulants, such as caffeine or ephedrine, has been reported to increase manic episodes. Many individuals report using stimulants during manic periods to prolong or accentuate their experience. Individuals with bipolar disorder vary their drinking pattern according to different phases of the illness (Reich, Davies, & Himmelhoch, 1974), with chronic and excessive drinking predominating during mania, and periodic excessive drinking during depression. Weiss and Mirin (1989) found that cocaine has been used in both phases of bipolar disorder, in ever increasing doses.

In addition to the issues presented by the depressed phases of their illness, treatment for persons with bipolar disorder must address the impairment in judgement that occurs during manic episodes, and the effects of substance abuse on judgment. Treatment strategies often focus on building a repertoire of acceptable responses to manic or hypomanic impulses.

Psychotic-spectrum disorders. Alcohol, cocaine, and marijuana are the most common drugs of abuse among individuals with psychosis (Schneirer & Siris, 1987). These individuals may attempt to reduce side effects of psychotropic medication through substance abuse. Nicotine has also been found to reduce side effects (Decina, Caracci, Sandik, & Berman, 1990). Substance use may also serve to “mask” cognitive symptoms, or may occur in response to low energy or depression (Decker & Ries, 1993). For example, alcohol use may serve to reduce anxiety related to mental health symptoms. Alcohol or other drugs may exacerbate psychotic symptoms and may also contribute to medication non-compliance.

Program modifications for individuals with a co-occurring psychotic disorder include interventions that address disordered cognitions and communication style. Common modifications include reduced use of abstract concepts and confrontation, and greater structure and use of written materials. Persons with schizophrenia use alcohol and drugs for many of the same reasons as other offenders. Education in refusal skills, alternative strategies to ‘fight boredom, and building supportive social networks is essential for offenders with co-occurring psychotic disorders.

Anxiety Disorders. Drugs and alcohol are often used to reduce panic and generalized anxiety. However, increasing use of alcohol tends to heighten these symptoms. Posttraumatic stress disorder and substance use disorder co-occur at a “relatively high” rate (Najavits, Weiss, & Liese, 1996). The presence of either disorder alone can increase the risk for the onset of the other disorder. Anxiety and substance abuse disorders have a more enduring relationship than other co-occurring disorders, in which abstinence often leads to symptom reduction (Brown & Schuckit, 1988).

Treatment of co-occurring anxiety disorders focuses on the context in which anxiety is heightened. This may require interventions to improve social skills or to modify cognitions associated with difficult interpersonal situations. Treatment may also involve development of drug-free adaptive responses to traumatic situations. Skills and techniques to address anxiety-induced insomnia may also be needed.

Attention-Deficit/Hyperactivity Disorder (AD/HD). There is growing evidence that approximately half of these disorders occur in adulthood, and often co-exist with anxiety, mood, antisocial personality and substance use disorders (Hills, in press). The most common drug of abuse among this group is marijuana. It is often difficult to distinguish impulsivity, hyperactivity, and distractibility from substance abuse, particularly stimulant abuse. If present, substance use and mood disorders are usually treated prior to use of medication (Wilens, Prince, Biederman, Spencer, and Frances, 1995).

Interpersonal difficulties, social skill deficits, and cognitive skill building to address impulsiveness and aggression are often the foci of treatment interventions for persons with co-occurring AD/HD disorders. Repetition of important themes and skill rehearsal are often provided with this population.

Personality Disorders. Personality disorders are quite common among offenders with co-occurring disorders, both in community and institutional settings. Antisocial personality disorder

and borderline personality disorder are the most common among offenders, and are both characterized by difficulties in impulse control and high rates of substance use disorders. Mood disorders are commonly found among persons with borderline personality disorder. For each of the personality disorders, impaired judgement and impulsivity are exacerbated by co-occurring substance use.

Many of the symptoms of antisocial personality disorder (e.g., repetitive involvement in criminal behavior, lying to or conning others, impulsivity, irresponsibility) are also exhibited by chronic substance abusers, and often remit following involvement in long-term substance abuse treatment. Thus, it may be useful to delay providing definitive Axis II diagnoses for individuals involved in treatment, and whose interpersonal behavior and antisocial lifestyle has likely resulted from their chronic substance abuse. Many clinicians recommend that diagnosis of substance use should be completed prior to consideration of personality disorders.

Each personality disorder presents different challenges in developing treatment services. The presence of a mood or anxiety disorder in an individual with antisocial personality disorder is considered a positive prognostic indicator for treatment (Woody, McLellan, Luborsky, & O'Brien, 1985). As the symptoms of personality disorders are typically expressed in interpersonal contexts, most interventions focus on the cognitions and behaviors associated with the drug use and impulsive acts.

What are the Barriers to Accessing Treatment Among Individuals with Co-Occurring Disorders in Community Corrections Settings?

There are a range of barriers to accessing dual diagnosis treatment in community settings. As the complexity of the individual's presentation increases, the list of appropriate and available treatment resources typically decreases. Probation and parole officers often have little opportunity to interact with community providers, who themselves may be unaware of viable service options. Listed below are some common difficulties in placing or retaining offenders in dual diagnosis treatment.

Discontinuity in treatment services from the institution to the community. Offenders with co-occurring disorders are frequently released from jail or prison with little more than a phone number to assist them in continuing their mental health or substance abuse treatment. Very often they are discharged with no more than three days of medication and with little information about how to continue receiving these medications. Under these circumstances, offenders often discontinue involvement in treatment; leading to recurrence of symptoms and criminal recidivism.

Long waiting lists for counseling or residential services. Long waiting lists can serve as a barrier to continued involvement in treatment. For impulsive persons with limited motivation, a delay in obtaining services may be a decisive factor in discouraging involvement in treatment. Often appointments are structured such that a new client cannot gain direct access to a psychiatrist until they have completed a screening interview, which also tends to prevent the use of psychiatric services among individual's with co-occurring disorders.

Exclusionary criteria. Many substance abuse and mental health programs are reluctant to serve offenders, or screen out individuals with co-occurring disorders. If programs do not specifically describe themselves as serving those with co-occurring disorders, persons seeking treatment who present with a complex symptom history are often discouraged from entering treatment. Ironically, it is likely that more than half of the individuals in community mental health settings have a co-existing substance use disorder which may or may not have been diagnosed or addressed during treatment.

Limited availability of specialized dual diagnosis treatment services. In community and correctional settings, there are very few specialized treatment programs. Competition for these specialized resources can be intense, and offenders may be seen as undesirable treatment candidates.

Limited awareness of available dual diagnosis treatment programs. Probation and parole officers who make referrals to existing services often have only limited knowledge of the scope of available treatment resources.

Reliance on publicly-funded, community-based services. Offenders with co-occurring disorders must often rely on these services as they lack the resources to pay for treatment. As a result, they must compete with other low-income individuals to receive adequate and timely service. As public dollars for community services have become more scarce, dual diagnosis treatment services have become more difficult to obtain.

Requirement of medical clearance. Attempts to receive services for co-occurring disorders may be inhibited by requirements for medical clearance, which may include use of medical and laboratory tests. Most offenders have limited resources to obtain these preliminary tests. Obtaining these test results often leads to a delay in receiving treatment services, and can discourage involvement in treatment.

Confidentiality issues. Because persons with co-occurring disorders are often seen in multiple service settings, increased communication is required among service providers. This process often becomes complicated by service providers' reluctance to share information from their clinical records. Most often this is based on reasonable clinically-based concerns about the appropriate use of records. However, information from clinical records is sometimes withheld due to distrust and/or competition between mental health and substance abuse service providers. Sharing of clinical information is always allowed if a valid consent form has been signed. These forms are readily available and used commonly in most treatment settings.

How Can Individuals with Co-occurring Disorders be Integrated Within Existing Community Treatment Programs?

As noted previously, many community mental health and substance abuse treatment programs have traditionally excluded individuals who have co-occurring disorders. In reality, a large proportion of those already in mental health or substance abuse treatment have co-occurring disorders, although these may not always be detected or addressed in treatment. In order to best meet the needs of this population, treatment programs would optimally develop specialized dual diagnosis services or "tracks," although this sometimes requires additional planning, staff resources, training, supervision, and space.

Barring the development of specialized services, community treatment programs should develop reasonable steps to accommodate the needs of individuals with co-occurring disorders, such as those related to mental health counseling and medications. Depending on symptom severity, it may not be necessary to have the offender leave the service setting to which they were initially assigned. For example, if cross-program consultation services are provided, special needs (e.g., mental health counseling) may be addressed effectively. Similar collaborative arrangements can be made for individuals who are identified during the course of mental health treatment to have a serious substance abuse problem.

Guidelines for Placement in Community Treatment Services

As noted previously, many mental health and substance abuse treatment programs in the community have traditionally excluded offenders with co-occurring disorders. Restrictive eligibility criteria used in many of these programs are often based on inaccurate myths about this population (e.g., regarding violence potential, dangerousness, and treatment resistance). Lack of staff training and experience related to co-occurring disorders increases the likelihood of use of restrictive and exclusionary admission criteria. The following guidelines should be considered regarding placement of offenders with co-occurring disorders in community treatment programs:

- Mental health and substance abuse treatment programs that serve individuals who are supervised in the community should strive to be inclusive in admitting individuals with co-occurring disorders and other potentially disabling conditions (e.g., physical handicaps).
- Many probationers and parolees with mental health problems have successfully participated in substance abuse treatment programs. Similarly, many with substance abuse problems have been successfully involved in mental health programs.
- Community mental health and substance abuse treatment programs should not restrict admission solely on the basis of co-occurring disorders or a history of treatment for one or both disorders, but should instead consider the degree to which these disorders lead to functional impairment that inhibits effective program participation.
- Key indicators that suggest potential impairment in functioning within community treatment programs include:
 - Paranoia, hallucinations, delusions, severe depression, or mania (i.e., hyperactivity and agitation) that occurs frequently, is obvious to others, is disruptive to group activities, or that otherwise prevents constructive interaction with treatment staff or participants.

- Lack of stabilization on psychotropic medication, or failure to adhere to medication.
- Suicidal thoughts or other behavior.
- Inability to achieve sustained abstinence from drugs or alcohol, even when involved in progressively more intensive treatment services.
- Each community treatment program should evaluate its' capacity to work with individuals who have co-occurring mental health or substance abuse problems. This should include examination of existing program resources, other community mental health and substance abuse services, and identification of levels of functioning needed to participate effectively in the program.
- Training should be provided to screening, assessment, and treatment staff in identification of mental health symptoms, the nature and course of mental health disorders, commonly prescribed psychotropic medications, referral for mental health services, drug testing, and in methods of substance abuse treatment.

What Types of Community Treatment Resources are Needed for Individuals with Co-Occurring Disorders?

Offenders with co-occurring disorders are quite heterogeneous and require a broad range of treatment services during the lengthy period of recovery. Service requirements vary as a function of the symptom severity of each of the presenting disorders. As described previously, offenders with co-occurring disorders may require several phases or stages of treatment. These may include acute stabilization of mental health and substance use disorders, involvement in engagement or persuasion activities, and “active” treatment, followed by a “recovery” or prolonged stabilization phase. During each of these stages, assessment and treatment activities will address different symptomatic or functional issues. Listed below are several important points of contact or treatment settings that are used during community supervision of individuals with co-occurring disorders.

Case management. Case management services are frequently considered the ‘core’ set of services provided for offenders with co-occurring disorders. Case managers often negotiate contact across various different 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 also help

to coordinate and monitor scheduled appointments, and provide important linkages to community supervision officers.

Psychiatric services. Psychiatric services are needed to evaluate and monitor use of medication, and to provide education regarding the interactive effects of medication with alcohol and illicit drugs, importance of adherence to medications, and the side effects of medication. Psychiatrists also can provide support for the continued use of medication while offenders are involved in peer support groups.

Central intake. A central, single point of initial contact for police, probation officers, family members, treatment staff, and other providers is used in some jurisdictions to help coordinate the collection and exchange of information, and to strengthen the process of referral to treatment and ancillary services. Use of a central intake location also insures that standardized screening is conducted for offenders with co-occurring disorders, whose disorders may otherwise go undetected. Central intake facilities are also useful in compiling information regarding offender characteristics and service needs. In addition to screening, key services provided include detoxification, physical/medical examination, psychiatric consultation, psychological evaluation, consultation with community supervision officers, and triage to mental health or substance abuse services.

Non-residential/day/outpatient treatment. Most of the “core” dual diagnosis treatment services are provided in non-residential settings or treatment phases.. These services are of varying intensity and are typically provided over a period of several years. Non-residential services are consistent with the current managed health care environment, in which inpatient services are typically reserved for short-term treatment of acute problems. Non-residential settings present several challenges for offenders with co-occurring disorders who may reside in an area in which they have previously experienced substance abuse problems.

Non-residential programs range from less intensive (e.g., one to two hours, one to two days per week) to more intensive (e.g., four to five hours, four to five days per week). Key services include motivation and engagement groups, symptom monitoring and stabilization,

psychoeducational and therapy groups focused on the interaction between disorders, medication use and adherence, stress management, anger management, relapse prevention, problem solving, and involvement in recovery and peer support programs. These settings also provide family involvement, vocational services, case management, and access to psychiatric services.

Residential or inpatient treatment. These services are usually reserved for individuals with severe symptoms or functional impairment. Individuals who are suicidal, dangerous to themselves or others, or who require close observation to monitor their medication regimen are often placed in residential treatment. This setting is also used for individuals who are unable to achieve sustained abstinence in the community. Key services provided in residential settings include acute symptom stabilization, medication monitoring and adjustment, and observation for suicidal behavior. Longer-term residential programs focus on developing lifestyle modifications.

Detoxification. Detoxification services are used for individuals who are experiencing acute intoxication and withdrawal, and who require a short-term secure environment. Detoxification provides an important alternative to arrest or placement in costly residential treatment programs. These services also provide a good opportunity to provide screening, linkage to mental health, substance abuse, and other treatment services, and to address relapse prevention issues. Key detoxification services include stabilization of withdrawal symptoms, and establishment of abstinence prior to placement in treatment.

Halfway houses. Halfway houses frequently are used in the transition between residential or institutional services to the community, and provide a supportive environment to assist in maintaining abstinence. Halfway houses are quite useful in developing linkages with peer support networks in the community. They are also used whenever more structure and supervision might be required, such as for offenders who require monitoring of medication adherence, and development of vocational and independent living skills. The availability of halfway houses is limited in many jurisdictions. In addition, more halfway houses are needed that include mental health and substance abuse services.

SUPERVISION AND CASE MANAGEMENT STRATEGIES

Community supervision officers are faced with numerous challenges in working with offenders who have co-occurring disorders. In the absence of comprehensive and integrated services in institutions and in the community, these individuals tend to repeatedly cycle through treatment, probation caseloads, jail, and prison, and are at high risk for substance abuse relapse and other behaviors that often lead to involvement in the criminal justice system. Offenders with co-occurring disorders are more likely to reoffend or to receive sanctions when they are not taking medication, when they are not in treatment, and when they are experiencing mental health symptoms. Community supervision of offenders 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.

Goals of supervision for offenders with co-occurring disorders include the following:

- Enhance public and institutional safety.
- Provide ongoing monitoring and surveillance.
- Promote ongoing involvement in treatment.
- Reduce substance abuse and mental health symptoms.
- Stabilization on medications, and detoxification from drugs and alcohol.
- Develop enhanced awareness of the consequences of behavior, the relapse process, and the importance of treatment.

Community supervision strategies for offenders with co-occurring disorders should consider several unique characteristics of this population. One important consideration is that even moderate levels of alcohol or drug use may trigger recurrence of mental health symptoms or other behavior problems that may lead to criminal behavior. As a result, conditions of probation and parole should restrict use of alcohol, frequent drug testing should be provided, and community supervision officers should carefully monitor the early warning signs of substance use.

Offenders with co-occurring disorders are more likely to have cognitive limitations that affect their community supervision, such as difficulties in attention and concentration, memory, abstract reasoning, problem solving, and planning ability. For example, they may not understand

or remember critical information regarding their court or 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 of these limitations, instructions may need to be repeated several times by community corrections officers, and regular written reminders provided of upcoming appointments and consequences of infractions and non-compliance with treatment requirements.

Individuals with co-occurring disorders have a wide range of functional abilities related to community supervision tasks and demands. As a result, treatment and supervision requirements should be matched to the offender's level of functioning. For example, flexibility should be provided to adjust these requirements according to demonstrated abilities to handle confrontation, group interaction, and to provide sustained attention during **treatment** activities (Pepper & Hendrickson, 1996). Offenders with co-occurring disorders tend to be more disorganized than others who are supervised in the community, and benefit from considerable daily structure and external monitoring to insure adherence to rules and regulations. A final consideration in adapting supervision strategies for offenders with co-occurring disorders is that these individuals may not respond favorably to confrontation (e.g., regarding their "addiction" history).

Offenders with co-occurring disorders who are supervised in the community are likely to have contact with a range of criminal justice and treatment staff, particularly in communities that do not have specialized dual diagnosis programs and in which mental health and substance abuse services are provided concurrently in separate locations. Each of these staff will have differing roles and responsibilities; philosophies regarding supervision, management, and treatment; and tolerance for "risk" to the community. Within this context, conflicts sometimes arise related to sharing of information, responding to critical incidents (e.g., positive drug tests, contraband discovered at offender's residence or in treatment setting, missed treatment or supervision appointments, change in attitude regarding treatment), and evaluating progress in treatment. Offenders 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.

Conflict arising from involvement of multidisciplinary staff can be greatly reduced through use of treatment teams that include both community supervision and treatment staff. Treatment teams provide an important opportunity to discuss contrasting goals and approaches endorsed by supervision and treatment staff, and to develop consensus regarding roles of each of the team members. Treatment teams also provide a vehicle to share information about the offender's status and treatment participation, to identify and review critical incidents, to develop appropriate sanctions or other responses to these incidents, and to update the treatment and supervision plan. It is often useful for treatment teams to discuss the types of critical incidents that are likely to occur during the course of community supervision, to develop agreements regarding the types of information to be shared between supervision and treatment staff regarding critical incidents, and to review the types of general responses (e.g., sanctions) that might be developed as a result of these incidents.

Relapse prevention approaches can provide a unifying organizational structure, theme, and vocabulary for treatment teams (Clear, Byrne, & Dvoskin, 1993; Peters, 1994). These approaches focus on early identification of and response to warning signs, high risk situations, and other precursors of mental health and substance abuse problems through use of a community relapse prevention network. Treatment teams also provide a useful forum by which to promote cross-training of staff in issues related to co-occurring disorders.

As noted previously, community supervision strategies may need to be adapted for offenders who have co-occurring disorders. Effective supervision strategies for this population include the following:

- Recognition of special service needs (e.g., individual counseling, transportation, housing, medical care, vocational support).
- Use of supportive rather than confrontative approaches in discussing substance abuse and related problem areas, and in monitoring compliance with conditions of community supervision.
- Provide support (e.g., verbal praise) for small successes and indicators of progress.
- Adjust expectations regarding the response to supervision in recognition of the disruptive effects of mental health symptoms.
- Apply flexibility in responding to infractions (e.g., missed appointments).

- Use concrete directives, frequently repeat directives, and assess the offender's understanding of directives.
- Promote a highly structured set of daily activities, and support the offender's use of planning skills to organize daily activities.
- Take initiative to schedule appointments for the offender (as needed), and monitor attendance at appointments and treatment activities.
- Provide ongoing monitoring of recurrence of mental health and substance abuse symptoms (e.g., through assertive questions regarding mental health status and symptoms, by contacting collaterals, and frequent drug testing).
- Use of multidisciplinary teams that include community supervision officers and mental health and substance abuse treatment staff, for purposes of monitoring progress towards supervision and treatment goals and developing responses to infractions and other offenses.

Offenders with co-occurring disorders are best served by officers with special caseloads that focus on mental health needs, substance abuse needs, or co-occurring disorders. Caseloads should be smaller than ordinary to accommodate the need for more intensive supervision, monitoring, and ongoing contact. Officers should have specialized training in issues related to co-occurring disorders, and significant prior experience in supervising traditional probation caseloads. In the absence of this type of training, unusual and unpredictable behaviors related to mental health disorders are often interpreted by community supervision staff as noncompliance with supervision rules, rather than as indicating the need for mental health consultation and treatment.

What are the Characteristics of Case Managers and Community Corrections Staff who are Most Effective in Working: with this Population?

The following staff characteristics are desirable among community supervision officers, case managers, treatment staff, and others working with offenders who have co-occurring disorders:

- Understands and respects the rehabilitative goals of community supervision activities.
- Patient in working with individuals who have disabilities, and able to provide reinforcement for small steps toward supervision and treatment goals.
- Able to maintain a long-term perspective regarding realistic community supervision and treatment outcomes.
- Interested in principles of counseling, psychology, and rehabilitation.

- Has prior educational course work in psychology or social sciences.
- Has previous work experience in mental health or allied health care fields.
- Experienced in supervising offenders with mental health and substance abuse problems, and familiarity *with* local mental health and substance abuse treatment agencies.
- Able to set clear boundaries between work and personal life.
- Has a strong social/family support system and manages stress effectively.

What Type of Specialized Community Supervision Orders Should be Developed for Individuals with Co-Occurring Disorders?

Conditions of supervision developed by the court at the time of sentencing can encourage involvement and successful completion in dual diagnosis treatment services. These conditions optimally provide a blend of specific requirements (e.g., drug testing twice weekly) and more general guidelines (e.g., complete an assessment and enroll in treatment as required by the treatment provider), to enhance the flexibility of community treatment agencies and supervision officers in developing recommendations based on information that may not be available at the time of sentencing.

The vast majority of offenders with co-occurring disorders will not successfully comply with requests from community supervision officers to obtain ongoing community treatment services on a voluntary basis (Pepper & Hendrickson, 1996). As a result, court-ordered treatment is the only reliable means to insure that offenders receive specialized treatment services, particularly in the absence of family members, friends, or employers who might otherwise provide leverage and external motivation for involvement in treatment. For some offenders, court-ordered treatment may reduce the shame and stigma associated with involvement in a dual diagnosis program by allowing them to temporarily attribute their participation in treatment to requirements imposed by the judge or probation officer.

The following types of community supervision orders have been found to be useful for offenders with co-occurring disorders:

- 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.
- Abstinence from illegal drugs.
- Use of alcoholic beverages is prohibited.
- The individual will not visit businesses whose major source of income is the sale of alcoholic beverages.
- Report to the community supervision officer as ordered.
- Abide by standard orders of curfew.
- Comply with other community supervision orders (e.g., fees, victim restitution).

Training Issues

Cross-training should be provided for community supervision officers, case managers, treatment staff, and others who provide services for offenders with co-occurring disorders. Through this process, the different professional disciplines can inform each other of key strategies for supervision, management, and treatment of this population. For example, community supervision officers can review the type of information related to critical incidents (e.g., positive drug screens) 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.

Several key training issues for staff working with offenders who have co-occurring disorders include the following:

- Identification of signs and symptoms of mental illness and substance abuse.
- Awareness of the range and scope of mental health disorders (e.g., diagnostic categories and definitions, course of disorders, cognitive symptoms).

- When and how to arrange for mental health evaluation.
- Characteristics of psychotropic medications (e.g., common medications for different disorders, side effects), interactive effects of medications with drugs and alcohol, and effects of medications on drug testing.
- Development and use of an integrated system of sanctions and treatment to respond to critical incidents.
- Flexibility in responding to noncompliance with community supervision rules (e.g., missed appointments).
- Use of supportive rather than confrontative treatment and supervision approaches.
- Adjusting expectations regarding outcomes of supervision (e.g., developing long-term goals of abstinence).
- Identification of existing community treatment resources and ancillary services.
- Strategies for accessing community treatment resources and ancillary services.

SUMMARY

A significant number of persons with co-occurring mental health and substance use disorders are involved in the criminal justice system, including an estimated 3-11 percent with diagnosable Axis I disorders. A large proportion of these individuals are placed under community supervision. Offenders with co-occurring disorders are at higher risk for a range of problem behaviors and for criminal recidivism. Recidivism is due in part because the “dual disorders” are undiagnosed or are inadequately addressed in the numerous criminal justice settings and service systems that are encountered.

Screening for co-occurring disorders should be provided for all offenders placed under community supervision, given the high rates of those disorders. Screening should occur at the earliest possible point after involvement with the justice system and while under community supervision. Ongoing screening should be provided as an individual is transferred between supervision officers, agencies, or jurisdictions. Standardized screening approaches should include examination of the criminal justice history, mental health disorders, substance use disorders, the interactive effects of co-occurring disorders, motivation and readiness for treatment, suicidal thoughts and behavior, and infectious disease. Interview, test; archival, and other collateral sources of information should be used in screening. Several validated screening instruments are available to examine both mental health and substance use disorders.

A full assessment of the offender’s co-occurring disorders typically occurs after referral to treatment. Assessment and diagnosis are optimally delayed for four to six weeks for individuals who have not attained sobriety, in order to clarify symptoms of co-occurring disorders. A complete picture of the person’s history of mental health and substance use disorders should be obtained, in addition to examination of interactive effects of the disorders, family and social relationships, medical history and status, and criminal justice history and status. When time permits, a comprehensive battery of tests and structured interviews should be used in the assessment.

Treatment of offenders with co-occurring disorders should focus on obtaining integrated treatment services. Due to the chronic and relapsing course of severe mental illness and substance

use disorders, a comprehensive range of services are often required during the course of the person's involvement in-treatment. These services may include case management, intensive outpatient or residential services, psychiatric or psychopharmacological consultation, and detoxification services.

Varying models of intervention have been developed to address the needs of persons with co-occurring disorders. Therapeutic communities have been modified as have 12-step programs. Cognitive-behavioral interventions that were previously designed to address mental illness have been expanded and modified to address co-occurring substance use. Relapse prevention programs have also been modified to address the interaction between mental health and substance use disorders. Treatment adaptations for offenders with co-occurring disorders include more individualized services, greater emphasis on psychoeducational and supportive approaches, greater use of individualized counseling, more gradual presentation of material, shorter duration of treatment groups, use of visual and other learning aids, and higher staff-to-client ratios.

Key principles of treatment that should be adapted within programs serving offenders with co-occurring disorders include definition of both disorders as "primary," integration of mental health and substance abuse treatment services, and individualized programming according to symptom severity and functional impairment. Community dual diagnosis programs should be comprehensive in scope and flexible in their ability to serve offenders with different diagnoses and differing levels of motivation. Treatment programs should provide interventions of graduated intensity that include an initial focus on motivation, persuasion, and commitment to recovery; **and** a subsequent focus on development of coping skills and lifestyle change. Programs **should provide** opportunities for ongoing participation in treatment services, for psychiatric **consultation, and for** involvement in peer support groups.

Community supervision of persons **with co-occurring disorders requires additional** monitoring to review abstinence and recurrence of symptoms, and to insure compliance with court requirements. Smaller, "special needs" caseloads are useful to respond effectively to the increased demands placed on community supervision officers. Supervision approaches should **be modified** for offenders with co-occurring disorders to include use of multidisciplinary

treatment/supervision teams, flexibility in responding to infractions, and use of supportive rather than confrontative techniques. Supervision officers and others working with this challenging population should be involved in cross-training related to the complicated symptom presentation, the interactive nature of co-occurring disorders, use of an integrated system of sanctions and **treatment** services, as well as specialized management, supervision, and treatment strategies.

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About the GAINS Center

The National GAINS Center for People with Co-Occurring Disorders in the Justice System was established in 1995. The Center gathers information about mental health and substance abuse services provided in the justice system, tailors materials to the specific needs of localities, and provides technical assistance to help them plan, implement and operate appropriate, cost-effective programs.

The GAINS Center is a federal partnership between two centers of the Substance Abuse and Mental Health Services Administration - the Center for Substance Abuse Treatment and the Center for Mental Health Services - and the National Institute of Corrections.

The GAINS Center is operated by Policy Research, Inc. in collaboration with the Louis de la Parte Florida Mental Health Institute. For more information, contact:



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