

Residential Substance Abuse Treatment (RSAT)

Training and Technical Assistance

RSAT Training Tool: Understanding Co-Occurring Disorders and Applying Integrated Treatment Strategies for Adult Correctional Populations

This curriculum is a cross-disciplinary training curriculum designed to increase knowledge and awareness of the relationship between substance use and mental health disorders among people involved in RSAT jail and prison programs. It is directed at program planners and coordinators, counselors, case managers, behavioral healthcare providers, correctional officials and others.

Lisa Braude, PhD
Niki Miller, M.S. CPS

November 23, 2011



BJA
Bureau of Justice Assistance
U.S. Department of Justice

AHP
Advocates for
Human Potential, Inc.

TASC
Treatment Alternatives for Safe Communities



This project was supported by grant No. 2010-RT-BX-K001 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

**RSAT TRAINING TOOL: UNDERSTANDING CO-OCCURRING DISORDERS &
APPLYING INTEGRATED TREATMENT STRATEGIES FOR ADULT
CORRECTIONAL POPULATIONS**

**LISA BRAUDE, PHD
NIKI MILLER, M.S. CPS
ADVOCATES FOR HUMAN POTENTIAL, INC.**

***THE AUTHORS WOULD LIKE TO ACKNOWLEDGE THE FOLLOWING FOR THEIR
CONTRIBUTIONS TO THIS CURRICULUM: CHRISTINA WIGGLESWORTH, DEBRA
BOISVERT, KAYLA BOISVERT AND NOAH SHIFMAN.***

Table of Contents

Introduction.....	3
Relevance to Correctional Environments.....	7
Module I: Introduction to Co-Occurring Disorders	9
Module II: Screening and Assessment Practices for Co-Occuring Disorders	18
Module III: Best Practices for Inmates with Co-Occurring Disorders.....	28
Module IV: Implementing Integrated Treatment in Corrections	42
Works Cited:	50

RSAT TRAINING TOOL: UNDERSTANDING CO-OCCURRING DISORDERS & APPLYING INTEGRATED TREATMENT STRATEGIES FOR ADULT CORRECTIONAL POPULATIONS

Introduction

AUDIENCE:

Residential Substance Abuse Treatment (RSAT) program staff, addiction professionals, case managers, correctional staff, mental health counselors, correctional officers, volunteers, peer recovery support specialists and Chaplains.

PURPOSE:

This curriculum is a cross-disciplinary training designed to increase knowledge and awareness of the relationship between substance use and mental health disorders among people involved in RSAT jail and prison programs to ensure treatment for each condition supports recovery from the other.

The goal of this tool is to introduce general concepts and terminology, research, effective screening and assessment practices and interventions for RSAT programs serving people in substance use treatment that have co-occurring mental health and disorders.

OBJECTIVES:

The goals of this tool are to:

1. Increase knowledge about the origins of mental health and substance use disorders (i.e.: co-occurring disorders)
2. Increase knowledge about the nexus between co-occurring disorders and justice system involvement
3. Understand the principles of effective screening and assessment practices and tools to identify co-occurring disorders
4. Understand the principles of integrated substance abuse treatment for co-occurring disorders, and its impact on criminal behavior
5. Increase staff's ability to champion integrated treatment and to educate clients about the resources for sustaining recovery from both disorders.

The modules contain participatory exercises, resources for additional learning, and a review of the topics covered. While it is impossible to address all aspects of programs and practices, the resources offer more complete information on a number of content areas.

Why? There is no doubt that substance use can exacerbate symptoms of mental health disorders. In turn, mental health problems can contribute to the initiation of substance use, hasten a client's progression into dependency, and prompt a return to drug and alcohol use. In worst case scenarios, treatments that focus solely on one disorder without considering the other may actually aggravate symptoms. Examples include addiction treatment that discourages the use of non-addictive psychiatric medications even when the medications provide the client with needed relief and improved quality of life; or mental health treatment that include prescribing addictive tranquilizers to clients with histories of alcohol abuse, often resulting in a poly-addicted client.

Historically, there have been territorial issues and disagreements among disciplines about which disorder is primary, more serious and whether one precipitated the other. When clients are caught in the middle of different, incomplete systems of care and don't get effective help for their full range of needs, their risk of ending up in the criminal justice system increases. Today, we know that getting clean and sober is not a panacea guaranteed to clear up any mental health disorder; just as therapy into the deep seated reasons for drug use is not likely to produce a cathartic experience "curing" an opiate dependent individual of their compulsion to use.

For many offenders, the justice system is the first point of entry into substance use treatment. Others may have made multiple attempts at treatment and recovery, but untreated mental health problems continue to sabotage each period of sobriety, thus resulting in a revolving door of recidivism (Miller & McDonald, 2009). Still others have sought mental health services while their substance use went untreated, eventually, contributing to their criminal justice involvement. Unfortunately, many individuals are not diagnosed with co-occurring disorders until they enter the justice system.

Compared to other offenders, when people with co-occurring disorders (COD) are incarcerated, it is likely to result in a significantly longer stay, more disciplinary actions while in prison, and more incidents of victimization while incarcerated (Wolf, Shi, & Blitz, 2008). When offenders with COD's are released, they are more likely to be homeless, suicidal, use substances, and not surprisingly, rearrested (Monahan et al., 2001; Peters, Sherman, & Osher, 2008).

However, just as one disorder can aggravate the other, one recovery can support the other. The challenge for RSAT staff is to understand how these conditions interact and provide inmates the tools to manage recovery from both substance use disorders and mental illness, attending to each before it triggers the other.

The [National Institutes of Health](#) and the [Substance Abuse and Mental Health Services Administration](#) agree that both substance use and mental health disorders are brain conditions that respond better to an integrated approach to treatment and to achieving and sustaining recovery.

APPROACH:

Substance abuse treatment services for people with co-occurring disorders may be delivered in a few different ways, but mounting evidence supports the third approach – integrated treatment – for individuals with co-occurring disorders.

1. Sequential treatment—targeting one disorder first and then the other disorder, often in separate systems of care
2. Parallel treatment—distinct treatment and interventions that target each disorder separately, but delivered during the same time frame, usually by different providers
3. Integrated treatment—specialized interventions that work concurrently for both substance use and mental health recovery

This manual will focus on the third approach both because it has proven the most efficacious and RSAT programs are in an ideal position to pursue it. The most recent literature identifies the basic competencies for administering integrated treatment. This training introduces these competencies, including:

- Prevalence, course, signs, and symptoms of co-occurring disorder
- Interaction of symptoms of mental and substance use disorders
- Strategies for enhancing accuracy of screening and assessment information among those who have co-occurring disorders
- Use of specialized screening and assessment instruments
- Integrated treatment approaches and other evidence-based practices
- Supervision and sanction approaches for individuals with co-occurring disorders
- Specialized services available in the community for justice-involved individuals with co-occurring disorders, and procedures for initiating referrals for assessment and treatment services (Peters et. al., 2008).

For RSAT clients with co-occurring disorders, integrated treatment is the most appropriate course of treatment. This curriculum discusses the benefits of integrated screening, assessment, and treatment strategies.

This curriculum discusses the benefits of integrated screening, assessment, and treatment strategies for RSAT inmates.

Each of the modules in this series is centered on six basic principles to foster professional development and promote safe, effective and efficient service provision. These principles include:

1. *Evidence-based strategies*-There is extensive research that looks at treatment strategies in “real world” settings, such as jails and prisons that has identified the practices that are the most effective with different populations. These “evidence-based” practices identify the best practices in behavioral health services that are compatible with effective substance use treatment, institutional security, and offender rehabilitation.
2. *Integrated interventions*- We will spend most of this training discussing integrated strategies. To briefly introduce this concept, “integrated” refers to strategies that attend to all of an individual’s needs with a general emphasis on values and personal responsibility; targeting trauma, substance use recovery issues, mental health and wellness, developing pro-social attitudes and reducing associated risk factors for recidivism.
3. *Recovery-oriented approaches*- The old adage, “once an addict always an addict” no longer applies today. Science has shown us that recovery from addiction and from mental illness is possible. Approaches that are recovery-oriented focus on the individual strengths and needs of clients and ensure they receive the community support, such as housing, that they need.
4. *Present day accountability*- While inmates’ life histories may be characterized by patterns of illegal and anti-social behavior, the intention of treatment is to increase coping skills, enhance client motivation, teach and reinforce pro-social behavior, and hold clients accountable for mastering their thoughts and controlling their behavior.
5. *Culturally aligned content*- RSAT staff must account for the overriding issues related to access to care for individuals re-entering the community, and racial and economic disparities and stigma. Re-entry linkages and resources are critical challenges for RSAT staff and require a realistic appraisal of the level of marginalization clients’ face. Also, the cultural issues of the different professions align when treatment is integrated; correctional staff, mental health professionals, substance abuse treatment providers and community-based supports.
6. *Strength-based orientation*- People with co-occurring disorders are especially susceptible to being labeled. Providers in one or both systems may have written them off as resistant or hopeless. Treatment is most effective when RSAT staff can help clients learn to recognize their strengths in some areas that can help them compensate for deficits in other areas.

Relevance to Correctional Environments

Both the corrections field and the behavioral health fields have identified evidence-based approaches based on research and evaluation data. Although each system has different goals and outcome measures, there are many areas of overlap. Correctional treatment programs and correctional environments both have two primary goals: (1) to reduce disruptive behavior within the institution; and (2) to reduce the risk of recidivism when offenders are released to the community.

It is useful for staff of RSAT programs to understand that risk and need principles and approaches aimed decreasing criminal behavior and recidivism work the same way for offenders with behavioral health disorders. Research on risk and needs among offenders has been validated for people with COD's. The major predictors of recidivism for people with COD's are factors like criminal associates, criminal history and criminal thinking (Prins & Draper, 2009) Good correctional practices require environments that are highly structured and safe, with predictable limits, incentives and boundaries, as well as swift and certain consequences, applied fairly and consistently. These values are congruent with key characteristics of an effective treatment approach: safety, predictability, and consistent boundaries, rewards and limits. Treatment within correctional facility-based therapeutic communities presents a unique opportunity to help people with COD's that they may not have had prior to involvement with the justice system.

RSAT programs are in a unique position to provide:

- A long term treatment environment for learning new behaviors and coping skills, and an extended period to test, practice and adopt them while interacting with peers who are doing the same
- Treatments that can immediately reward and reinforce new behavior and pro-social interactions and provide immediate sanctions for returns to criminal or addictive behaviors with progressive measures, affording opportunities for "course correction" without terminating treatment.

This course explores workforce challenges and opportunities in a correctional environment while introducing integrated treatment practices for substance abuse and co-occurring mental health disorders. It also presents recent research findings that have shaped new integrated approaches. This curriculum is tailored to adult RSAT programs in correctional environments and the challenges of providing integrated treatment within the limitations of prison or jail settings.

This manual stresses a realistic approach to understanding dually-diagnosed offenders. ***As with all trainings in this series, staff and inmate safety is an overriding common goal.*** The information provided begins with the premise that the most successful interventions within prisons, jails and community residential facilities have goals that are congruent with the primary duties of

correctional staff: safety of inmates in custody, staff and institutional security and rehabilitation. Specifically, in the case of offenders with co-occurring disorders, controlling contraband within institutions, decreasing critical incidents and use of seclusion and restraint, linkages to appropriate community supports prior to release and reducing recidivism are other correctional goals that are supported by integrated treatment.

Module I: Introduction to Co-Occurring Disorders

- A. Signs and Symptoms of Co-Occurring Disorders
- B. Origin of Co-Occurring Disorders
- C. Prevalence in Correctional Populations
- D. Relevance for RSAT Programs

Learning Objectives

After completing this module, participants will be able to:

- Define co-occurring disorders
- Recognize the signs, symptoms and interactions of co-occurring disorders
- Understand the prevalence of co-occurring disorders in correctional populations
- Consider the relevance of this curriculum to RSAT programs

Pre/Post-Test: True or False

1. Co-occurring disorders describe a condition where an individual is physically dependent on more than one drug. **F**
2. Dual-diagnosis is another way of referring to a co-occurring disorder. **T**
3. Adults in the criminal justice system have lower rates of co-occurring disorders than adults in the general population. **F**
4. It is more effective to treat substance abuse first and then mental illness so offenders can benefit from mental health treatment. **F**
5. It is very rare for a person with alcoholism to have a co-occurring disorder. **F**
6. People with co-occurring disorders are more likely to relapse than people with only a substance abuse disorder. **T**
7. Many people never develop either type of disorder despite first degree relatives with mental health and or substance use problems **T**

SIGNS AND SYMPTOMS OF CO-OCCURRING DISORDERS

What are Co-occurring Disorders?

A “co-occurring disorder” is used to describe a simultaneous substance use disorder and a mental health disorder.

Mental health exists on a continuum. Many people experience feelings of anxiety or depression and have emotional or psychological difficulties at various times throughout their lives. But, when thinking and coping are diminished to the point of affecting a person’s capacity to meet the ordinary demands of life, a mental health disorder may require treatment.

Mental illnesses are health conditions that often result in a diminished capacity for coping with the ordinary demands of life. They may involve changes in the brain that can affect many areas of functioning and behavior, but can respond to a combination of treatments, including psychiatric medications.

Addiction is defined as a chronic, condition that is characterized by compulsive drug seeking and use, despite harmful consequences. Addiction changes the way the brain works, interfering with the signals that reward pleasure and reject pain.

Other fields may have different concepts of dual diagnosis or co-occurring disorders. For example, a geriatric nurse may define a co-occurring disorder as dementia and a medical condition, such as high blood pressure or an early childhood specialist may define it as ADHD and a learning disability. For RSAT programs, people with co-occurring disorders have a substance use disorder(s) and one or more mental health disorder(s) identified in the Diagnostic and Statistical Manual of Mental Disorders - IV (DSM-IV). A diagnosis of a co-occurring disorder (COD) means any mental health disorder can be established independent of the substance use disorder, rather than symptoms resulting from substance use. People with co-occurring disorders may be diagnosed with more than one mental health disorder, but for our purposes we are referring to people with both a substance use and any mental health disorder.

Some examples of co-occurring substance abuse disorders and mental health disorders:

- **Major depressive disorder** with **methamphetamine dependence**
- **Alcohol abuse** with **panic disorder**
- **Poly-drug abuse** and **alcohol dependency** with **schizophrenia**
- **Borderline personality disorder** with **opiate dependency**

Both substance use and mental health disorders can vary in their severity, chronicity and the degree of impairment they cause. Both disorders may be

severe or mild, or one may be more severe than the other. Either or both disorders may involve episodes of acute symptoms, or a chronic, ongoing condition and may change over time. One disorder may be far more pronounced than the other at different stages of a person's life. Lastly, when individuals stop using substances, symptoms of a co-occurring mental health disorder can improve significantly, become more severe or suddenly appear.

CORRECTIONAL OFFICER CHECKLIST OF MENTAL HEALTH DISORDER SYMPTOMS

Correctional officers are often in the best position to notice changes in an inmate's behavior. Many may be signs of co-occurring disorders that should prompt a correctional officer to bring the inmate to the attention of correctional mental health providers.

Signs that may indicate a need for a clinical assessment or intervention:

- Feelings of helplessness and hopelessness**
- Loss of interest in daily activities**
- Appetite or weight changes**
- Sleep issues**
- Changes in levels of energy**
- Strong feelings of worthlessness or guilt**
- Concentration problems**
- Anger, rage and reckless behavior**
- Feelings of euphoria or extreme irritability**
- Unrealistic, grandiose beliefs**
- Starving, refusing food or binge eating and purging**
- Cuts, scars and burns or other evidence of self injury**
- Rapid speech and racing thoughts**
- Impaired judgment and impulsivity**
- Excessive tension and worry**
- Feeling restless or jumpy**
- Irritability or feeling "on edge"**
- Racing heart or shortness of breath**
- Nausea, trembling, or dizziness**

If an inmate appears to be exhibiting behaviors that are uncharacteristic or seemingly dangerous to him/herself or other inmates, a mental-health-trained

clinician should be contacted. Follow facility protocol for security staff and mental health staff and applicable policies and protocols for evaluating safety and suicidality; the client should not be left alone or unsupervised.

PREVALENCE OF CO-OCCURRING DISORDERS

Less severe disorders, such as anxiety disorders, affect nearly one out of five Americans. More severe psychotic disorders, such as schizophrenia, affect only 1% of the overall population.

However, these rates are higher for people with substance abuse or dependence and much higher among people involved with the justice system (Kessler, Chiu, Demler, & Walters, 2005). We also know that:

- clients with mood or anxiety disorders are about twice as likely to also have a co-occurring substance disorder
- clients with substance use disorders are roughly twice as likely to be diagnosed with a co-occurring mood or anxiety disorder
- rates of co-occurring disorders also vary by gender; women offenders have overall higher rates of mental health disorders
- types of disorders can vary among men and women in drug treatment; antisocial personality disorder is more common in men, while women have higher rates of major depression, posttraumatic stress disorder, and other anxiety disorders. (NIDA, 2007).

What is the prevalence of co-occurring disorders?

- Approximately 8.9 million (4%) adults in the U.S. have co-occurring disorders (SAMHSA, 2009)
- Approximately three-quarters of adults in jail or prison who have a substance use issue also have a mental health issue^{1, 2}

Prevalence Chart: Substance Abuse, Mental Illness, Both

Population	Prevalence	Source
Percentage of people in prison who use substances that report a mental health problem.	74 %	BJS (2006) MH Problems of People in Prisons and Jails ¹
Percentage of jail inmates with serious mental disorders that have a substance use disorder	76%	Decriminalizing MI :Background & Recommendations, NAMI 2008 ²
Percentage of people in substance abuse treatment that have a mental health disorder	More than 50%	CAST TIP 42 (2007) Subs. Abuse Tx for Persons with CODs

Percentage of male inmates with serious mental health disorders.	14.5%	Steadman, H., Osher, F., Clark Robbins, P., Case, B. & Samuels S. (2009)
Percentage of female inmates with serious mental health disorders.	31%	Steadman, H., Osher, F., Clark Robbins, P., Case, B. & Samuels S. (2009).
Percentage of people in jails that report having a mental health problem	64%	BJS (2006) MH Problems of People in Prisons and Jails
Percentage of people in jails with symptoms of a psychotic disorder	24%	BJS (2006) MH Problems of People in Prisons and Jails
Percentage of youth in juvenile facilities that have a mental health disorder	70%	Youth with MH Disorders in the Juvenile Just. System 2006. Shufelt, JL & Coccozza, JJ.
Percentage of people with serious mental disorders that are incarcerated in their lifetime	40%	Torrey, Kennard, Eslinger, Lamb and Pavle 2010. More MI Persons in Jails and Prisons Than Hospitals: A Survey of the States

EXPERIENCING CODS

Substance use and mental health disorders affect changes in brain processes and chemistry. While there have been studies on the impact each has on the brain, there is less research on how the two intersect. It is not clear why some people end up with a substance use disorder, mental health disorder, or both, while others with more pronounced risk factors and fewer protective factors do not. Different individuals experience the symptoms of co-occurring disorders in

Other terminology:

- co-morbid disorder
- co-morbidity
- concurrent disorders
- dual diagnosis
- dually diagnosed
- mentally ill substance abuser (MISA)
- substance abusing mentally ill (SAMI)
- double winner
- double trouble
- co-occurring recovery
- recovering consumer/ survivor

different ways and with differing levels of severity. A mental health diagnosis that can be debilitating for one offender may be under control and hardly an issue for another.

Both Biology and Environment Contribute to Co-Occurring Disorders

Scientific research tells us that addiction and mental illness affect both the brain and behavior. Researchers have identified many biological factors and are beginning to search for the genetic variations

that contribute to the development and progression of substance use and mental health problems.

Some people with co-occurring disorders come from families with no history of addiction or mental illness. On the other hand, many people never develop either

type of disorder despite first degree relatives with mental health and or substance use problems. However, it is understood that **childhood trauma** and **age of initiation of substance use** have both been implicated in the development of COD's (Dick & Agrawal, 2008). Research has shown that this is not inevitable, and exposure to even a significant number of risk factors in a child's life does not necessarily mean that substance use or mental health problems will follow. The interaction between heredity and environment appears to activate a genetic predisposition in some cases and mitigates it in others. What we know today is that protective factors can support healthy behaviors and attitudes and balance out and buffer risk factors. This is true for substance abuse and mental illness as well as other behavioral health disorders, such as eating or gambling disorders.

Both mental health and substance use disorders result in compulsive behaviors that weaken a person's ability to control impulses, despite the negative consequences.

People can enter this cycle at any point. Clients may have:

- Experienced trauma, childhood abuse or victimization and discovered substances helped them to manage and tolerate the emotional and psychological effects.
- Been prescribed a controlled substance for medical reasons and developed an addiction to it, which led to increased feelings of hopelessness that developed into a mood disorder.
- Started using drugs recreationally and developed an addiction, which contributed to symptoms of a mood disorder.
- Used substances to relieve feelings of insecurity and instill confidence resulting from bi-polar disorder then developed a dependency on them.

EXERCISE 1: WHO HAS A CO-OCCURRING DISORDER?

Instructions: After reading the information on each client, check off all items that apply. Take your best guess at who probably has a co-occurring disorder, and who doesn't, based the kind of information that is generally available on RSAT inmates. We will review answers and explanations in the next module on screening and assessment.

Sara- age 22: convicted of opiate trafficking; a history of violent victimization by partner. Began using prescription opiates in 6th grade—supplementing with heroin before arrest. Experienced intense opiate withdrawals following incarceration. Would not cooperate with state’s attorney; claimed boyfriend knew nothing about opiate trafficking ring.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Roger- age 54: convicted of felonious sexual assault on a child. Reports periodic alcohol use. Successfully paroled for 9 months; passed urine screens. Violated the terms of release by moving in with a woman and her two young children. Depressed about having parole revoked and feeling suicidal.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Brian – age 33: In college, began heavy use of cocaine and binge drinking. Started having violent episodes with roommates and dropped out of school. Family found him living in an abandoned building. Remained homeless, was arrested for public nudity, drunk and disorderly and shoplifting, etc. more than 25 times. Last time he hit an officer because he thought he saw an alien telling police to arrest him.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Steve- age 29: Self-injures—visible scarring on arms and shoulders. Psychiatric medications make it difficult to keep him awake during group. Reports he was raped by cell mate. Attempted suicide during second week in jail. History of attempted suicide by barbiturate overdose.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Marsha- age 42: Both children in placement. Abused crack and alcohol for several years. Speaks about her time on the streets with pride and nostalgia. Cycles through periods of intense moods; rarely fully present during groups. She is either completely withdrawn or else talking through the entire group without letting other participants speak.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

WHAT DOES THIS MEAN FOR RSAT PROGRAMS?

RSAT staff should be sensitive to the fact that a significant percentage of substance abusers may also have a mental health disorder (Glaze & James, 2006; NAMI, 2008)

RSAT staff should expect that co-occurring mental health problems will be the expectation and not the exception for offenders in substance abuse treatment. By law, inmates with serious medical conditions have a legal right to treatment — including screening, assessment and mental health treatment. Minimally, according to the National Commission on Correctional Health Care standards for some of the elements of care and treatment of mental health disorders in correctional facilities must include (Hills, Siegfried, and Ickowitz, 2004):

- A mental health screening within 2 hours and assessment within 14 days of entry to the institution
- A mental health examination, including evaluating risk of suicide
- Information within 24 hours of arrival of the types of mental health services available and how to access them
- A health appraisal within 7 days of arrival that includes taking a history of any prior mental health problems, hospitalizations, psychotropic medications, suicide attempts, and alcohol and other drug abuse
- Stabilization of any symptoms and intervention in the event of an acute psychiatric event or suicide attempt
- Privacy and confidentiality with regard to diagnosis and treatment.

Therefore, the following areas are considerations for RSAT programs:

- **Collaboration-** RSAT programs are responsible for substance abuse programming that integrates effective approaches for offenders with co-occurring mental health disorders. Correctional facilities have legal responsibility to provide mental health care. Processes for collaboration with mental health services can integrate treatment through a team approach and unified treatment plans.
- **Screening and assessment-** RSAT program staff can set up a system for mental health and substance abuse screening, assessment and information sharing with mental health staff. RSAT programs can monitor clients and track and report improvement, emergence and worsening of symptoms during treatment.
- **Integrated treatment interventions-** RSAT programs may select interventions and curricula that have been shown to result in improvement in both substance use and mental health symptoms. Cognitive-behavioral interventions have been successful with offenders, and with mental health

and substance use disorders as well as several other approaches that we will discuss in module three.

- **Case management and re-entry-** Case management and community-based treatment needs vary among offenders with co-occurring disorders, depending on the severity of each condition. Resources for medication management and other psychiatric services upon release are required. Securing eligibility for benefits prior to release and establishing connections to community networks is key.
- **Peer and community-based support –** People with co-occurring mental health problems may benefit from mental health peer support as well as addiction recovery support or may have a decided preference for one or the other. Offering choices and a variety of peer support resources is desirable. Developing social connectedness and pro-social contacts is also critical to success.

Module II: Screening and Assessment Practices for Co-Occurring Disorders

- A. Screening and assessment tools
- B. Identification of co-occurring disorders
- C. Risk, Need and Responsivity Principle

Learning Objectives

After completing this module, participants will be able to:

- Identify the general core components and frequently used screening tools for co-occurring disorders for RSAT clients
- Identify the general core components and frequently used assessment tools for co-occurring disorders for RSAT clients
- Understand the challenges and shortcoming related to screening and assessment practices and tools
- Identify the principles of risk, need and responsivity in identifying treatment needs for co-occurring disorders

Pre/Post-Test

1. Evidence-based means that the evidence from a criminal case is used in the treatment process. **F**
2. It is important to consider a client's strengths and supportive people in his or her life when identifying an appropriate treatment strategy. **T**
3. The purpose of screening is not to provide a diagnosis but to establish the need for an indepth assessment. **T**
4. Integrated treatment for co-occurring disorders cannot be implemented in jails or prisons. **F**
5. Within the integrated treatment context, both co-occurring disorders are considered primary. **T**
6. Screening tools provide information that the practitioner and client can use to create a treatment plan. **F**
7. Risk Needs and Responsivity theory states that programs should only target needs associated with criminal behavior in the highest risk offenders in order to have the desired impact. **T**

SCREENING TO IDENTIFY CO-OCCURRING DISORDERS

Screening → **Assessment** → **Treatment Plan**

Effectively serving individuals with co-occurring mental and substance use disorders requires integrated screening and assessment. Integrated screening is a brief process that should occur soon after the individual is admitted to a correctional facility. It is aimed at detecting likely substance use disorders and co-occurring mental disorder(s). Individuals who screen positive for a likely disorder should receive an in-depth substance use and mental health assessment.

A comprehensive screening process can include exploration of the relationship between substance abuse and mental illness, shared triggers, and a preliminary or immediate determination of a variety of related service needs including medical care and housing. The goal is to identify individuals who *might* have co-occurring disorders and related service needs.

According to Peters, et al., (2008), the goals of screening include:

- Detection of current mental health and substance use symptoms and behaviors
- Determination if current symptoms or behaviors are influenced by co-occurring disorders
- Examination of cognitive deficits
- Identification of violent tendencies or severe medical problems that may need immediate attention
- Determination of eligibility and suitability for specialized co-occurring disorders treatment services.

About, 80% of facilities screen for mental health disorders upon intake (Hills, Siegfried, and Ickowitz, 2004). Individuals who screen positive should be referred for an in-depth, integrated assessment by a clinician at the institution. This assessment can then be factored into other corrections considerations, such as security level, prison or jail-based service needs or risk for self-harm while incarcerated.

Screening for substance use disorders and mental health conditions should be administered at the point of intake into the jail or prison.

Correctional officers, classification staff and case managers may also routinely screen inmates for

Screening for COD seeks to answer a “yes” or “no” question:

Does the substance abuse client being screened show signs of a possible mental health problem?

OR

Does the mental health client being screened show signs of a possible substance abuse problem?



substance abuse and mental health problems, and refer clients to mental health staff and to substance abuse counselors for further assessment. This screening often includes:

- Having an individual respond to a specific set of questions
- Scoring those questions
- Taking the next "yes" or "no" step in the process.

EXAMPLES OF SCREENING TOOLS


Mental Health Screens in Substance Abuse Treatment Settings



The following charts include examples of mental health screening tools that have been assessed as reliable for identifying a possible mental health disorder for substance abuse treatment clients.

	Description
Modified MINI Screen (MMS) 	22 Yes-No items that screen for anxiety and mood disorders, trauma exposure and PTSD, and non-affective psychoses
Mental Health Screening Form III (MHSF III) 	18 Yes-No items about current and past symptoms covering schizophrenia, depressive disorders, PTSD, phobias, intermittent explosive disorder, delusional disorder, sexual and gender identity disorders, eating disorders, manic episode, panic disorder, obsessive-compulsive disorder, pathological gambling, learning disorders, and mental retardation
K6 Screening Scale	The tool consists of 6 items, each with a 0-4 point rating scale, that screen for general distress in the last 30 days (Kessler, et al., 2003). Maximum precision is in the clinical range of the scale, that is, for people with anxiety or mood disorders or non-affective psychoses whose level of functioning is seriously impaired.
Brief Mental Health Jail Screen (BMHJS)	The BMHJS is a tool that takes less than 3 minutes; contains only 8 yes or no questions; is simple to incorporate into the booking process by corrections officers; is quickly administered.

Substance Abuse Screens in Mental Health Settings

The following chart includes examples of substance use screening tools for clients. RSAT clients must have a substance use disorder to be eligible for the program. The following screens include screens for substance abuse that are often used to determine whether mental health clients have a co-occurring substance use disorder.

	Description
Modified Simple Screening Instrument for Substance Abuse (MSSI-SA) 	16 items, 14 of them scoreable; most items tap symptoms of alcohol and drug dependence, including prescription and over-the-counter medications, during the past six months. Several items tap lifetime and current use problems for respondents and lifetime use problems for family members.
CAGE Adapted to Include	A modified version of the CAGE screen for alcohol problems, the CAGE-

Drugs (CAGE-AID)  (PDF)	AID is a four-item conjoint screen for alcohol and substance abuse.
Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) 	The tool consists of seven items or questions regarding each of ten substances (a total of 70 questions) and one item or question about drug injection. A specific "substance involvement" (risk) score is calculated for each substance, and that score drives a recommendation for no intervention, brief intervention, or more intensive treatment for each substance.
TCUDS-II	The Texas Christian University Drug Screen II (TCU-DSII) is a screening tool that enables corrections staff to quickly identify individuals who report heavy drug use or dependency and therefore might be eligible for treatment. Questions are based on the DSM-IV and the National Institute of Mental Health Diagnostic Interview Schedule.

RISK ASSESSMENTS AND ITS VALIDITY FOR CO-OCCURRING DISORDERS

Screening → **Assessment** → **Treatment Plan**

Assessment of RSAT clients for the purpose of *risk classification* in a correctional facility is very different than forensic clinical assessments, which have a goal of integrating mental health and substance use treatment needs into treatment programs.

At entry into a correctional facility the risk assessment process helps determine the level of danger, or risk, an offender might pose and what type of prison or jail programming will target the offender's problem areas to reduce the potential for irreverent behavior. Before an inmate enters the general prison or jail population, correctional officials have to determine:

- What level of security is best;
- Where the offender should be housed, and
- What type of rehabilitation programs should be prioritized?

Although risk classification has a different underlying purpose, the premise which guides risk assessment overlaps with clinical assessment in a very key way. They both indicate treatment needs that must be met in order to reduce the likelihood of future criminal behavior.

This premise is called Risk, Needs and Responsivity (RNR) Theory. RNR theory is based on research about factors associated with criminal behavior. The theory states that programs should only target needs associated with criminal behavior in the highest risk offenders in order to have the desired impact. Risk and needs assessment should tell us the "**who, what, and how**" of rehabilitation programming for each individual offender (Latessa, 2010). Risk assessments act as a preliminary screening tool. They can eliminate low risk/low need offenders that will not need further screening and assessment while others move on to the next level of determination programming needs. The same indicators such as, criminal values and criminal associates, that are reliable predictors of recidivism,

in general, are definitely the best predictors of recidivism in offenders with COD's (Prins & Draper, 2009).

***Clinical assessment is a process for defining the nature of a problem and developing specific treatment plans to address that problem
Assessment is an ongoing process that should be repeated over time to capture the changing nature of the individual's status as he or she moves through recovery.***

FORENSIC CLINICAL ASSESSMENT

A number of assessment instruments have been developed and have been validated by research with offenders. An integrated assessment gathers key information about mental health and substance use in the context of how one relates to the other. The client is engaged in a process that allows a practitioner to:

- Establish a rapport with the client
- Determine the presence (or absence) of a co-occurring disorder
- Determine individual readiness for change (desire for treatment?)
- Identify the individual's strengths and problem areas that may influence treatment and recovery
- Begin developing a trusting, supportive relationship.

The assessment establishes a baseline of problem severity, symptoms, and behaviors. It marks a starting place that can be compared to repeated assessments to track the progress of individuals with co-occurring disorders over time. Lastly, assessments provide information that the practitioner and client can use to create a treatment plan.

Standardized assessment tools are most effective when they are one component of a more comprehensive approach. Since inmates entering RSAT programs are likely to have undergone screening for both substance abuse and mental health upon intake into the facility, it is important to review any information captured in the offender record and become familiar with the screening tools used upon intake into the facility.

Effective assessments are centered on the individual's understanding of his or her problem(s) and his or her goals. An integrated assessment should gather detailed information pertaining to:

- A chronological history of symptoms and past treatments of both substance use and mental disorders.
- A description of current strengths, supports, limitations, or cultural issues that will impact treatment.

- Individual perception of needs for change, and how confident they are in their ability to change.
- Level of functioning, problem severity and duration - to inform level care, intensity of treatment.
- Family history, work history, significant relationships, religious and cultural beliefs --goals and ambitions. Screening for past trauma, current safety and trauma-related mental health symptoms may also be appropriate.
- The client's care choices and preferences, his or her understanding of shared decision making; ensure clients' understanding and knowledge of their rights.
- A formal diagnosis is established by referral to a psychiatrist, clinical psychologist, or other qualified behavioral healthcare professional.

CLINICAL ASSESSMENT TOOLS

There are a few assessment tools that have been evaluated and “endorsed” to assess for co-occurring disorders in justice settings. Many of these tools have to be used in combination by RSAT staff to accurately identify co-occurring disorders. The most prevalently used tools are described in the chart below.

Title:	Description:
The Psychiatric Research Interview for Substance and Mental Disorders (PRISM)	Semi-Structured interview; Measures DSM-IV diagnoses on Axis I and II (Alcohol, Drug, Psychiatric Disorders); Differentiates the primary disorder from substance induced disorders or effects of withdrawal; 45-90 minutes to complete
Minnesota Multiphasic Personality Inventory-2 (MMPI-2)	Tests adult psychopathology; 60-90 minutes to complete; 567 True/False Questions; 5 th grade reading level
Personality Assessment Inventory (PAI)	Tests adult psychopathology; 50-60 minutes to complete; 344 items; 22 non overlapping scales; 4 th grade reading level
The Addiction Severity Index (ASI)	Semi-Structured Interview; Measures 7 substance-abusing problem areas; 50-60 minutes to complete; Past 30 day and lifetime problems are measured; 200 item; 7 subscales
Global Assessment of Functioning (GAF)	Clinicians judgment of overall functioning; 100 point scale; 3 minutes to establish score; Higher score = healthier client

EXERCISE II: USING THE GAF TO ASSESS TREATMENT FUNCTIONING

The [Global Assessment of Functioning \(GAF\)](#) is a tool used for justice populations to determine how well an individual will do in treatment based on his or her ability to function in society. It is used for reporting the clinician's judgment

of the individual's overall level of functioning and carrying out activities of daily living. This information is useful in planning treatment and measuring its impact, and in predicting outcome. The GAF is a numeric scale (0 through 100) used to rate the social, occupational and psychological functioning of adults. The scale is presented and described in the DSM-IV-TR.

Read the vignette about Evelyn. Using the information provided, take your best guess on where she would fall on the GAF score based on the descriptions provided in the functioning box of the tool.

Evelyn’s Story

Evelyn, a 22 year old female, was removed from her abusive home and placed in foster care at six years old. By the age of 14 she had lived in seven foster homes, and was using marijuana every day. She dropped out of school at 15 and engaged in prostitution to earn enough money to live on her own. Soon after, Evelyn started drinking heavily and taking valium to relax her nerves and get through the night. She was court ordered to a substance abuse treatment program after several appearances in juvenile court, but did not remain abstinent for longer than 30 days after she finished the program. She began hearing voices in her head and hallucinating when she was 17. This time, she was court ordered to attend a mental health program. When she was 21, Evelyn had her two year old daughter removed from her care when was arrested for the sixteenth time for solicitation. At this time, she was ordered to undergo a clinical assessment. Problematically, Evelyn does not feel motivated to participate in treatment and cannot see much of a future upon release.

Score	Functioning
91–100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
81-90	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
71-80	If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning
61-70	Some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	Moderate symptoms or any moderate difficulty in social, occupational, or school functioning.
41-50	Serious symptoms or any serious impairment in social, occupational, or school functioning.
31-40	Some impairment in reality testing or communication or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
21-30	Behavior is considerably influenced by delusions or hallucinations or serious impairment in communications or judgment or inability to function in all areas.
11-20	Some danger of hurting self or others or occasionally fails to maintain minimal personal hygiene or gross impairment in communication.
1-10	Persistent danger of severely hurting self or others or persistent inability to maintain minimum personal hygiene or serious suicidal act with clear expectation of death.
0	Not enough information available to provide GAF.

What are the shortcomings of standardized assessments?

Although the current generation of forensic clinical screening and assessment tools has a higher level of reliability and more comprehensive training materials than previous tools, assessment tools are actuarial tools, and they are standardized to serve a wide range of populations:

- There is no one-size-fits-all risk assessment tool. Agencies frequently employ multiple versions of tools at different points throughout the criminal justice system, with a special emphasis on pre-release assessment to help determine the level of parole supervision and the need for community-based services.
- Recent research on assessing gender-specific risk factors suggests that indicators related to co-occurring disorders are important predictors of recidivism in women that have not been included in most of assessments. (Van Voohris, Salisbury, Wright, & Bauman, 2008).
- Actuarial tools are only valid for the populations on which they have been tested. Validation studies establish cut off scoring points for low, medium and high risk inmates. The distribution of scores is predictable, but the numerical values should be “calibrated” as soon there are a large enough number of inmates assessed within the new population.
- Cultural sub-groups and racial and ethnic minorities have often been excluded from research. These populations may have very different interpretations and responses to standardized questions. Few instruments are based on the cultural norms of diverse populations.
- There is no substitute for connecting with a client and establishing a therapeutic alliance relationship. This is strongly supported by research. One disadvantage for case managers using standardized tools is that some of them provide little opportunity to establish a connection with the individual.

For a full discussion of clinical tools see: [“Screening and Assessment for Co-Occurring Disorders of People in the Justice System”](#) and [The Reentry Policy Council of the Justice Center at the Council of State Governments Risk Assessment Chart](#).

EXERCISE III: REVIEWING SIGNS AND SYMPTOMS OF CODS

Now that we have reviewed screening and assessment tools, let’s take a look at the profiles from Exercise I and re-consider each case for CODS:

Sara- age 22; convicted of opiate trafficking; a history of violent victimization by partner. Began using prescription opiates in 6th grade— supplementing with heroin before arrest. Experienced intense opiate withdrawals following incarceration. Would not cooperate with state's attorney; claimed boyfriend knew nothing about opiate trafficking ring.

Roger- age 54, convicted of felonious sexual assault on a child. Reports periodic alcohol use. Successfully paroled for 9 months; passed urine screens. Violated the terms of release by moving in with a woman and her two young children. Depressed about having parole revoked and feeling suicidal.

Brian – age 33. In college, began heavy use of cocaine and binge drinking. Started having violent episodes with roommates and dropped out of school. Family found him living in an abandoned building. Remained homeless, was arrested for public nudity, drunk and disorderly and shoplifting, etc. more than 25 times. Last time he hit an officer because he thought he saw an alien telling police to arrest him.

Steve- age 29. Self-injures—visible scarring on arms and shoulders. Psychiatric medications make it difficult to keep him awake during group. Reports he was raped by cell mate. Attempted suicide during second week in jail. History of attempted suicide by barbiturate overdose.

Marsha- age 42. Both children in placement. Abused crack and alcohol for several years. Speaks about her time on the streets with pride and nostalgia. Cycles through periods of intense moods; rarely fully present during groups. She is either completely withdrawn or else talking through the entire group without letting other participants speak.

Sara- There is no indicator that Sara has a mental health disorder, but there are indicators that she is dependent on opiates. From this description Sara does not appear to have a co-occurring disorder. There is a history of victimization, which is a risk factor; however, it does not mean a mental health disorder is present. Ongoing screening for mental health issues and follow up assessment as indicated would be appropriate for Sara while she is in the RSAT program.

Roger- Many offenders that do not have a depressive disorder state they are depressed about their situation. There is nothing in Roger's profile that indicates he has a mental disorder; it is uncertain whether he has a substance use disorder. Screening and assessment, especially with regard to Roger's drinking, is required before we can determine if he is appropriate for RSAT. He does not appear to have a co-occurring disorder.

Brian- Brian's profile points to a serious mental disorder and alcohol abuse or dependency. His hallucinations may be symptoms of schizophrenia or other psychotic disorder. His use of alcohol indicates he probably has a co-occurring disorder. An assessment is required before we can determine if he is appropriate for RSAT. It will give us more information about his level of stability and his drinking problem.

Steve- Steve appears to be experiencing significant depression and should be assessed. He is a suicide risk and also at-risk for sexual violence. He may not have a substance use disorder, but should be screened and assessed, as indicated. Steve may need treatment and support, but not for substance use, and, therefore not in the context of RSAT.

Marsha- Marsha shows signs of having a co-occurring disorder. She may be showing signs of bi-polar disorder. As she undergoes the assessment process, it will be important to monitor her mood changes and other signs of bi-polar disorder, and to refer her to a mental health clinician who is qualified to make a diagnosis.

Module III: Best Practices for Inmates with Co-Occurring Disorders

- A. Origins of and Introduction to Integrated Treatment
- B. Myths and Facts about treatment for CODs
- C. Proven and Promising Practices for Inmates with CODs

Learning Objectives

After this module, participants will be able to:

- Identify the principles of integrated treatment for COD
- Identify evidence-based strategies for inmates with various levels of mental health and substance abuse problem severity

Pre/Post-Test

1. Treatment strategies can be standard and do not need to be tailored to individuals. **F**
2. Motivational interventions are designed to make inmates feel guilty about past behavior. **F**
3. It doesn't matter how long an individual is involved in treatment, as long as the treatment is intensive. **F**
4. Integrated treatment is defined as a type of treatment whereby family members are involved in all treatment phases. **F**
5. Medication assisted treatment involves a nurse administering a client's medications on a daily basis. **F**
6. People with co-occurring disorders are very difficult to treat and require highly skilled staff with specialized training. **F**
7. Release planning should begin the day the treatment plan is developed. **T**

INTRODUCTION TO INTEGRATED TREATMENT

Historically, treatment for co-occurring substance use and mental health disorders was not available due to separate funding streams, licensing and credentialing of providers and clinicians, different eligibility guidelines and different treatment philosophies and practices. Patients with dual disorders received conflicting therapeutic messages; the stigma, shame, and discrimination experienced by some consumers prevented them from seeking care.

Early substance abuse treatment modalities, especially the ones that targeted offenders, included confrontational approaches that elicited basic human responses; surrender or resistance. Increased resistance was met with more confrontation. Counselors sought to “break inmates down to build them up.” For many individuals, this approach was counterproductive, especially for those with CODs. In the mid-1990s, substance abuse strategies became more supportive of fostering individual strengths and motivating clients to change (Sciacca, 1997).

Substance abuse treatment strategies required complete abstinence from mood-altering substances. Not only did Federal substance abuse funding require abstinence-based programming, substance abuse counselors were concerned that even physician-prescribed medication to treat the symptoms of a mental illness would trigger a return addictive use. This approach was in conflict with mental health treatment that often embraced harm reduction strategies and medication management.

At the same time, mental health treatment programs rarely understood addicted clients and people in recovery. They sometimes prescribed medications with a high potential for abuse, when better alternatives were available for people with substance use disorders. Expectations and assumptions were often deficit-based and recovery was not a guiding concept until more recently.

Both systems endorsed sequential treatment, and often expected clients deal with one disorder and put the other on hold. It was unrealistic to expect clients to arrive at a point when one treatment should end and the other begins. Recovery is an individualized process—dictated by levels of severity, needs, strengths, and preferences of each client.

Lastly, providers offered treatment on parallel tracks, simultaneously but through separate systems of care. For example, an individual participating in group therapy through a substance abuse treatment provider and attending a 12-step group, also receives individual therapy and medication monitoring at a mental health center. Coordination between the two is dependent on individual relationships between providers and program staff, and on referrals and partnerships (CSAT, 1995). When conflicting messages about recovery interfere, clients tend to pay the price. Whereas increased coordination and

integrated treatment result in one consistent message about treatment and recovery from the entire treatment team.

Integrated approaches recognize barriers individuals must overcome and view recovery as a holistic shift in identity and lifestyle. Treatment combines elements of both into a unified and comprehensive treatment program for clients with dual disorders.

Studies based in substance abuse treatment centers addressing a range of disorders have demonstrated better treatment retention and outcomes when mental health services are integrated onsite (CSAT, 2007).

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. Ideally, integrated treatment involves clinicians cross-trained in both mental health and addiction with a unified case management approach. This makes it possible to monitor and treat clients through various stages of recovery.

There are a number of principles of integrated treatment on which experts in the field agree (Mueser, Noordsy, & Drake, 2003; SAMHSA, 2010):

- Co-occurring disorders must be expected and clinical services should incorporate this assumption in all screening, assessment, and treatment planning
- Within the treatment context, both co-occurring disorders are considered primary
- Empathy, respect, and the belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the specific needs and personal goals of unique individuals at different points of treatment and recovery
- The role of an individual's community in treatment and aftercare and how an individual is reintegrated into his or her community post-release from incarceration are major factors in recovery.

EXERCISE IV: MYTHS, MISCONCEPTIONS AND FACTS ABOUT CODs

Take a look at these common myths about people with CODs. Have any of these myths ever influenced your thinking? Which ones may have influenced others in various service systems? Which has the most influence on clients' perceptions of themselves as persons in co-occurring recovery?

Myth: *Just get to the root of your depression, then you won't drink anymore.*

Fact: Experience and research demonstrate that individuals with co-occurring disorders (COD) are at higher risk for:

- relapsing

- reoffending
- homelessness
- victimization (BJS, 2008).

Myth: *Just stop using drugs and your psychological problems will take care of themselves.*

Fact: People with COD's progress more rapidly from initial use to dependence and are less likely to complete treatment and adhere to medication regimes than those with only one disorder. Greater rates of hospitalization, difficulties in social functioning and more frequent suicidal behavior are some of the challenges they face upon entry into a prison or jail and initiating abstinence from substance use (Prins & Draper, 2009).

Myth: *People with co-occurring disorders are high-end consumers of services.*

Fact: The vast majority of people with COD's do not get any treatment. According to Corbett, Nikkel and Drake, 2010, p 1: "only 10% of clients with co-occurring disorders receive any treatments, even nonintegrated treatments, for both disorders, and only 4% receive integrated interventions."

Myth: *People with co-occurring disorders are very difficult to treat and require highly skilled staff with specialized training.*

Fact: There are many practices that have been evaluated and shown to be effective for people with COD's that do not require extensive training. Some of them involve case management, supported employment, contingency management, housing first programs and peer support (Drake, O'Neal, & Wallach, 2008). Licensure and extensive knowledge of psychiatric interventions are not required for every effective approach.

Myth: *You can't do much for offenders with COD's until they hit bottom and decide to change.*

Fact: Motivation is dynamic and can be influenced through effective engagement techniques. Trained staff can use these techniques to increase the likelihood that offenders will become motivated to change (Walters, Claerk, Gingerich and Metzger, 2007).

Myth: *Offenders with co-occurring mental health disorders are violent and dangerous.*

Fact: According to the Bureau of Justice Assistance the rate of violent crimes among offenders with mental disorders is the same as for other offenders (2008). People with mental health disorders, however, are far more likely to be victims of violence. In 2004 nearly a quarter of people with mental illness were victims of crime, a rate 11 times higher than the general population (Teplin, McClelland, Abram, & Weiner, 2005). In prison both male and female offenders with COD's are sexually victimized nearly three times as often as other inmates.

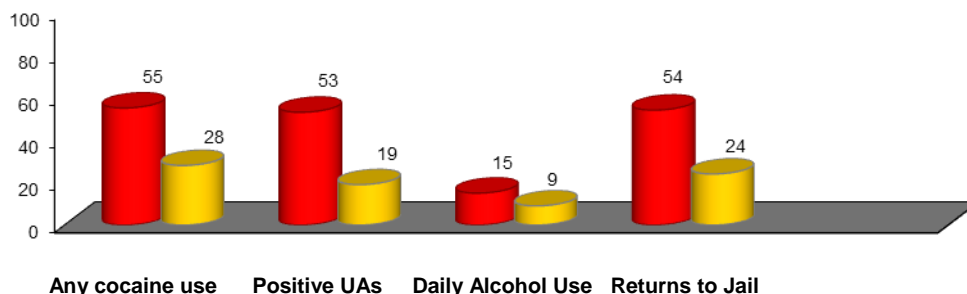
CORRECTIONAL-BASED TREATMENT STRATEGIES

Screening → **Assessment** → **Treatment Plan**

The two primary principles regarding treatment planning for inmates with CODs which apply regardless of the treatment strategy are the dosage principle and pre-release planning. After these two principles are discussed, this section provides examples of evidence-based treatment models for inmates and other offenders with CODs.

Dosage

The effectiveness of any strategy is dependent on whether it has been administered appropriately and for sufficient time to “kick in” or produce an impact. This is called the “dosage principle”. This is especially relevant for inmates with CODs, who have greater needs and pose a higher risk for relapsing and (re)offending. Long term programs, such as RSAT are much more effective, especially when they are followed up with services in the community upon release. We know the longer the individual stays engaged with treatment and recovery support, the better his or her chances of recovery are. Higher-risk offenders require significantly more structure and services than lower-risk offenders.



Source: NIDA, 2006. Treatment is Key: Addressing Drug Abuse in Criminal Justice Settings

The graph above shows the difference in returns to substance use and jail among offenders who had more than 90 days of treatment (the yellow column) and those who had less than 90 days treatment (red column). The differences are dramatic; the group that had the benefit of more than 90 days of treatment had significantly lower returns to custody and positive drug tests.

In light of these data treatment for offenders with CODs should be six months or longer whenever possible. New research on the threshold of Cognitive Behavioral Therapy required to bring about change in high risk offenders indicates a minimum of 300 hours of cognitive-based interventions delivered over a period of 6-12 months is required (Bourgon & Armstrong, 2006; Latessa, 2004; Gendreau & Goggin, 1995).

Pre-release Planning

Regardless of the treatment approach while individuals are incarcerated, release planning should begin the day the treatment plan is developed. Many resources have long waiting lists and eligibility requirements that involve complicated paperwork, especially for offenders, who are typically not priority clients.

According to NIDA:

“Treatment must last long enough to produce stable behavioral changes. In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior. Individuals with severe drug problems and co-occurring disorders typically need longer treatment (e.g., a minimum of 3 months) and more comprehensive services”.

EFFECTIVE PRACTICES FOR INMATES WITH COD

There are a number of approaches that are effective for offenders with both substance use and mental health disorders. The premise of all of these strategies is to change motivation, attitudes, thinking and behaviors. The section will review these approaches and their application to treating RSAT clients with COD's.

Cognitive-Behavioral Therapy – “Cognitive” models target a person’s attitudes and thought processes, teaches individuals to recognize their thinking errors and to replace them with rational, pro-social thoughts. Practices like role plays, skill rehearsal and reinforcement allow individuals to try out new behaviors.

Research on cognitive behavioral treatment (CBT) in both the behavioral health and the correctional literature has demonstrated its effectiveness in a prison and jail settings at not only reducing recidivism, but also in treating substance use and mental health problems. A meta-analysis found CBT programs to reduce recidivism by an average of 35% (Landenberger & Lipsey, 2005).

Cognitive -- targets attitudes and thought processes
Behavioral -- practices role modeling and reinforcement

Cognitive behavioral strategies are focused on changing the offender’s thinking patterns in order to change future behavior. They are often the approach of choice for working with inmates because they can be facilitated by correctional staff and they target observable behaviors.

There are a variety of cognitive behavioral therapy formats that target criminal thinking and substance use. Several of them are aimed at increasing coping skills and can also be very helpful to clients with mental health disorders. The most effective interventions have a strong behavioral component that provides opportunities for participants to *practice* new behavior patterns and skills with feedback from program staff. It is reliably effective with a wide variety of personal problems and behaviors, including those important to criminal justice, such as substance abuse and anti-social, aggressive, delinquent and criminal behavior (<http://www.nij.gov/journals/265/what-is-cbt.htm>).

Unlike many other approaches to psychotherapy, CBT emphasizes the notion of personal responsibility, while ensuring clients are provided with the coping and problem solving skills they will need to succeed in everyday life. CBT focuses on the present rather than the past. CBT first concentrates on developing skills to recognize distorted or unrealistic thinking when it happens, and then to changing that thinking or belief to alter the negative behavior that contributed to justice involvement, such as continued substance misuse.

Most CBT programs are offered in small group settings, incorporate lessons and exercises involving role play, modeling or demonstrations. Individual counseling sessions are often part of CBT. Clients are given homework and conduct experiments between sessions. These components are used to gauge the individual's readiness for change and foster engagement in that change. A willingness to change is necessary for CBT or any other treatment to be effective in reducing further criminal behavior.

The typical CBT program is provided by trained professionals or para-professionals. Training for non-therapist group facilitators often involves 40 hours or more of specialized lessons and skill building. Licensed and certified therapists are often part of cognitive programs, especially those involving individual counseling.

Brand name programs, such as *Thinking for a Change (T4C)*, a free program by the National Institute of Corrections for correctional agencies, often limit clients to 20-30 sessions, lasting over a period of up to 20 weeks. The rationale is that the more treatment provided or the more sessions participants attend over time, the greater the impact on and decrease in recidivism.

Primary Cognitive-Behavioral Therapy Programs for Offenders (Handout for Slide 83)

Name of Curriculum	Approach	Target Clients	Structure
<p>Aggression Replacement Training</p>	<p>Social skills training (the behavioral component) teaches interpersonal skills to deal with anger-provoking events.</p> <p>Anger control training (the affective component) seeks to teach at-risk youth skills to reduce their affective impulses to behave with anger by increasing their self-control competencies.</p> <p>Moral reasoning (the cognitive component) is a set of procedures designed to raise the young person's level of fairness, justice, and concern with the needs and rights of others.</p>	<p>Originally designed to reduce anger and violence</p> <p>More recently adapted for adults.</p>	<p>1 hour classes for 10 weeks.</p>
<p>Criminal Conduct and Substance Abuse Treatment</p>	<p>Phase I: Challenge to Change. This phase involves the client in a reflective-contemplative process. A series of lesson experiences is used to build a working relationship with the client and to help the client develop motivation to change.</p> <p>Phase II: Commitment to Change. This phase involves the client in an active demonstration of implementing and practicing change. The focus is on strengthening basic skills for change and helping the client to learn key CBT methods for changing thought and behavior that contribute to substance abuse and criminal conduct.</p> <p>Phase III: Ownership of Change. This phase, the stabilization and maintenance phase, involves the client's demonstration of ownership of change over time. This involves treatment experiences designed to reinforce and strengthen the commitment to established changes.</p>	<p>Adult substance-abusing offenders. The recommended client age is 18 years or older.</p>	<p>Long-term (9 months to 1 year), intensive, cognitive-behavioral-oriented treatment program.</p> <p>Assessment process is essential for beginning relationship with provider.</p> <p>Can be presented in either a community or an incarceration setting.</p> <p>Consists of 12 treatment modules that are structured around 3 phases of treatment.</p> <p>Each module is taught in a logical sequence with basic topics covered first.</p>
<p>Moral Reconciliation Therapy</p>	<p>Nine personality stages of anticipated growth and recovery are identified in the program:</p> <p>Disloyalty: Typified by self-centered behavior and a</p>	<p>Adult and juvenile offenders, juveniles, substance abusers, and others with "resistant personalities."</p> <p>Initially designed specifically for criminal justice-based drug treatment, MRT has</p>	<p>Open-ended groups meet once a month or up to five times per week</p> <p>Institutional,</p>

	<p>willingness to be dishonest and blame and victimize others.</p> <p>Opposition: Includes the same behaviors as “disloyalty,” only occurring less often.</p> <p>Uncertainty: Person is unsure of how he or she stands with or feels about others; these individuals still make decisions based on their own pain or pleasure.</p> <p>Injury: Destructive behavior still occurs, but recognition of the source of the problem also occurs; some responsibility for behavior is taken and some decisions may be based on consequences for others.</p> <p>Nonexistence: Person feels alienated from things but has a few satisfying relationships; these individuals sway between making decisions based on formal rules and decisions based on pleasure and pain.</p> <p>Danger: Person commits to goals and makes decisions primarily on law and societal values; when regression occurs, these individuals experience anguish and loss of self-esteem.</p> <p>Emergency: Social considerations are made, but “idealized ethical principles” influence decisionmaking.</p> <p>Normal: These individuals are relatively happy, contented people who have chosen the right goals for themselves and are fulfilling them properly; decisionmaking based on pleasure and pain has been virtually eliminated.</p> <p>Grace: The majority of decisions are based on ethical principles; supposedly, only a small percentage of adults reach this stage.</p>	<p>since been expanded for use with offenders convicted of driving while intoxicated (DWI), domestic violence, and sex offenses; parenting skill and job attitude improvement; and to address general antisocial thinking</p>	<p>community corrections settings, can be used concurrently with other programs in which offenders may participate</p> <p>The program consists of 35 sessions, running from 8 to 12 weeks, with 6 to 8 participants</p>
<p>Reasoning and Rehabilitation</p>	<p>Trainers are encouraged to add to or modify the program to best serve specific types of offenders.</p>	<p>Can be used in a broad range of institutional or community corrections settings or concurrently with other programs in which offenders may participate.</p>	<p>35 sessions, running from 8 to 12 weeks, with 6 to 8 participants.</p> <p>15-session edition that seeks to target those over age 18 whose antisocial behavior led them to</p>

			social services or criminal justice agencies.
Relapse Prevention Therapy	<p>RPT clients are taught to:</p> <ul style="list-style-type: none"> ▪ Understand relapse as a process, not an event. ▪ Identify and cope with high-risk situations. ▪ Cope effectively with urges and cravings. ▪ Implement damage control procedures during lapses to minimize their negative consequences and get back on the road to recovery. ▪ Stay engaged in treatment, particularly after relapses occur. ▪ Create a more balanced lifestyle. <p>Instead of reacting to a lapse or relapse with a sense of self-blame and failure, treats these so-called failures as temporary setbacks that may ultimately have positive outcomes and become prolapses.</p> <p>Prolapses are defined as mistakes that clients learn from that improve their eventual chances of success.</p>	<p>Originally developed as maintenance program to prevent and manage relapse following addiction treatment.</p> <p>Addresses several key questions about relapse both as a process and as an event:</p> <ol style="list-style-type: none"> 1. Are there specific situational events that serve as triggers for relapse? 2. Are the determinants of the first lapse the same as those that cause a total relapse to occur, if not, how can they be distinguished from one another? 3. How does an individual react to and conceptualize the events preceding and following a lapse and how do these reactions affect the person's subsequent behavior regarding the probability of full-blown relapse? 4. Is it possible for an individual to covertly plan a relapse by setting up a situation in which it is virtually impossible to resist temptation? 5. At which points in the relapse process is it possible to intervene and alter the course of events so as to prevent a return to the addictive habit pattern? 6. Is it possible to prepare individuals during treatment to anticipate the likelihood of relapse and to teach them coping behaviors that might reduce the likelihood of lapses and the probability of subsequent relapse? 	No prescribed structure.
Thinking for a Change	National Institute of Corrections training to increase offenders' awareness of self and others. It integrates cognitive restructuring, social skills, and problem solving.	Adults and juveniles and males and females in state correctional systems, local jails, community-based corrections programs, and on probation or parole.	<p>A brief 15-minute pre-screening session to reinforce the participant's need for the program and the necessity of positive participation.</p> <p>Small groups (8 to 12 individuals) are</p>

			<p>encouraged in order to facilitate interactive and productive feedback.</p> <p>The program can be used concurrently or consecutively with other treatment programs.</p> <p>The curriculum is divided into 22 lessons, each lasting 1 to 2 hours.</p> <p>No more than one lesson should be offered per day; two per week is optimal.</p> <p>At least 10 additional sessions be held using a social skills profile developed by the class. Lessons are sequential, and program flow and integrity are important.</p>
--	--	--	--

Adapted from: Cognitive Behavioral Therapy: A Review and Discussion for Corrections Professionals at <http://static.nicic.gov/Library/021657.pdf>

Medication Assisted Treatment- Both mental health and substance use disorders can improve through the appropriate use of medications. Medication assisted treatment (MAT) can help to stabilize and manage withdrawal symptoms, reduce cravings, and decrease the potential for relapse for offenders receiving treatment for substance use disorders. In the treatment of mental disorders, **a variety of anti-depressant, anti-anxiety, anticonvulsant, anti-psychotic, and mood-stabilizing medications** have been very effective and can be in conjunction with psycho-therapy. Medication interactions are an important consideration in treatment for a client with a co-occurring disorder and should be monitored by the prescribing physician, preferably one experienced with both addiction medicine and psychiatric medication management.

According to the American Correctional Association, 73% of correctional facilities prescribe psychotropic medications to inmates; on the average, one out of ten offenders take medications while incarcerated as part of their treatment for mental health disorders (BJS, 2000).

Opiate Replacement Therapy (ORT) – One type of MAT is opiate replacement therapy. For example, longer acting and less euphoric opioids, such as Methadone, Buprenorphine (Subutex), Naltrexone (Vivitrol) and combination Naltrexone and Buprenorphine (Suboxone) are used to replace illegal opioid drugs such as heroin. The principle behind ORT is that an opiate addict will be able to regain a normal life and schedule while being treated with a substance that stops him or her from experiencing withdrawal symptoms and drug cravings, but doesn't provide strong euphoric effects from the drug.

The transitional period from incarceration to community supervision is a high risk period for overdose among opiate dependent offenders (Binswanger et al., 2007). Although the use of opiate replacement therapy inside correctional facilities has mainly been limited to pregnant women, many programs refer offenders to opiate replacement therapy upon release, though community-based treatment providers. Research studies have shown that beginning opiate replacement therapy prior to release can substantially increase the length of time re-entering offenders remain in community based treatment programs (Kinlock, Gordon, Schwartz, Fitzgerald, & O'Grady, 2009).

Use of Psychiatric Medications- These medications, such as anti-depressants or mood stabilizers, can be extremely helpful for inmates with anxiety, depression or mood disorders. However, some inmates resist medications and have a low rate of compliance with treatment recommendations. Mental health advocates have also raised concern that some state prisons overmedicate inmates. One study found that over 40% of inmates were prescribed tranquilizers used to treat psychotic disorders for “off label” uses (Felner, 2006).

RSAT staff needs to be aware of the potential benefits of medication assisted treatments for substance use disorders and also of potential drug interactions for client's with co-occurring disorders who may be taking psychiatric medications.

It is within the scope of an offender's constitutional rights to refuse medication for a mental health condition. This right cannot be over ridden without a court order. Courts have upheld forced medication of inmates with mental health disorders in under certain conditions, but generally an inmate's consent to medical treatment is required.

More commonly, psychiatric medications are discontinued upon release due to lack of continuity of care. Offenders are routinely released with a two week's supply of meds and may not have a way to pay for their prescribed medications. RSAT staff should work with clients, community mental health providers and case managers to ensure RSAT clients with mental health disorders, preparing for release to community supervision, are able to continue medication regimes.

Motivational Strategies – Three primary strategies which are designed to motivate offenders in treatment to abide by treatment and supervision requirements have demonstrated promise through research. These include:

motivational interviewing, motivational enhancement therapy, and contingency management.

Motivational Interviewing (MI) - Although there are very few studies on with incarcerated individuals, MI it has been effective in community corrections (Walters, Clark, Gingerich and Meltzer, 2007). Motivation is seen as a dynamic factor that can be shaped and changed. Many offenders may be ambivalent about treatment and recovery, but they usually are motivated to comply with the conditions of release. MI as a counseling technique/style can be utilized throughout RSAT programs. According to NIDA: "When providing correctional supervision of individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Nonmonetary "social reinforcers" such as recognition for progress or sincere effort can be effective" (2006, p 21).

Tips for Implementation:

1. Rewards should outnumber punishments 4:1
2. Reinforcers should be clearly defined and immediate
3. If punishments are used graduated sanctions that allow for corrective action are best.

Motivational Enhancement Therapy- This evidence-based practice has been successful with both adults and adolescents in the NIDA Blending Initiative (Martino et al., 2010) and the Cannabis Youth Treatment Study (Dennis et al. , 2004), respectively. It combines the use of MI with a review of assessment information in two to three individual counseling sessions to build motivation and prepare clients for group counseling.

Contingency Management- is a system of pre-determined rewards used to acknowledge and reinforce target behaviors. In community-based programs negative urine screens and other target behaviors are reinforced through the use of non-monetary awards. Contingency management programs within institutional settings have been effectively adapted through the use of behavioral contracting and increased privileges (Gendreau, Listwan and Kuhns, 2011).

Illness Management and Recovery (IMR) – IMR refers to a set of practices that teach people with severe mental illness how to manage their disorder, and how to work with treatment providers, friends and family in achieving and sustaining recovery. Although it was designed for individuals with serious mental illness, the context of the practices align with current substance use disorder treatment, which empowers people to cope effectively with symptoms and gives individuals greater control over their own treatment and lives.

There is a lack of controlled research on IMR-related programs in criminal justice settings. However, evidence supporting their use in other contexts suggests that they can be adapted to an offender with mental illness in a variety of settings (Mueser & MacKain, 2008). Mueser and MacKain, 2008 indicate that

components of IMR, SILS, and WRAP can all be adapted to meet the unique demands across institutional and community settings:

Jails. Considering the brief to intermediate length of time individuals may spend in jail, this setting is most appropriate for mental health screening, educating consumers about the basic facts of mental illness and its treatment, and fostering motivation for learning illness self-management skills. Subsequent work on formulating personal recovery goals and competence at illness self-management can be accomplished in either outpatient mental health or prison settings.

Prisons. IMR-related programs can be implemented in prison settings, with the combined focus on articulating personal long-term goals and learning the rudiments of illness self-management.

There are four primary practices which fall under the guise of IMR, which have been found effective.

Psychoeducation is teaching information about mental illness and its treatment using primarily didactic approaches, which improves consumers' understanding of their disorder and their capacity for informed treatment decision-making.

Behavioral tailoring is helping consumers fit taking medication into daily routines by building in natural reminders (such as putting one's toothbrush by one's medication dispenser), which improves medication adherence and can prevent relapses and rehospitalizations. Relapse prevention training reduces the chances of relapse and rehospitalization by teaching consumers how to recognize situations that trigger relapses and the early warning signs of a relapse, and developing a plan for responding to those signs in order to stop them before they worsen and interfere with functioning.

The Social and Independent Living Skills (SILS) program is a series of teaching modules, based on the principles of social skills training, that helps consumers learn how to manage their mental illness and improve the quality of their lives. Module topics include Symptom Management, Medication Management, Basic Conversational Skills, Community Re-entry, and Leisure for Recreation.

Wellness Recovery and Action Plan (WRAP) is a peer based program aimed at helping consumers develop a personalized plan for managing their wellness and getting their needs met, both individually and through supports from significant others and the mental health system.

Module IV: Implementing Integrated Treatment in Corrections

- A. The Modified Therapeutic Community Setting
- B. Staff Readiness to Provide Integrated Treatment
- C. Agency Readiness to Provide Integrated Treatment

Learning Objectives

After completing this module, participants will be able to:

- Identify the practices for a Modified Therapeutic Community program for co-occurring disorders
- Assess staff readiness to administer evidence-based integrated treatment
- Ensure appropriate staff training and credentialing for staff conducting assessments and administering treatment for co-occurring disorders.

Pre/Post-Test

1. A modified therapeutic community for co-occurring disorders is less intensive than a traditional therapeutic community model. **T**
2. If clinical staff are not ready to administer integrated treatment, the intervention may not be administered effectively. **T**
3. Reentry programs and aftercare are important components of a modified therapeutic community model (MTC). **T**
4. Traditional TCs and modified TCs both emphasize the role of the community and self-healing in recovery. **T**
5. Key elements of an MTC include therapy and abstinence of all mental health medications. **F**
6. It should be standard protocol to re-assess and refer all RSAT inmates prior to release from the jail/prison. **T**
7. RSAT inmates in an MTC do not have to accept personal responsibility for their treatment process. **F**

INTEGRATED TREATMENT PRACTICES

As a recap, integrated treatment programs coordinate all elements of treatment and rehabilitation to ensure that everyone works collaboratively toward the same goals. Regardless of the primary type of treatment (e.g.: medication assisted treatment or cognitive modalities), the following basic principles apply to all integrated treatment strategies, and have relevancy for both treatment staff and corrections officers. Fidelity, or ensuring that each of these elements are integrated into the treatment approach whenever relevant, will better ensure consistency in administering the program, and more successful outcomes.

How can RSAT programs adapt the Therapeutic Community approach?

The modified therapeutic community (MTC) is a comprehensive treatment model that makes three key alterations for individuals with co-occurring disorders: it is more flexible, less intense, and more individualized.

Like all TC programs, MTC seeks to develop a culture where clients learn through a self-help process to foster change in themselves and others, and where the community becomes the healing agent. The difference is that this integrated residential treatment program has a specific focus on public safety outcomes for persons with COD. It is a derivative of the therapeutic community and has demonstrated lower rates of reincarceration and a reduction in criminal activity in MTC participants. The core principles and methods of the TC that are especially relevant to the treatment of co-occurring disorders include:

- providing a highly structured daily regimen;
- fostering personal responsibility and self-help in managing life difficulties;
- using peers as role models and guides with the peer community acting as the healing agent within a strategy of “community-as-method” (the community provides both the context for and mechanism of change);
- regarding change as a gradual, developmental process and moving clients through progressive treatment stages;
- stressing work and self-reliance through the development of vocational and independent living skills; and promoting pro-social values within healthy social networks to sustain recovery.

MTCs include a community treatment element in their recovery. The objective is to treat the underlying substance abuse issues, which are related to continued criminal activity. By addressing the addiction problems of offenders while dealing with mental health disorders at the same time, MTCs aim to prevent future drug use and offending and reduce recidivism. The program benefits the offender by controlling substance use and providing treatment for mental health disorders,

the public by reducing future offending, and the criminal justice (and health care) system by reducing the number of the offender's future interactions.

As compared to the standard TC approach, the MTC incorporates increased flexibility, reduction in the duration of various activities, less confrontation, increased emphasis on orientation and instruction, fewer sanctions, more explicit affirmation for achievements, greater sensitivity to individual differences, and greater responsiveness to the special developmental needs of the clients, all of which serve to maximize social learning opportunities. The MTC program requires that all participants have strong involvement and input into the "community" in order to feel involved and responsible. Staff members act as role models and steer the community members toward gaining greater control over their lives, their disorders, and their opportunities upon reentry. MTC requires the involvement of treatment specialists, therapists and psychiatric services, group managers, program directors, and correctional security personnel. Key elements of the program include group therapy, individual therapy, monitoring of mental health, and medication management. These elements are linked to recovery stages in four phases:

Phase 1: Admission and Orientation

Phase 2: Primary Treatment

Phase 3: Live-in Reentry

Phase 4: Live-out Reentry

In the best case scenario, upon release from custody, inmates should continue treatment in the community for up to six months in a recovery home program. The program helps inmates continue the treatment that began while in prison, including examination and alteration of criminal thinking and behavior, mastering community living and integrating with society, gaining employment, and fostering connections with a larger recovery community.

Treatment models are not mutually exclusive. RSAT inmates may be appropriate for multiple treatment models that are integrated into a comprehensive treatment plan.

EXERCISE V: SELECTING A TREATMENT STRATEGY

Let's revisit Evelyn again. Based on her GAF score and your introduction to evidence-based treatment principles for inmates, what type(s) of treatment might you recommend (e.g.: CBT, MAT, etc.)? How would this model fit within the structure of an MTC?

Evelyn's Story

Evelyn, a 22 year old female, was removed from her abusive home and placed in foster care at six years old. By the age of 14 she had lived in seven foster homes, and was using marijuana every day. She dropped out of school at 15 and engaged in prostitution to earn enough money to live on her own. Soon after, Evelyn started drinking heavily and taking valium to relax her nerves and get through the night. She was court ordered to a substance abuse treatment program after several appearances in juvenile court, but did not remain abstinent for longer than 30 days after she finished the program. She began hearing voices in her head and hallucinating when she was 17. This time, she was court ordered to attend a mental health program. When she was 21, Evelyn had her two year old daughter removed from her care when was arrested for the sixteenth time for solicitation. At this time, she was ordered to undergo a clinical assessment. Problematically, Evelyn does not feel motivated to participate in treatment and cannot see much of a future upon release.

DEVELOPING INTEGRATED TREATMENT SKILLS

This training tool included these topics to introduce RSAT staff to the basic principles and practices of integrated treatment for inmates with CODs. Specifically, as discussed in Module I, the basic competencies for administering integrated treatment include:

- Prevalence, course, signs, and symptoms of co-occurring disorder
- Interaction of symptoms of mental and substance use disorders
- Strategies for enhancing accuracy of screening and assessment information among those who have co-occurring disorders
- Use of specialized screening and assessment instruments
- Integrated treatment approaches and other evidence-based practices
- Supervision and sanction approaches for individuals with co-occurring disorders
- Specialized services available in the community for justice-involved individuals with co-occurring disorders, and procedures for initiating referrals for assessment and treatment services (Peters et. al., 2008).

There are standardized training practices for introducing and preparing staff to administer integrated treatment.

SAMHSA has a five module training guide that presents the core elements of integrated treatment one module at a time, using vignettes, discussion exercises and examples from experts in the field. Other treatment executives have identified the core systemic needs to effectively implement an integrated treatment program.

Some include:

- the need comprehensive framework for program licensing and site certification, or specified programs that are exempt from existing requirements
- removal of regulatory barriers that discourage providers from serving this population
- creation of incentives through adequate reimbursement
- the need mechanism to cross-train professionals and continuously develop skill base of non-credentialed workers
- the need to align all elements of the system to promote mastery of content defined as important: intake process, treatment plan, staff evaluations, etc.
- the need for regular clinical supervision
- Prior to implementing an intervention, there are fidelity principles in place to assess “readiness” to administer a treatment strategy.

[The Five Modules in Training Frontline Staff:](#)

1. Basic Elements and Practice Principles
2. Practical Knowledge of Common Substances
3. Stages of Treatment and Core Processes
4. Practical Skills for Integrated Treatment

Clinicians and program managers may also become credentialed through an independent certification in co-occurring disorders available to practitioners in either mental health or substance abuse services or as an add-on to a licensed professional's existing credential. Two levels of co-occurring credentials are now offered by the International Certification and Reciprocity Consortium:

- Certified Co-Occurring Disorders Professional (CCDP) for associate and bachelor's level practitioners, and
- Certified Co-Occurring Disorders Professional Diplomat (CCDPD), for master's and doctoral level practitioners.

These credentials were developed in Pennsylvania and were accepted by the International Certification and Reciprocity Consortium. The credentials have now been adopted by at least fifteen other states.

CERTIFICATION

Many states have developed state-level certification for practitioners providing services to individuals with co-occurring disorders. For example:

- Oklahoma and New Mexico have established statewide certifications for Licensed Alcohol and Drug Counselors that include some COD competencies, but that are not a specific COD credential.
- The District of Columbia developed an Educational Certificate in Co-occurring Disorders, a local practitioner's credential, which is jointly sponsored by the local mental health agency and the substance abuse agency.
- In Virginia, an independent board offers certification by a process similar to securing a license. However, it is not associated with the state licensing process.
- Minnesota is working to develop a certificate program open to both addictions and mental health counselors.

In some states certification is required. For example, according to [SAMHSA](#):

- In Illinois, certification is required for individuals who provide co-occurring disorders services.
- In Missouri, all major treatment organizations are required to become certified in co-occurring disorders.
- In Delaware, all programs that receive funding from the State Mental Health Department must be certified in co-occurring disorders, and all licensed mental health practitioners will be encouraged to be COD certified.

EXERCISE VI: STAFF READINESS ASSESSMENT

Answering the questions below will help RSAT program administrators and leadership generate an ongoing “to-do” list (or implementation plan) to guide your steps in implementing an Integrated Treatment program. The answers are designed to help RSAT administrators understand the components of the evidence-based model that are already in place at the agency and the work that still remains (SAMHSA, 2009).

Think about your program or institution. Complete the assessment below. The extent to which you understand these questions will give you an idea of your institution or program’s readiness to implement an integrated treatment strategy within your RSAT program. Check any areas that you feel you do NOT know or completely understand.

- Which practitioners will be designated as staff (integrated treatment specialists) for your Integrated Treatment program?

- Who will supervise and direct the Integrated Treatment program (Who will be the program leader)?
- What will the roles of the program leader and integrated treatment specialists look like?
- What will be the size of the integrated treatment specialists' caseloads?
- What will be the size of the program leader's caseload?
- What will your supervisory structure look like (How often does the program leader meet with integrated treatment specialists and the agency director)?
- How will your integrated treatment specialists be supervised?
- How will you screen and diagnose consumers with co-occurring disorders?
- What will your procedures be for assessing consumers' stage of treatment?
- How will you identify and refer consumers to your Integrated Treatment program?
- How will you prepare consumers of your Integrated Treatment program for release from incarceration?
- How will you provide access to comprehensive services for consumers in your Integrated Treatment program upon release from incarceration?
- What are your assessment procedures for consumers in your program (Will you use integrated comprehensive, longitudinal, and context assessments)?
- What will your procedures be for providing integrated treatment planning?
- How will integrated treatment specialists communicate and collaborate with other treatment team members, including medication prescribers, facility medical staff and post-release health providers?
- How will you educate medication prescribers (e.g. facility medical personnel) about the evidence-based practice?
- What types of group treatment will you provide for consumers with co-occurring disorders?
- How will family interventions be provided to families or other supporters of consumers in your program?
- To which alcohol and drug self-help groups will you refer consumers in your program?
- What will your procedures be for identifying consumers who do not respond to integrated treatment? What types of secondary interventions will you provide to them?
- How will you measure your program's fidelity to the evidence-based model?
- How will the system for collecting consumer outcome data work?

- How will your Integrated Treatment program staff relate to advisory groups?
- How will your Integrated Treatment program staff relate to correctional officers?
- How will correctional officers be engaged to support your Integrated Treatment program participants?

WRAP UP AND CONCLUSION

This training curriculum was designed to increase knowledge and awareness of the relationship between substance use and mental health disorders among people involved in RSAT jail and prison programs and aftercare. RSAT staff should have a solid background for identifying the signs and symptoms of co-occurring disorders and understanding the fundamentals of integrated screening, assessment and treatment.

Other topics in this series include: trauma and substance use disorders, aftercare and recovery, and substance use disorders and HIV/AIDS and communicable diseases.

Works Cited:

Andrews, D. A., Dowden, C., & Gendreau, P. (1999). Clinically relevant and psychologically informed approaches to reduced re-offending: A meta-analytic study of human service, risk, need responsivity and other concerns in justice contexts. Carleton University, Ottawa, Canada.

Bourgon, G., & Armstrong B. (2006). Transferring the principles of effective treatment into a "Real World" setting. *Criminal Justice*, 32(1), 3-25.

Bureau of Justice Statistics. (2009). National crime victimization survey: Criminal victimization, 2008. U.S. Department of Justice.

Center for Substance Abuse Treatment. (1993). Mental health and addiction treatment systems: Philosophical and treatment approach issues. Treatment Improvement Protocol. US DHHS.

Center for Substance Abuse Treatment. (1995). Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse(TIP) Series, No. 9. (DHHS Publication No. (SMA) 95-3061). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005). Substance abuse treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol (TIP) Series, No. 42. (DHHS Publication No. (SMA) 05-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2007). Substance Abuse Treatment for Persons with Co-Occurring Disorders Inservice Training. DHHS Publication No. (SMA) 07-4262. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Corbett, M., Nikkel, R. E., & Drake, R. E. (2010). Alcohol & Drug Abuse: Dual Diagnosis Anonymous of Oregon. *Psychiatric Services* 61, 738-740.

Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison- A high risk of death for former inmates. *New England Journal of Medicine* 365, 157-165.

Dennis, M., Godley, S., Diamond, G., Tims, F., Babor, T., Donaldson, J., . . . Funk, R. (2004). The cannabis youth treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment* 27(3), 197-213.

Dick, D., & Agrawal, A. (2008) The Genetics of Alcohol and Other Drug Dependence. *National Institute of Justice Publications*, 31(2), 111-118.

Drake, R. E., O'Neal, E. L., & Wallach, M. A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment, 34*(1), 123-138.

Felner, J. (2006). A corrections quandary: Mental illness and prison rules. *Harvard Civil Rights–Civil Liberties Law Review, 41*, 391-412.

Gendreau, P. and C. Goggin. (1995). Principles of effective correctional programming with offenders. Center for Criminal Justice Studies and Department of Psychology, University of New Brunswick, New Brunswick.

Gendreau, P., Listwan, S. J., & Kuhns, J. B. (2011). Managing prisons effectively: The potential of contingency management programs. Retrieved November 3, 2011 from <http://www.publicsafety.gc.ca/res/cor/rep/fl/2011-04-mpe-eng.pdf>

Glaze, L., & James, D. (2006). *Mental Health Problems of Prison and Jail Inmates* (NIJ 213600). Retrieved from Bureau of Justice Statistics: <http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=789>

Hills, H., Siegfried, C., & Ickowitz, A. (2004). *Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment*. Washington, DC: US Department of Justice, National Institute of Corrections.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005) Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry, 62*(6), 617-627.

Kinlock, T. W., Gordon, M. S., Schwartz, R. P., Fitzgerald, T. T., & O'Grady, K. E. (2009). Methadone maintenance for prisoners: Results at twelve-months post-release. *Journal of Substance Abuse Treatment, 37*, 277-285.

Latessa, E. J. (2010). What works and what doesn't in reducing recidivism: Applying the principles of effective intervention to offender reentry. Presented by: Center for Criminal Justice Research, Division of Criminal Justice. University of Cincinnati: www.uc.edu/criminaljustice

Latessa, E.J. (2004). The challenge of change: Correctional programs and evidence based practices. *Criminology & Public Policy, Vol. 3*(4), 547-560.

Martino, S., Brigham, G. S., Higgins, C., Gallon, S., Freese, T., Albright, L., Condon, T. (2010). Partnerships and pathways of dissemination: The NIDA-SAMHSA blending initiative in the clinical trials network. *Journal of Substance Abuse Treatment 38*(Suppl 1), S31-S43.

Miller, N., & MacDonald. (2009, March). *Women, substance abuse & marginalization: The impact of peer led leadership training on women in recovery*. Paper Presentation at the Academy of Criminal Justice Science, Boston, MA.

Monahan, J., Steadman, H., Silver, E., Appelbaum, P., Robbins, P., Mulvey, E., Roth, L., Grisso, T., & Banks, S. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. New York: Oxford University Press.

Morrissey, J., & Meyer, P. (2005, February). *Extending ACT to criminal justice settings: Applications, evidence, and options*. Paper presented at the Evidence-Based Practice for Justice Involved Individuals: Assertive Community Treatment Expert Panel meeting, Bethesda, MD.

Mueser, K., and MacKain, S. (2008). *Illness Management and Recovery*. CMHS National GAINS Center

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

NAMI, (2008). *Decriminalizing Mental Illness: Background and Recommendations*. Retrieved from http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=67126

National Institute on Drug Abuse (NIDA). (2007). *Comorbid Drug Abuse and Mental Illness, A Research Update from the National Institute on Drug Abuse*. Retrieved November, 2, 2011 from <http://drugabuse.gov/tib/comorbid.html>

National Institute on Drug Abuse (NIDA). (1998). *NIDA probes the elusive link between child abuse and later drug abuse*. Retrieved June, 22, 2011 from http://archives.drugabuse.gov/NIDA_Notes/NNVol13N2/DirrepVol13N2.html

National Institute on Drug Abuse (NIDA). (2006). *Principles of drug abuse treatment for criminal justice populations: A research-based guide*. Retrieved April 22, 2011 from: http://www.nida.nih.gov/PDF/PODAT_CJ/PODAT_CJ.pdf.

National Institute on Drug Abuse (NIDA). (2006). *Treatment is the key: Addressing drug abuse in criminal justice settings*. NIDA Advisory Council Meeting, September 20, 2006. Presentation by Redonna K. Chandler, Ph.D., Branch Chief Services, Research Branch Division of Epidemiology, Services, and Prevention Research. National Institute on Drug Abuse.

Peters, R. H., Bartoi, M. G., & Sherman, P. B. (2008). Screening and assessment of co-occurring disorders in the justice system. Delmar, NY: CMHS National GAINS Center

Peters, R. H., Sherman, P. B. & Osher, F.C. (2008). Treatment in jails and prisons. In K.T. Mueser & D.V. Jeste (Eds.), *Clinical handbook of schizophrenia* (pps. 354-364). New York: Guilford Press.

Polcin, D. L. (2003). Rethinking confrontation in alcohol and drug treatment: consideration of the clinical context. *Substance Use and Misuse*, 38(2), 165-184.

Prins, S. & Draper L. (2009). Improving outcomes for people with mental illnesses under community corrections supervision: A guide to research-informed policy and practice. Council of State Governments.

Sciacca, K. (1997). Removing barriers: Dual diagnosis and motivational interviewing. *Professional Counselor* 12(1), 41-46.

Substance Abuse and Mental Health Services Administration (2010). Integrated treatment for co-occurring disorders evidence based practices (EBP) kit, (SMA08-4367). Retrieved from <http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367>

Substance Abuse and Mental Health Services Administration (2009), Office of Applied Studies, National Survey on Drug Use and Health, 2008 and 2009. Retrieved from <http://www.samhsa.gov/co-occurring/topics/data/disorders.aspx>

Substance Abuse and Mental Health Services Administration. Rates of Co-Occurring Mental and Substance Use Disorders. Retrieved from <http://www.samhsa.gov/co-occurring/topics/data/disorders.aspx>

Substance Abuse and Mental Health Services Administration. Workforce: Assessing Practitioners and Organizations Competencies. Retrieved from <http://www.samhsa.gov/co-occurring/topics/your-workforce/assessing-practitioners.aspx>

Substance Abuse and Mental Health Services Administration. Workforce: Creating Incentives to Promote Workforce Development. Retrieved from <http://www.samhsa.gov/co-occurring/topics/your-workforce/creating-incentives.aspx>

Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime Victimization in Adults With Severe Mental Illness Comparison With the National Crime Victimization Survey. *Arch Gen Psychiatry* 62(8), 911-921.

Van Voorhis, P., Salisbury, E., Wright, E. & Bauman, A. (2008). Achieving accurate pictures of risk and identifying gender responsive needs: Two new assessments for women offenders. National Institute of Corrections.

Walters, S. T., Clark, M. D., Gingerich, R., & Meltzer, M. L. (2007). *Motivating offenders to change: A guide for probation and parole* National Institute of Corrections, US Department of Justice (NCJ 219080).

Wolff, N., Shi, J., & Blitz, C. (2008). Racial and Ethnic Disparities in Types and Sources of Victimization Inside Prison. *Prison Journal*, 88(4), 451-472.

Additional Resources:

Abram, K. M., & Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees. *American Psychologist*, 46(10), 1036–1045.

Center for Substance Abuse Treatment. Substance Abuse and Mental Health Service Administration. (2007). Substance Abuse Treatment for Persons with Co-Occurring Disorders In service Training. (DHHS Publication No. (SMA) 07-4262). Retrieved from http://www.kap.samhsa.gov/products/trainingcurriculums/pdfs/tip42_curriculum.pdf

Center for Substance Abuse Treatment. Substance Abuse and Mental Health Service Administration. (1999). Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series 35. (DHSS Publication No. (SMA) 99-3354). Retrieved from http://www.adp.ca.gov/SBI/pdfs/TIP_35.pdf

Conway, K. P., Compton, W., Stinson, F. S., & Grant, B. F. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the national epidemiologic survey on alcohol and related conditions. *Journal of Clinical Psychology*, 67(2), 247-257.

GAINS Center (2009). Ending an American tragedy: Addressing the needs of justice- involved people with mental illnesses and co-occurring disorders. National Leadership Forum on Behavioral Health/Criminal Justice Services. Retrieved October 11, 2011 from: <http://www.gainscenter.samhsa.gov/html/nlf/pdfs/AmericanTragedy.pdf>

Hawkins, D. J., Catalano, R. F., Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention.

Morrissey J, Meyer P, & Cuddeback G. (2007). Extending Assertive Community Treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43(5).

National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2004). The Prevalence of Co-Occurring Mental Illness and Substance Use Disorders in Jails. Retrieved from <http://gainscenter.samhsa.gov/pdfs/disorders/gainsjailprev.pdf>

National Institutes of Health, National Institute on Drug Abuse. (2007). Comorbid drug abuse and mental illness. Retrieved from <http://www.drugabuse.gov/tib/comorbid.html>

National Institutes of Health, National Institute on Drug Abuse. (2011). NIDA InfoFacts: Comorbidity: Addiction and other mental disorders. Retrieved from <http://drugabuse.gov/infofacts/comorbidity.html>

National Institutes of Health, National Institute on Drug Abuse. (2010). Drugs, brains, and behavior: The science of addiction. (NIH Pub No. 10-5605). Retrieved from <http://www.nida.nih.gov/scienceofaddiction/sciofaddiction.pdf>

Psychological Bulletin, 112(1), 64-105. doi: 10.1037/0033-2909.112.1.64.
National Alliance on Mental Illness. (2003). Dual Diagnosis and Integrated Treatment of Mental Illness and Substance Abuse Disorder. Retrieved from http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23049

Roger Przybylski for the RKC Group. (2008). What works: Effective recidivism reduction and risk-focused prevention programs. *A Compendium of Evidence-Based Options for Preventing New and Persistent Criminal Behavior*. Prepared for Division of Criminal Justice, Colorado Department of Public Safety

Substance Abuse and Mental Health Service Administration, U.S. Department of Health and Human Services. (2002). Report to congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. Retrieved from <http://www.samhsa.gov/reports/congress2002/chap1ucod.htm>

Steadman, H., Osher, F., Clark Robbins, P., Case, B. & Samuels S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60: 761-765.