

WELCOME to the Residential Substance Abuse Treatment (RSAT)
Training and Technical Assistance (TTA) National Resource Center

RSAT Training Tool: Co-occurring Disorders and Integrated Treatment Strategies

TASC
Treatment Alternatives for Safe Communities

AHP
Advocates for
Human Potential, Inc.



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Audience

Residential Substance Abuse Treatment (RSAT) program staff, including:

- ▶ addiction professionals
- ▶ mental health professionals
- ▶ case managers
- ▶ correctional staff
- ▶ peer recovery support specialists
- ▶ correctional clergy

Purpose

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 and aftercare in order to ensure treatment for each condition supports recovery from the other.

Goal

Introduce general concepts and terminology, outcome evaluation data, effective screening and assessment practices, and interventions for RSAT programs serving people in substance use treatment that have co-occurring mental health and substance use disorders.

Objectives

- ▶ Increase knowledge about the origins of mental health and substance use disorders
- ▶ Increase knowledge about the nexus between co-occurring disorders and justice system involvement
- ▶ Understand the principles of integrated substance abuse screening, assessment, and treatment for co-occurring disorders, and its impact on criminal behavior

Objectives

- ▶ Understand the principles of integrated substance abuse treatment for co-occurring disorders, and its impact on criminal behavior
- ▶ Increase staff's ability to champion integrated treatment and to educate clients about the resources for sustaining recovery from both disorders.

Curriculum Principles

- ▶ Evidence-based strategies
- ▶ Integrated interventions
- ▶ Recovery-oriented approaches
- ▶ Present day accountability
- ▶ Culturally aligned content
- ▶ Strength-based orientation

Practices and Principles

Basic competencies to deliver integrated treatment:

- ▶ Prevalence, course, signs, and symptoms of co-occurring disorder
- ▶ Interaction of symptoms between mental and substance use disorders
- ▶ Strategies for enhancing accuracy of screening and assessment information among those who have co-occurring disorders

Practices and Principles

- ▶ 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 and procedures for initiating referrals for assessment and treatment services (Peters et. al., 2008).

Course Relevancy

Correctional treatment programs and correctional environments both have two primary goals:

- (a) reduce disruptive behavior within the institution;
- (b) reduce the risk of recidivism when offenders are released to the community.

Course Relevancy

RSAT programs are in a unique position to provide:

- ▶ Long term treatment for learning, and testing new behaviors and coping skills
- ▶ Practice interactions among peers who are doing the same
- ▶ Treatments that can immediately reward and sanction behaviors with progressive measures

Course Relevancy

Good practice (correctional & treatment):

- ▶ highly structured and safe environments
- ▶ predictable limits
- ▶ consistent incentives and boundaries
- ▶ swift and certain consequences
- ▶ fair and consistent responses

Overall priority = safety and security

Module I: Signs and Symptoms of Co-Occurring Disorders

Module I: Topics

- ▶ Signs and Symptoms of Co-Occurring Disorders
- ▶ Origins of Co-Occurring Disorders
- ▶ Prevalence in Correctional Populations
- ▶ Relevance for RSAT Programs

Module I: Learning Objectives

- ▶ 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

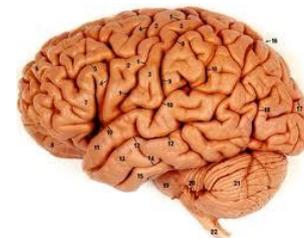
Module I: Pre-Test

1. Co-occurring disorders describe a condition where an individual is physically dependent on more than one drug.
2. Dual-diagnosis is another way of referring to a co-occurring disorder.
3. Adults in the criminal justice system have lower rates of co-occurring disorders than adults in the general population.
4. It is more effective to treat substance abuse first, and then mental illness so offenders can benefit from mental health treatment.
5. It is very rare for a person with alcoholism to have a co-occurring disorder.
6. By law, inmates with serious medical conditions have a legal right to treatment —including mental health treatment
7. People with co-occurring disorders are more likely to relapse than people with only a substance abuse disorder.

Signs and Symptoms

Addiction is a chronic, condition with a high potential for relapse, characterized by compulsive drug seeking and use, despite harmful consequences.

- ▶ can affect every area of a person's life
- ▶ involve changes in the brain
- ▶ may respond to medications
- ▶ symptoms and severity fluctuate
- ▶ individual response to treatment approaches vary



Signs and Symptoms

Mental health disorders (mental illnesses) are conditions that can disrupt a person's thinking, feeling, mood, behavior, and ability to relate to others.

- ▶ can affect every area of a person's life
- ▶ involve changes in the brain
- ▶ may respond to medications
- ▶ symptoms and severity fluctuate
- ▶ individual response to treatment approaches vary



Signs and Symptoms

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

A mental disorder should be established independent of the substance use disorder, rather than symptoms resulting from substance use.

Prevalence in Corrections

Approximately 8.9 (4%) million adults in the U.S. have co-occurring disorders

- ▶ people in substance abuse treatment that have a mental health problem = 50%
- ▶ people in prison who use substances also report a mental health problem = 74%
- ▶ people in jail with mental health disorders that also have a substance use problem= 76%

Prevalence in Corrections

Inmates with serious medical conditions have a legal right to treatment —including mental health treatment. Facilities must screen for mental health disorders and suicide risk and offer treatment to stabilize offenders who attempt suicide or have acute psychiatric symptoms.

Relevance to RSAT Programs

What are some recognizable signs of a co-occurring disorder that a correctional officer may notice?

Exercise I

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 upon RSAT criteria and the information provided. We will review answers and explanations in the next module, in the screening and assessment section.

Who Has a Co-Occurring Disorder?

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

Who Has a Co-Occurring Disorder?

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

Who Has a Co-Occuring Disorder?

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

Who Has a Co-Occurring Disorder?

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

Who Has a Co-Occurring Disorder?

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 talking through the entire group without letting other participants speak.

SUD

Mental Illness

Neither

Co-occurring disorder? yes no

Relevance to RSAT Programs

RSAT staff should expect that co-occurring mental health problems will be the expectation and not the exception for offenders in substance abuse treatment

Exercise II

Marco and Selma have co-occurring disorders. Give two examples of how their mental disorders and substance use interact.

Signs and Symptoms

Marco's Story

Marco, a 19-year old male, was raised by his mother and father. His father was an alcoholic who often disappeared for days on end. His mother worked long hours to support Marco and his sister. Marco describes himself as a quiet child, who often felt anxious, and didn't connect well with other children in the neighborhood or at school. He started using marijuana when he was twelve and injecting heroin at fifteen. He never drank alcohol because he associated that with his father's erratic and disappointing behavior. When he is high, Marco says he feels confident and happy. When he is not high, he finds little to look forward to in life and thinks about death. Marco was recently arrested again for shoplifting; something that he acknowledges is wrong, but says he can't stop himself from doing, even when he knows it is risky. He likes to smoke a joint, and then cruise the stores. He can't help himself once he's there. He was ordered to undergo a clinical assessment and was diagnosed with major depressive disorder, opiate dependence and cannabis abuse.

Signs and Symptoms

Selma's Story

Selma is a 32-year-old woman with paranoid schizophrenia. She was raised in a working class neighborhood with her parents and three siblings. She was very involved in her church and enjoyed school. Selma began experiencing hallucinations at the age of 18, shortly after high school graduation. Although at times she experiences few, if any, symptoms, other times her anxiety is so severe that she cannot leave her house. As a result, she has had difficulty holding down a job and feels embarrassed and socially inept. She drinks heavily during those periods, avoids social situations and lives in complete isolation. Unfortunately, the drinking exacerbates some of her symptoms of anxiety and her hallucinations, and in turn leads to increased dependence on alcohol to provide relief from the fear and paranoia. Selma was convicted of forgery and theft by unauthorized taking after she passed stolen checks for several thousand dollars.

Relevance to RSAT Programs

- ▶ Collaboration
- ▶ Screening and assessment
- ▶ Integrated treatment interventions
- ▶ Case management and re-entry
- ▶ Peer and community-based support



Take a Short Break

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

Module II: Topics

- ▶ Screening and assessment tools
- ▶ Identification of co-occurring disorders
- ▶ Risk, Need and Responsivity Principle

Module II: Learning Objectives

- ▶ 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

Module II: Learning Objectives

- ▶ 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

Module II: Pre-Test

1. Evidence-based means that the evidence from a criminal case is used in the treatment process.
2. It is important to consider a client's strengths and supportive people in his or her life when identifying an appropriate treatment strategy.
3. The purpose of screening is not to provide a diagnosis but to establish the need for an in-depth assessment.
4. Integrated treatment for co-occurring disorders cannot be implemented in jails or prisons.
5. Within the integrated treatment context, both co-occurring disorders are considered primary.
6. Screening tools provide information that the practitioner and client can use to create a treatment plan.
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.

Screening

Screening 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?

Screening

All practitioners can be trained to screen for co-occurring disorders. 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

Screening

- ▶ 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/severe medical problems that may need immediate attention
- ▶ Determination of eligibility/suitability for specialized treatment services.

Evidence-based Mental Health Screening Tools

	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.

Evidence-based Substance Use Screening Tools

	Description
<u>Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)</u>	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.
<u>CAGE Adapted to Include Drugs (CAGE-AID)</u>	A modified version of the CAGE screen for alcohol problems, the CAGE-AID is a four-item conjoint screen for alcohol and substance abuse.
<u>Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)</u>	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.
<u>TCUDS-II</u>	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.

Assessment

Clinical assessment
vs.
Risk assessment

Risk and Need Assessment

Risk classification assessment:

- ▶ What level of security is best
- ▶ Where the offender should be housed
- ▶ What type of rehabilitation programs should be prioritized to reduce potential for disruptive behavior in the correctional facility

Risk and Need Assessment

Risk, Needs, Responsivity Theory (RNR):

- ▶ Risk assessments act as a preliminary screening tool
- ▶ Weed out low risk individuals/target highest risk offenders
- ▶ Certain needs increase the likelihood of reoffending.

Clinical Assessment

Clinical assessment:

- ▶ Nature of the substance abuse/mental health problem
- ▶ Individual readiness for change (desire for treatment?)
- ▶ Establish a rapport with the client
- ▶ Baseline: how has the problem improved or changed over time

Clinical Assessment

Clinical assessment:

- ▶ Chronological history of symptoms and past treatments of both substance use and mental disorders.
- ▶ Current strengths, supports, limitations, or cultural issues that will impact treatment.
- ▶ Clients perception of needs for change, and how confident they are in their ability to change.

Clinical Assessment

Clinical assessment:

- ▶ Level of functioning, problem severity and duration
- ▶ Family history, work history, significant relationships, religious and cultural beliefs
- ▶ Client care choices and preferences

Risk and Need Assessment

The risk (or likelihood) of posing a safety risk while incarcerated, and for relapse and recidivism once released, should dictate the type of individual services an inmate with COD receives in an RSAT program

Evidence-based Clinical Assessment

Title:	Description:
<u>The Psychiatric Research Interview for Substance and Mental Disorders (PRISM)</u>	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
<u>Minnesota Multiphasic Personality Inventory-2 (MMPI-2)</u>	Tests adult psychopathology; 60-90 minutes to complete; 567 True/False Questions; 5 th grade reading level
<u>Personality Assessment Inventory (PAI)</u>	Tests adult psychopathology; 50-60 minutes to complete; 344 items; 22 non overlapping scales; 4 th grade reading level
<u>The Addiction Severity Index (ASI)</u>	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
<u>Global Assessment of Functioning (GAF)</u>	Clinicians judgment of overall functioning; 100 point scale; 3 minutes to establish score; Higher score = healthier client

Exercise III

Exercise 3: 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.

Evidence-based Assessment

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 she was arrested for the sixteenth time for solicitation. At this time, she was ordered to undergo a clinical assessment.

Using the GAF

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.

Assessments

Shortcomings of Forensic Clinical Assessments:

- ▶ Actuarial tools, and they are standardized to serve a wide range of populations
- ▶ Weak cultural, ethnic and gender-specific indicators of risk
- ▶ Formulaic-may provide little opportunity to establish a connection with client

Exercise IV

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.

Who Has a Co-Occurring Disorder?

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.

Who Has a Co-Occurring Disorder?

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.

Who Has 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.

Who Has a Co-Occurring Disorder?

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.

Who Has a Co-Occurring Disorder?

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.



Take a Short Break

Module III: Topics

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

Module III: Topics

- ▶ Origins of and Introduction to Integrated Treatment
- ▶ Proven and Promising Practices for Inmates with CODs

Module III: Learning Objectives

- ▶ Identify the principles of integrated treatment for COD
- ▶ List the basic practices that work for inmates with co-occurring disorders
- ▶ Identify the appropriate case management strategies for inmates with various levels of mental health and substance abuse problem severity

Module III: Pre-Test

1. Treatment strategies can be standard and do not need to be tailored to individuals
2. Motivational interventions are designed to make inmates feel guilty about past behavior.
3. It doesn't matter how long an individual is involved in treatment, as long as the treatment is intensive.
4. Integrated treatment is defined as a type of treatment whereby family members are involved in all treatment phases.
5. Medication assisted treatment generally means a persons is not motivated and needs medication to help them remain in treatment.
6. People with co-occurring disorders are very difficult to treat and should only be approached by highly skilled staff with intensive training.
7. Release planning should begin the day the treatment plan is developed.

Integrated Treatment

Mental health and substance abuse treatment mixed messages:

- ▶ abstinence-based vs. harm reduction
- ▶ confrontational vs. motivation
- ▶ no medication vs. medicate everyone
- ▶ The last decade both fields have begun to move toward strengths-based, client-centered, recovery oriented care.

Integrated Treatment

No treatment for co-occurring substance use and mental health disorders:

- ▶ separate funding streams
- ▶ funding required abstinence-based programming
- ▶ different licensing and credentialing of providers and clinicians
- ▶ different eligibility guidelines
- ▶ different treatment philosophies/practices

Integrated Treatment

Other treatment approaches:

- ▶ Sequential=addressing the most serious illness first.
- ▶ Parallel=treating simultaneously but through separate systems of care.

Integrated Treatment

Integrated approaches combine elements of both mental health and addiction treatment into a unified and comprehensive treatment program for patients with dual disorders.

Integrated Treatment

Core Principles of Integrated Treatment:

1. Co-occurring disorders are prevalent -- screening, assessment and treatment planning should reflect this assumption
2. Both co-occurring disorders are considered primary
3. Provider empathy, respect, and belief in capacity for recovery

Integrated Treatment

4. Individualized treatment at different points of treatment and recovery
5. Community re-integration and post-release supports = major factors in recovery

Exercise V

Exercise V: 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?

Myths and Facts

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

Myths and Facts

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

Myths and Facts

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. In fact, only 10% receive any treatment and 4% receive integrated treatment.

Myths and Facts

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

Fact: Many practices are effective that do not require extensive training, such as: case management, supported employment, contingency management, housing programs and peer support.

Myths and Facts

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

Fact: Coercion is effective to get clients to treatment. Ultimately, however, the client needs to move beyond coercion as the external motivating factor for change.

Myths and Facts

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

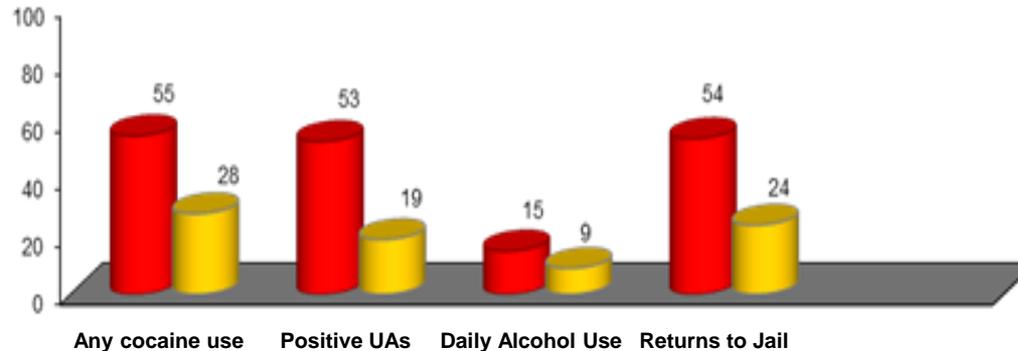
Fact: According to the Bureau of Justice Assistance the rate of violent crimes among offenders with mental disorders is the same as for other offenders (2008). People with mental health disorders, however, are far more likely to be victims of violence.

Selecting an Intervention Strategy

- ▶ Treatment for CODs should be six months or longer whenever possible.
- ▶ Release planning should begin the day the treatment plan is developed.
- ▶ Follow-up care (“aftercare”) or continuing care upon release improves post-release outcomes.

Selecting an Intervention Strategy

Days in Treatment by Outcome



Dosage Principle: 1) administered appropriately
2) administered for sufficient time

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

Selecting an Intervention Strategy

Examples of effective treatment models for COD:

- ▶ Cognitive Behavioral Therapy
- ▶ Medication-Assisted Treatment
- ▶ Motivational Strategies
- ▶ Illness Management and Recovery

Cognitive Behavioral Therapy

- ▶ Target attitudes and thought processes
- ▶ Teaches recognition of thinking errors and replacement with rational, pro-social thoughts
- ▶ Role plays, skill rehearsal and reinforcement
- ▶ May be facilitated by correctional staff
- ▶ Target observable behaviors (e.g.: following jail/prison rules; using verbal skills vs. physical behaviors)
- ▶ Emphasizes personal responsibility
- ▶ Effective in reducing recidivism and treating substance use and mental health problems

Cognitive Behavioral Therapy

Handout: (p. 32 of Training Tool)

Primary Cognitive-Behavioral Therapy Programs
for Offenders

Medication Assisted Treatment

Psychiatric Medication Management

- ▶ Benefits: Stabilizes psychiatric symptoms, provides relief to clients and can increase treatment engagement.
- ▶ Risks: Lack of continuity of care upon release, side effects, inmate refusal (forced medication by court order is ethically problematic) and mis-medication or overmedication.

Medication Assisted Treatment

Opiate Replacement Therapy

- ▶ Benefits: Stabilizes and manages withdrawal symptoms, reduces cravings, and decreases the potential for relapse and risks associated with IV drug use (HIV etc).
- ▶ Risks: Lack of availability within facilities, costs, medication interactions, over reliance on meds rather than recovery supports, stigma.

Motivational Strategies

- ▶ Goal is to motivate offenders in treatment to abide by treatment and supervision requirements:
 - ▶ Motivational Interviewing (MI): positive reinforcement of behavior; verbal encouragement and recognition of progress
 - ▶ *Motivational Enhancement Therapy*: combines MI, a review of assessment information, and 2-3 individual counseling sessions to build motivation and prepare clients for group counseling
 - ▶ *Contingency Management*: system of pre-determined rewards used to acknowledge and reinforce target behaviors (behavioral contracting; “carrot and stick”)

Illness Management & Recovery

- ▶ Teaches 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.
 - ▶ Psychoeducation
 - ▶ Behavioral tailoring
 - ▶ The Social and Independent Living Skills (SILS)
 - ▶ Wellness Recovery and Action Plan (WRAP).



Take a Short Break

Module IV: Implementing Integrated Treatment in Corrections

Module IV: Topics

- ▶ The Modified Therapeutic Community Setting
- ▶ Staff Readiness to Provide Integrated Treatment
- ▶ Agency Readiness to Provide Integrated Treatment

Module IV: Learning Objectives

- ▶ 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

Module IV: Pre-Test

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

Modified Therapeutic Community

Modifications to traditional TC model:

- ▶ it is more flexible, less intense, and more individualized.
- ▶ Self-help culture
- ▶ provides a highly structured daily regimen
- ▶ Community as healing agent
- ▶ Specific focus on public safety outcomes for persons with COD.

Modified Therapeutic Community

Modifications to traditional TC model continued:

- ▶ 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 special developmental needs of the clients.

Modified Therapeutic Community

Relevance to CODs:

- ▶ provides a highly structured daily regimen
- ▶ fosters personal responsibility and self-help in managing life difficulties
- ▶ uses peers as role models
- ▶ regards change as gradual
- ▶ Stresses self-reliance

Modified Therapeutic Community

Key elements: group therapy, individual therapy, monitoring of mental health, and medication management

Recovery stages in four phases:

Phase 1: Admission and Orientation

Phase 2: Primary Treatment

Phase 3: Live-in Reentry

Phase 4: Live-out Reentry

Implementing Integrated Treatment

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

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

Implementing Integrated Treatment

Evelyn's Story

Evelyn, a 32 year old female, was removed from her abusive home and placed in foster care at six years old. After living in seven foster homes, 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 participated in a substance abuse treatment program, 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 was arrested for the sixteenth time for solicitation, and ordered to undergo a clinical assessment. Evelyn was diagnosed with a co-occurring substance use disorder and schizophrenia. She was referred to an integrated treatment program to address her substance use issues and to stabilize her on medication that will reduce the hallucinations. Problematically, Evelyn does not feel motivated to participate in treatment and cannot see much of a future upon release.

Preparing the Workforce

Basic competencies to deliver integrated treatment:

- ▶ 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

Preparing the Workforce

- ▶ 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 and procedures for initiating referrals for assessment and treatment services (Peters et. al., 2008).

Preparing the Workforce

Also, two levels of co-occurring credentials are now offered by the International Certification and Reciprocity Consortium:

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

Exercise VI

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.

Exercise VI

- 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?

Exercise VI

- 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?

Exercise VI

- 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?

Exercise VI

- 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?

Module I: Learning Objectives

- ▶ 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

Module II: Learning Objectives

- ▶ 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

Module III: Learning Objectives

- ▶ Identify the principles of integrated treatment for COD
- ▶ List the basic practices that work for inmates with co-occurring disorders
- ▶ Identify the appropriate case management strategies for inmates with various levels of mental health and substance abuse problem severity

Module IV: Learning Objectives

- ▶ 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

For more information on RSAT training and technical assistance visit:

<http://www.rsat-tta.com/Home>

or email Jon Grand, RSAT TA Coordinator at jgrand@ahpnet.com