

RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

RSAT Training Tool: Integrated Substance Abuse Treatment for Clients with Co-Occurring Mental Health Disorders

Updated Edition 2019

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2019

by Niki Miller M.S. CPS

This cross-disciplinary training curriculum is designed to increase knowledge about the co-occurrence and interaction between substance abuse and mental health disorders among custody populations involved in RSAT programs. It is designed to support addiction professionals, program, security and mental health staff, counselors, case managers and correctional administrators responsible for delivering programming to individuals in need of alcohol and drug treatment who may also have mental health disorders.

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**RSAT TRAINING TOOL:
INTEGRATED SUBSTANCE ABUSE TREATMENT for CLIENTS with
CO-OCCURRING MENTAL HEALTH DISORDERS**

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RSAT TRAINING TOOL: INTEGRATED SUBSTANCE ABUSE TREATMENT FOR CLIENTS WITH CO-OCCURRING MENTAL HEALTH DISORDERS

Introduction

AUDIENCE:

Residential Substance Abuse Treatment (RSAT) program staff, addiction professionals, case managers, correctional staff, mental health staff, counselors, correctional officers, medical staff, volunteers, peer recovery support specialists and collaborating community-based behavioral health service providers.

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.

This tool introduces general concepts and terminology, research pertaining to integrated screening and assessment practices and evidence-based interventions for alcohol and drug treatment programs that serve justice-involved individuals who may have co-occurring mental health disorders.

OBJECTIVES:

The following modules contain pre/post knowledge assessment quizzes, participatory exercises and summary reviews. This edition of the manual has been updated to align with the new Fifth Edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5), incorporates information on applying the integrated treatment models to justice populations, and references corresponding sections of the new RSAT Promising Practices Guidelines. There are also resources and links to practical tools and more information.

The goals of this tool are to:

1. Increase knowledge about the prevalence of co-occurring substance use and mental health disorders among justice populations
2. Increase knowledge about the nexus between co-occurring disorders and justice system involvement
3. Understand the principles of integrated screening and assessment practices and introduce tools that help identify co-occurring disorders
4. Understand the principles of integrated treatment for co-occurring disorders, collaborative care and its impact on criminal behavior
5. Increase staff's ability to champion integrated treatment and to educate clients about the resources to sustain recovery from both disorders.

Why the focus on co-occurring disorders (CODs)?

There is an unusually high prevalence of CODs among the custody population. Co-occurring disorders are associated with a variety of negative outcomes, including higher rates of relapse, violence, hospitalization, homelessness, and incarceration (Drake et al., 2001). Untreated CODs appear to increase the likelihood of justice system involvement. There is no doubt that substance use can exacerbate mental health symptoms. For example, certain substances such as cannabis, cocaine and other stimulants have been found to contribute to episodes of decompensation and suicidality (Reis, 2003) and precipitate psychotic relapse in people with schizophrenia who had previously achieved remission (Gururajan et al., 2012).

In turn, untreated mental health problems make the initiation of substance use and abuse more likely, hasten progression into dependency and contribute to relapses and returns to drug and alcohol use. In worst case scenarios, treatment that focuses solely on one disorder without considering the other can potentially hinder recovery. Examples include addiction treatment that discourages use of prescribed, non-addictive psychiatric medication that provides symptom relief and improves the client's quality of life; or mental health providers who fail to screen for substance use disorders (SUDs) and prescribe addictive medications to clients with alcohol or drug problems, which can result in a cross-addicted client.

Historically, there have been territorial issues and disagreements between both disciplines about which disorder is primary, more serious and whether one precipitated the other. When clients with both disorders get caught up in the incompatibilities between systems of care, treatment may not effectively address their full range of needs. Today, we know getting clean and sober is not a panacea guaranteed to clear up mental health disorders; just as therapy into the deep-seated reasons for drug use is not likely to produce insights that can relieve a substance-dependent individual's compulsion to use drugs and/or alcohol.

For many RSAT participants, the justice system is their first entry into substance abuse treatment. Some may have made multiple attempts at treatment and recovery, but undiagnosed mental health problems sabotaged each period of sobriety, resulting in a revolving door of recidivism (Miller & McDonald, 2009). Unfortunately, many individuals with SUDs are not diagnosed with co-occurring disorders until they enter a correctional facility. Others may have received mental health services while their substance abuse went unaddressed, eventually contributing to criminal behavior and justice system involvement.

When people with CODs are incarcerated, they are likely to have significantly longer stays compared to those without either disorder sentenced for similar crimes. They are subject to more disciplinary actions and more incidents of victimization in custody (Wolf, Shi, & Blitz, 2008). Upon release, they are more likely to be homeless, suicidal, use substances and to be rearrested (Monahan et al., 2001; Peters, Sherman, & Osher, 2008). For those with serious mental illness, comorbid substance use is associated with increased rates of incarceration, recidivism and non-adherence to treatment (Fazel et al., 2014).

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 to provide tools to help clients manage recovery from both and attend to each before it triggers the other. The National Institutes of Health and the Substance Abuse and Mental Health Services Administration agree that substance use and mental health disorders are brain conditions that respond better to an integrated approach to achieving and sustaining recovery. (See *RSAT Promising Practices, Section III, Practice H: Integrated treatment for individuals with co-occurring disorders*)

APPROACH:

Treatment services for people with CODs may be delivered in a few different ways, but mounting evidence shows there are advantages to the third approach listed below –integrated treatment.

1. **Sequential treatment**—often in separate systems of care, targeting one disorder first and then the other
2. **Parallel treatment**—distinct treatment delivered at the same time by different providers with interventions that target each disorder separately
3. **Integrated treatment**—specialized interventions that concurrently support both addiction and mental health recovery

For RSAT clients with co-occurring disorders, an integrated approach to substance abuse treatment is effective

This curriculum will discuss integrated screening, assessment and treatment strategies.

Although parallel and sequential treatment approaches are also used in custody settings, this manual will mainly focus on the third approach - integrated treatment. It is an effective approach that RSAT programs are often in an ideal position to apply.

The following modules introduce basic knowledge and competencies for integrated care, including:

- Prevalence, course, signs, and symptoms of co-occurring disorders
- Ways mental and substance use disorders interact
- Integrated screening and assessment tools and procedures
- Integrated case management and collaborative care
- Evidence-based interventions and practices
- Risk and needs assessment/rewards and sanctions and CODs
- Modifying therapeutic communities for clients with CODs
- Linking re-entering individuals with specialized services in their communities.

Each of the modules is informed by six basic principles that foster professional development and promote safe, effective and efficient service provision.

1. *Evidence-based strategies* -There is extensive research on effective treatment practices for co-occurring disorders in community settings. Some have been applied to justice populations and are compatible with substance abuse treatment in institutional settings and with other rehabilitation programming.
2. *Integrated interventions* - This refers to approaches that support recovery from both types of disorders and rehabilitation. Integrated interventions can address trauma and substance abuse, maintaining both addiction and mental health recovery and increasing pro-social behaviors.
3. *Recovery-oriented approaches* - Science and experience have shown recovery from addiction and mental illness is possible. A recovery-oriented focus on both individual strengths and needs supports long-term recovery. Individuals with both types of disorders at all levels of severity can and do transform their lives and recovery.
4. *Present day accountability* - While RSAT clients may have histories of illegal and anti-social behavior, the intention of treatment is to teach new coping skills, enhance client motivation, reinforce pro-social attitudes and hold clients accountable for controlling their behavior.
5. *Culturally aligned* - RSAT staff must account for racial and economic health disparities and how stigma and poverty limit access to care upon re-entry. Linking individuals to critical resources requires a realistic appraisal of challenges they may face. Cultural issues are more easily addressed when treatment is integrated.
6. *Strength-based orientation* – Re-entering individuals with co-occurring disorders are especially susceptible to being labeled. Providers in one or both systems may write them off as resistant or hopeless. Treatment is most effective when it helps clients recognize strengths in some areas that can help compensate for deficits in others.

Relevance to Correctional Environments

Both corrections and behavioral health have identified evidence-based approaches based on research and evaluation data. Each system has different goals and outcome measures, but there are also areas of overlap. Correctional programming has two primary goals: (1) to reduce disruptive behavior within the institution; and (2) to reduce the risk of recidivism upon re-entry into the community. Behavioral health services that effectively address co-occurring disorders are critical to achieving both of those goals.

Forensic research suggests applying risk and needs principles can help decrease criminal behavior and recidivism. Studies have confirmed that these principles also apply to justice-involved individuals with mental health disorders (Prins & Draper, 2009). Research on criminogenic risks and needs has been validated for people with CODs. Major predictors of recidivism are the same as for other justice-involved individuals and include criminal associates, criminal history and criminal thinking.

Good correctional practices require program environments that are highly structured with predictable limits, incentives and consequences for non-compliant behaviors - applied swiftly, fairly and consistently. RSAT programs present a unique opportunity to people with CODs they may not have had prior to incarceration. (See *RSAT Promising Practices, Section II*)

For example, RSAT programs are in a unique position to provide:

- Long term treatment environments where participants can learn and practice new behaviors and coping skills, and an extended period to adopt them as they interact with peers who are doing the same.
- Immediate rewards and reinforcers for new target behaviors and pro-social interactions, as well as progressive sanctions for returns to criminal or addictive behavior, affording opportunities for course corrections without terminating treatment.

This manual explores workforce challenges and opportunities when applying integrated treatment practices in RSAT programs. It also offers recent research that has helped shape integrated approaches. The curriculum stresses a basic, practical approach to working with dually-diagnosed clients: helping them achieve recovery by recognizing the need to attend to both conditions.

As with all trainings in this series, staff and participant safety is an overriding common goal.

The premise is that the most successful interventions within prisons, jails and transitional facilities have goals that are congruent with the primary duties of correctional staff: safety of individuals in custody, public safety, staff and institutional security and rehabilitation of the incarcerated population. Specifically, controlling contraband within institutions, decreasing critical incidents, minimizing use of seclusion and restraint, linking people to appropriate care and community supports prior to release and reducing recidivism are all goals that integrated treatment supports.

Module I: Introduction to Co-Occurring Disorders

- A. Signs and Symptoms of Co-Occurring Disorders
 - B. CODs among the Correctional Population
 - C. Relevance to RSAT Programs
- Review

Learning Objectives

After completing this module, participants will be able to:

- Define co-occurring disorders
- Recognize signs, symptoms and ways co-occurring disorders may interact.
- Compare the prevalence of co-occurring disorders among the general population and the RSAT population.

Pre/Post-Test: True or False (answers at the end of this module)

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 co-occurring disorders.
3. Adults in the criminal justice system have lower rates of mental health disorders but higher rates of substance use disorders than the general population.
4. It is sometimes more effective to treat substance abuse first and then mental illness so clients are better able to benefit from mental health treatment.
5. It is rare for a person with alcoholism to have a mental health disorder other than depression.
6. Re-entering individuals with a co-occurring disorder are more likely to recidivate.
7. People with co-occurring disorders are more likely to relapse and return to drug or alcohol use than people with only a substance use disorder.

SIGNS & SYMPTOMS of CO-OCCURRING DISORDERS

What are co-occurring disorders?

Keep in mind that other disciplines may have different definitions of what constitutes a dual diagnosis or co-occurring disorder. For example, a geriatric nurse may define a co-occurring disorder as dementia and a medical condition. An early childhood specialist may define it as ADHD with a developmental disability.

For our purposes, co-occurring disorders refer to people with a substance use disorder and at least one diagnosable mental health disorder identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), a reference guide that categorizes diagnostic criteria for all psychiatric disorders. People with CODs often have more than one mental health disorder. For example, more than half of individuals with panic disorder also have depression; 11% of people with social anxiety disorder also have obsessive compulsive disorder (Reis, 2003).

A diagnosed co-occurring disorder (COD) means a mental health disorder can be established independent of the substance use disorder, rather than a result of symptoms related to substance use.

Mental health exists on a continuum. Many people experience feelings of anxiety or depression or have emotional or psychological difficulties at various times throughout their lives, especially when they are incarcerated or withdrawing from substances. But, if thinking and coping are diminished to the point of affecting a person's capacity to meet the ordinary demands of life, they may have a diagnosable mental health disorder that requires treatment.

Mental illnesses are health conditions that can interfere with a person's day to day functioning. They can involve changes in the brain that affect behavior. They respond to a combination of treatments, including behavioral therapies, psychiatric medications, peer support and recovery self-management. Addiction is defined as a chronic condition characterized by compulsive substance abuse, despite harmful consequences. Addiction can also change the way the brain functions and interfere with reward and reinforcement signals, feelings of well-being and the way pain and pleasure are experienced.

Examples of co-occurring substance use and mental health disorders:

- *Major depressive disorder with methamphetamine use disorder*
- *Alcohol use disorder with panic disorder*
- *Cannabis use disorder and alcohol use disorder with schizophrenia*
- *Borderline personality disorder and post-traumatic stress disorder (PTSD) with an opioid use disorder.*

Both disorders can vary in their severity, chronicity and in the degree of impairment they cause. Each can range from mild to severe, or one may be significantly more pronounced than the other. Either or both disorders may involve acute episodes or may manifest as long-standing conditions that change over time. At different stages of people's life, they can develop one or both disorders, and each may increase or decrease in severity over time. The stage of recovery, level of motivation and treatment engagement can differ for each type of disorder (Minkoff, 2005). Lastly, when individuals stop using substances, symptoms of a co-occurring mental health disorder can worsen, improve significantly or suddenly emerge. For this reason, RSAT participants who begin to experience significant emotional or behavioral difficulties should be monitored and may require a repeat mental health screening or assessment during the months they spend in RSAT programs. (See *RSAT Promising Practices, Section I*)

CORRECTIONAL OFFICER CHECKLIST OF MENTAL HEALTH SYMPTOMS

Correctional officers spend long periods of time on housing units and are often in the best position to notice certain changes or deviations from an individual's normal behavior. Awareness of signs and symptoms that may suggest the presence of a co-occurring mental health disorder can prompt correctional officers to bring the issue to the attention of clinical staff.

Some of the signs that may indicate a need for clinical assessment or intervention:

- Expressions of deep sadness, helplessness and hopelessness
- Loss of interest in daily activities that were once enjoyable
- Appetite/weight changes; starving or bingeing and purging
- Sleep problems, nightmares or staying awake for extended periods
- Changes in energy levels or concentration
- Strong feelings of worthlessness or guilt
- Sudden rages, anger and reckless behavior
- Feelings of euphoria or extreme irritability
- Unrealistic, grandiose beliefs and thoughts
- Cuts, scars, burns or other evidence of self-injury
- Pressured speech and racing thoughts, impulsivity
- Flashbacks, re-experiencing traumatic events from the past
- Excessive fear, panic or worry; short of breath or rapid heart beat
- Restlessness, vigilant and watchful – appears on edge or irritable
- Irrational fears or paranoia
- Delusions, hearing voices or hallucinations

People without a mental health diagnosis can have an anxious or depressed response to temporary situational stressors. When someone is trying to abstain from habitual drug use, mild versions of one or two of the above symptoms are not uncommon, even after the acute withdrawal period has passed. Other individuals may be slightly depressed, anxious or impulsive by nature.

However, if an RSAT participant is suddenly distressed to the point that it interferes with his or her day-to-day functioning or exhibits uncharacteristic, unusual and disruptive behaviors that could present a danger to self or others, officers and program staff need to intervene.

The best course is to notify clinical staff so they can make sure an appropriate trained and qualified mental health professional assesses the situation and the individual. Facility security protocols, mental health assessment policies and suicide risk evaluation procedures should be followed. Individuals should not be left alone or unsupervised in the interim, nor should they be restrained or secluded unless behavior accelerates to the point where such critical steps are warranted. Placing an individual in seclusion, even for their own protection, can heighten suicide risk. Observation and verbal contact should be maintained. In most circumstances, a calm empathetic demeanor and assurance that staff is locating someone who may be able to assist, can help to contain the situation. A well-trained correctional officer who has experience working with mentally ill individuals or RSAT counselors and program staff can offer support in the interim.

Other terminology for CODs:

- ◆co-morbid disorder
- ◆co-morbidity
- ◆concurrent disorders
- ◆dual diagnosis
- ◆dually diagnosed
- ◆recovering consumer
- ◆double winner
- ◆double trouble
- ◆co-occurring recovery

CO-OCCURRING DISORDERS AMONG the CORRECTIONAL POPULATION

Less severe mental health disorders, such as anxiety, depression or mood disorders, affect nearly one out of five Americans. More severe psychotic disorders, such as schizophrenia, affect only 1% of the population. However, those rates are higher for people with drug and alcohol problems and ***much higher*** among people involved with the justice system (Kessler, Chiu, Demler, & Walters, 2005). We also know:

- People with mood disorders are about twice as likely to also have a co-occurring substance use disorder.
- People with substance use disorders are about twice as likely to also have a co-occurring mood or anxiety disorder.
- Rates of mental health disorders vary by gender; women have overall higher rates of most mental health disorders, with the exception of schizophrenia.
- Females are more likely to develop PTSD after experiencing a traumatic event (NIH, 2015).
- Some mental health disorders are common among men and women in correctional drug treatment programs (NIDA, 2007). For males: depression and antisocial personality disorder are common; for females: PTSD, major depression and anxiety disorders.

How prevalent are co-occurring disorders?

- Approximately, 4% of adults in the U.S. have a co-occurring disorder (SAMHSA, 2009).
- However, almost three-quarters of adults in jail or prison **with a substance problem** also have mental health problems, making the RSAT population **an atypical, extremely high-risk group.**
- In custody settings, women have higher rates of both substance use and mental health disorders than men; they are also likely to have two or more mental health diagnosis (Miller and MacDonald, 2009).

Prevalence: Research on Substance Use and Mental Health Disorders among Justice Populations

Population		Source
Percentage of people in prison who use drugs and alcohol that also report a mental health problem.	74 %	BJS (2006) MH Problems of People in Prisons and Jails
Percentage of people in jail with a serious mental disorders that also have a substance use disorder	76%	Decriminalizing MI :Background & Recommendations (NAMI, 2008)
Percentage of people in community addiction treatment that have a mental health disorder	↑50%	CAST TIP 42 (2007) Subs. Abuse Treatment for Persons with CODs
Percentage of male incarcerates with serious mental health disorders.	14.5%	Steadman, Osher, Clark, Robbins, Case & Samuels (2009)
Percentage of female incarcerates with serious mental health disorders.	31%	Steadman, Osher, Clark, Robbins, Case & Samuels (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 Juvenile Just. System (2006) Shufelt & Coccozza.
Percentage of people with serious mental disorders that are incarcerated in their lifetime.	40%	More MI Jails & Prisons than Hospitals (2010) Torrey, Kennard, Eslinger, Lamb & Pavle

ORIGINS of CO-OCCURRING DISORDERS

Substance use and mental health disorders are associated with changes in brain processes, function and chemistry. Some of these changes can exist prior to the onset of the disorder, especially with mental disorders, while others develop post-onset - and may persist. There have been many studies on the impact each of these types of disorders has on the brain, but less research on how the two intersect and interact. It is also unclear why some people end up with a substance use disorder, a mental health disorder or both, while others -sometimes with more risk factors- do not. Individuals experience the symptoms of co-occurring disorders in different ways and with differing levels of severity. A serious mental health diagnosis that can be debilitating for one individual may be manageable for another.

Heredity and Environment Can Contribute to Co-Occurring Disorders

Research tells us that addiction and mental illness affect both the brain and behavior. Researchers have identified many biological and neurological markers and are beginning to understand some of 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 where addiction or mental health problems have manifested for generations. On the other hand, many people with similar family histories and genetic profiles never develop either disorder. Others with CODs may have no known first degree relatives with either type of disorder. However, the presence of one can increase vulnerability to the other.

Research has shown that even exposure to a significant number of risk factors does not necessarily mean that substance use or mental health problems will follow. It appears that the interaction between heredity and environment can activate a genetic predisposition in some cases - and may mitigate it in others. What we know today is that protective factors can support healthy behaviors and attitudes and buffer risk factors, and that recovery is possible. This is true for all types of behavioral health disorders.

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

People can enter a cycle that may result in a co-occurring disorder at various points. RSAT participants may have:

- Developed a trauma-related disorder due violent or sexual victimization in childhood, and then discovered substances helped them tolerate the emotional, psychological and physiological effects.
- Developed a physical dependency on a prescribed medication taken for a medical condition that progressed into addiction, resulting in hopelessness and depression, which developed into a mood disorder.
- Started using drugs recreationally and eventually developed an addiction, which contributed to depressed feelings, suicide attempts or major depressive episodes.
- Used cocaine to instill confidence, improve mood, and relieve deep feelings of insecurity resulting from a bi-polar disorder, and then developed a dependency that progressed.
- Medicated an anxiety or sleep disorder with prescribed medications and/or alcohol, and then began to illicitly use sedative drugs – eventually leading to addiction.
- Been in long-term recovery from alcoholism when they began experiencing more frequent periods of depression that became increasingly difficult to manage.

RELEVANCE to RSAT PROGRAMS

RSAT staff should be aware that a significant percentage of program participants are likely to also have mental health disorders (Glaze & James, 2006; NAMI, 2008).

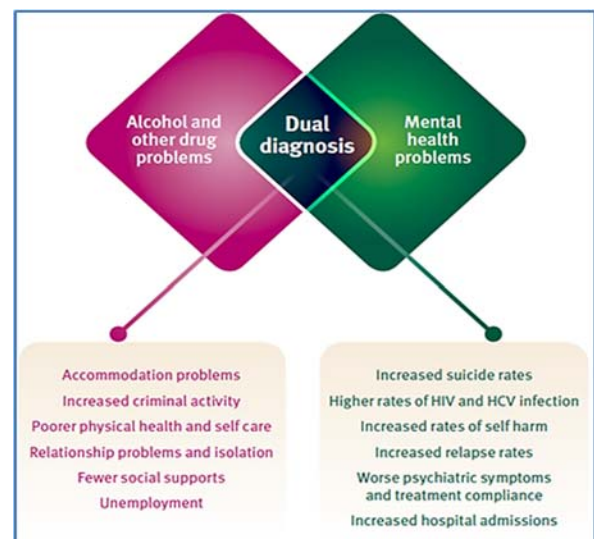
RSAT staff should consider co-occurring mental health problems the expectation rather than the exception for individuals in SUD treatment.

By law, people in custody with serious medical conditions have a legal right to care - including mental health screening, assessment and treatment. According to the National Commission on Correctional Health Care, standards for elements of care and treatment of mental health disorders for those entering correctional facilities should include (Hills, Siegfried, and Ickowitz, 2004):

- A mental health screening within 2 hours and assessment within 14 days
- A mental health examination, including an evaluation of suicide risk
- Information within 24 hours about the types of mental health services available and how to access them
- A health appraisal within 7 days that includes a history of prior mental health problems, hospitalizations, psychiatric medication use, suicide attempts, and an alcohol and other drug use history
- Stabilization of any symptoms and interventions in the event of an acute psychiatric event or suicide attempt
- Privacy and confidentiality with regard to diagnosis and treatment
(See *RSAT Promising Practices, Section I*)

The graphic below highlights some of the risks and treatment needs that can be important to address for people with CODs that are not as common among those with only one type of disorder. ***Therefore, several considerations are important for RSAT programs:***

- **Collaborative Care** - Correctional facilities have a legal responsibility to provide mental health care. RSAT programs are responsible for substance use disorder treatment. Many RSAT participants may be receiving mental health services before and during SUD treatment. It is important to ensure a framework for collaboration with mental health services is in place. Treatment coordination strategies include team approaches and unified treatment plans.
- **Screening and assessment** - Although most RSAT participants are likely to



Queensland Health Strategic Plan for People with Dual Diagnosis, 2003

have been screened for mental health disorders at intake into the facility, co-occurring disorders are dynamic. Symptoms can develop over time. Programs can set up a system for information sharing with mental health and for repeat screening and assessment as needed. RSAT programs can monitor clients' mental health disorders to track and report improved or worsening symptoms, and note the emergence of symptoms while clients are in treatment.

- **Integrated treatment interventions** - Integrated SUD treatment approaches are effective for those with co-occurring mental health disorders. RSAT program planners can work with mental health staff to select interventions that have been shown to improve both substance use and mental health symptoms. Several cognitive-behavioral interventions have been successful with justice populations that have co-occurring depression or trauma-related symptoms.
- **Integrated case management and re-entry planning** – Case management and community treatment needs vary among RSAT clients with CODs, depending on the severity of each condition. Resources for medication management and other psychiatric services upon release are often essential to ongoing recovery. Securing eligibility for benefits and setting up appointments, combined with a 'warm hand off' to community providers is essential. Some community SUD treatment providers have 'enhanced dual diagnosis' capacities, which can be taken into account when making referrals for continuing care.
- **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 they may have a decided preference for one or the other. There are also some co-occurring recovery peer support resources. Offering choices and a variety of peer support resources is desirable. Developing social connectedness and pro-social contacts is also critical to successful re-entry and recovery.

RSAT staffs are only expected to practice within the scope of their training and experience. This manual does not suggest they start treating mental health disorders. However, it does suggest ways to structure effective collaboration with mental health staff and psychiatric services. It is aimed at helping RSAT programs implement practices and interventions that have been shown to support co-occurring recovery and to apply the expertise they have in addiction treatment for custody populations to benefit individuals in need who also have mental health disorders.

Resources:

[TIP 42 - Substance Abuse Treatment for Persons with Co-occurring Disorders](#), 2013, Center for Substance Abuse Treatment:

EXERCISE 1: WHO HAS A CO-OCCURRING DISORDER?

(See end of Module II for a discussion of answers)

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 on the limited information that is often available on these RSAT participants. At end of the next module, there will be a review of answers and explanations.

Sara - age 22: *Convicted of opioid trafficking; a history of violent victimization by partner. Began using prescription opiates in sixth grade; was supplementing with heroin before arrest. She experienced intense opioid withdrawal in custody. Would not cooperate with state's attorney during her trial; claimed her live-in boyfriend knew nothing about any drug trafficking.*

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Roger - age 54: *Convicted of felonious sexual assault on a child. Reports periodic alcohol use, but successfully passed all urine screens for alcohol when he was paroled for 9 months. He violated his terms of release by moving in with a woman with two young children. He is depressed about having his parole revoked and reports he sometimes feels suicidal.*

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Brian – age 33: *Convicted of assaulting a police officer. He began heavy cocaine use and binge drinking in college and dropped out of school when he started having violent episodes with his roommates. His family found him living in an abandoned building. He remained homeless between multiple arrests for public nudity, drunk and disorderly, shoplifting, etc. (more than 25). This time he hit an officer because a “dark force” was prompting police to target him.*

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Steve - age 29: Convicted of possession of a controlled substance after an attempted suicide by barbiturate overdose. Self-injures, visible scarring on arms and shoulders. His psychiatric medications make it difficult to keep him awake during groups. He attempted suicide during his second week in custody after reporting he was raped by a cell mate.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Marsha- age 42: Convicted of theft by deception for passing bad checks. Both her children are in placement. She admits she abuses alcohol and used crack cocaine for several years and speaks about living on the streets with pride and nostalgia. She cycles through periods of intense moods, rarely seems to be fully present during groups and is either completely withdrawn or talking through the entire group without letting others speak.

- SUD
- Mental Illness
- Neither

Co-occurring disorder? yes no

Module One Pre/Post

Test Answer key:

1. F
2. T
3. F
4. F
5. F
6. T
7. T

Review

- A diagnosis of a co-occurring disorder means a mental health disorder can be established independent of the substance use disorder. A significant proportion of RSAT participants are likely to have co-occurring mental health disorders, often undiagnosed. Symptoms can improve, worsen or emerge at any point. Therefore, ongoing monitoring of signs and symptoms and repeated mental health screenings and assessments may be required.
- Many people experience feelings of depression and anxiety in response to situational stressors such as incarceration and while they are withdrawing from substances. But when changes in behavior become noticeable and symptoms start to interfere with their ability to function, they may have a diagnosable mental health disorder. When correctional officers on RSAT units are familiar with signs and symptoms, they can alert clinical staff to unusual behavior.
- Heredity and environment can contribute to both mental health and substance use disorders, although some people with many risk factors do not develop either, and others with few risk factors may develop both. Recovery is possible. Research indicates there are effective integrated interventions that help with **both recoveries**, appropriate for custody populations,
- Correctional facilities have a legal obligation to provide treatment for medical conditions including mental health disorders. RSAT programs can set up a framework for collaboration with mental health staff to ensure participants with mental health disorders are monitored, that appropriate integrated interventions are utilized, and re-entry planning links them to services that support recovery from both types of disorders.

See RSAT Promising Practice Guidelines:

- Section I – Intake, Screening and Assessment
- Section II – Treatment Programming
- Section III – Treatment Modalities and Structured Program Activities
- Section VIII – Transition and Aftercare Planning

Module II: Screening and Assessment for Co-Occurring Disorders

- A. Identifying CODs: Diagnosis and Classification
 - B. Integrated Screening Practices and Tools
 - C. Risk and Needs vs Clinical Assessment
- Review

Learning Objectives

After completing this module, participants will be able to:

- Explain screening processes for co-occurring disorders among RSAT clients and give examples of frequently used tools
- List challenges related to assessment and possible shortcomings of screening and assessment tools
- Discuss how risk, need and responsivity relates to treatment for people with co-occurring disorders

Pre/Post-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 any natural supports when developing a treatment plan.
3. The purpose of screening is not to provide a diagnosis but to establish whether there is a 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 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 programs should only target needs associated with criminal behavior among high risk individuals to have the greatest impact.

DIAGNOSTIC CRITERIA AND CLASSIFICATION OF DISORDERS

It is important for RSAT staff to understand the criteria used by qualified mental health practitioners during the assessment process to determine whether or not an RSAT participant is diagnosed with a co-occurring mental health disorder.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) is the newest version of the catalogue of diagnostic criteria and classification of behavioral health disorders. It is published by the American Psychiatric Association (APA, 2013), and is used by all mental health professionals. The new edition is organized according to a developmental framework based on current research. Diagnostic chapters are arranged from childhood disorders to those affecting the aged. It has chapters for similar disorders, organized to reflect differences across the lifespan. The DSM-5 is also more closely aligned with the new version of the *International Classification of Disorders, Eleventh Edition* (ICD-11) by the World Health Organization (WHO), which is due to be released soon and is used internationally.

Some of the new research that has helped shaped the DSM-5 includes:

- the influence of culture and gender;
- genetic and neurodevelopmental research; and
- symptoms occurring across multiple disorders.

Disorders are still placed into specific categories, but most are classified on a continuum according to severity. This is relevant to the new chapter on substance use disorders, now titled *Substance Use and Addictive Disorders*. In the past, separate criteria were listed for diagnosis of abuse or dependency. Now substance use disorders are categorized according to severity (mild, moderate or severe). Addictive behaviors such as gambling disorders are now also included (APA, 2013).

Another change relevant to RSAT is the new category for *Trauma and Stressor-Related Disorders*. In prior editions these disorders were under the broader category of anxiety disorders, but the new category reflects current research and practice.

RELEVANCE to RSAT PROGRAMS

Diagnostic criteria listed in the DSM is often used to develop screening tools and during the assessment process. The changes to the DSM-5 should help make the integrated screening and assessment process more accurate. Mental health and substance abuse services in community settings are adopting a 'universal screening' approach to the early detection of co-occurring disorders since the potential for dual diagnosis among both of the populations that present for treatment through *either* system is high. When treatment approaches and levels of care are informed by an integrated screening and assessment process, there is a better chance of successfully engaging and retaining clients with CODs in programs that meet the full range of recovery needs. As we learned in the last module, this universal screening and assessment is even more important in correctional settings, since there is likely to be a very high rate of individuals with undiagnosed CODs that must be addressed in the treatment planning process if they are to derive maximum benefit from RSAT programming.

IDENTIFYING CO-OCCURRING DISORDERS

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

Effectively serving populations with high rates of co-occurring mental health and substance use disorders requires integrated screening and assessment. The following section provides examples of screening and assessment tools used with criminal justice populations. For more examples, see the 2016 SAMHSA publication listed as a resource at the end this section.

Screening is a brief process that should occur soon after the individual is admitted to a correctional facility. Many forensic risk and needs assessments incorporate some degree of screening for mental health and substance use problems. But, most facilities administer separate screening instruments for substance use and mental health disorders.

Both risk and needs assessments and behavioral health screening tools are better at ruling out individuals who probably do not have a mental health or substance use disorder than they are at pin pointing those who have them. All good screening tools miss a small but acceptable percentage of individuals with these conditions. However, the screening process is very likely to flag a lot of individuals who do not actually have a behavioral health disorder. These individuals who are flagged during the screening process become candidates for an in-depth substance use and mental health assessment to determine whether or not they meet the diagnostic criteria for one or both disorders. 'False positives' during the screening process are expected. The assessment process clarifies who actually has a diagnosable disorder.

Integrated screening can include exploration of the relationship between substance abuse and mental health symptoms, shared triggers, and a preliminary determination of service needs. According to Peters, et al., (2008), the goals of integrated screening include detection of:

- Current mental health and substance use symptoms and behaviors
- Influence of co-occurring disorders on symptoms or behaviors
- Cognitive deficits or medical problems that may need immediate attention
- Violent or suicidal tendencies
- Suitability for specialized treatment for co-occurring disorders and mental health services

About, 80% of state prison facilities screen for mental health disorders upon intake (Hills, Siegfried, and Ickowitz, 2004) and refer individuals who screen positive for an in-depth, integrated

Screening for CODs Seeks to Answer a Yes or No Question

- Does a client with signs of a substance use disorder have signs of a mental health problem?
- Does a client with signs of mental health disorder have signs of a substance abuse problem?

assessment by a clinician. The results of the assessment can be factored into other classification considerations, such as security level, prison or jail-based programming needs, withdrawal severity or risk for self-harm while incarcerated. It should be noted that entry into a custody environment often exacerbates symptoms of mental health disorders, and may cause some individuals to appear to have higher levels of severity and symptomology than they normally experience. Repeating assessments once they have adjusted to the prison or jail environment may result in more accurate information about current symptoms (USF, 2002).

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

Many screening tools can be routinely administered by correctional officers, classification staff or case managers, so that appropriate individuals can be referred to mental health staff and/or addiction counselors for further assessment. Screening can include:

- Having an individual respond to a specific set of questions
- Scoring those questions
- Reviewing files and records and verifying responses
- Taking the next "yes" or "no" step in the process

Screening for potential severity of withdrawal symptoms is also critical for individuals who are intoxicated, report recent drug or alcohol use or test positive for drugs or alcohol at intake. Withdrawal from alcohol - and from sedatives with similar properties- may require medical management and is one of the leading causes of death in jails and lock-ups. Withdrawal symptoms associated with opioids and other drugs also may also require monitoring and sometimes medical management for individuals with serious health conditions.

Mental Health Screens Used in Correctional Settings

The following charts include examples of mental health screening tools that are commonly used with custody populations and have been evaluated as reliable.

Screening Tool	Description
<u>Modified MINI Screen</u> (MMS)	The MINI International Neuropsychiatric Interview is a 22 Yes/No item screen that identifies symptoms of anxiety and mood disorders, trauma exposure, PTSD, and non-affective psychoses.
<u>Mental Health Screening Form</u> (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 and several others with a high level of accuracy.
<u>K6 Screening Scale</u>	6 items rated on a four point Likert scale that screen for general distress in the last 30 days (Kessler, et al., 2003). Easily administered by non-clinical staff or can be self-administered. Widely used in addiction treatment settings to screen for mental health disorders.

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 and can be administered by corrections officers and intake staff.
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Some sample screening questions are listed below:

- Have you ever been in a hospital for emotional or mental health problems? (BMHJS)
- Have you ever heard voices no one else could hear or seen objects or things others could not see? (MHSF III)
- Have you been consistently depressed or down, most of the day, every day for the past two weeks? (MMS)
- During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?
_____ Number of days (K9 Screening)

Some correctional systems have designed their own mental health screening tools that have been validated with the population they serve. Most of these screening tools include similar questions both about the individual’s mental health history and current functioning.

Substance Abuse Screens Used in Correctional Settings

RSAT clients must have a substance use disorder to be eligible for the program. The chart below includes examples of screening tools for substance use disorders commonly used in custody settings, which have been evaluated for accuracy, brevity, and ease of administration by trained non-clinical staff by the Criminal Justice Drug Abuse Treatment Study project of the National Institute for Drug Abuse (Sacks et al., 2007). The following are all in public domain and were determined to equally meet these criteria.

Screening Tool	Description
Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)	16 items ask about symptoms of alcohol and drug dependence, including prescription and over-the-counter medications, during the past six months. Several items ask about lifetime and current use. Requires minimal training to administer or can be self-administered; no proprietary restrictions.
Addiction Severity Index Drug Use Section (ASI – Drug Screen)	24 items that can be administered by any trained staff in about ten to fifteen minutes. Available at no cost and printed in various Center for Substance Abuse Treatment monographs and Treatment Improvement Protocols.

Alcohol Dependence Scale (ADS)	25 questions that can be administered by trained staff and scored. Positive screen scores are divided in to quartiles that correspond to recommended ASAM levels of care based on problem severity.
TCU DS-II	Texas Christian University Drug Screen II enables staff to quickly identify individuals who report heavy drug use or dependency and could benefit from treatment. Questions are based on the DSM-5 and the National Institute of Mental Health Diagnostic Interview Schedule.

Risk and Needs vs Clinical ASSESSMENT

Assessment of RSAT clients for the purpose of *risk classification* in a correctional facility is very different from a *clinical assessment*, which has a goal of identifying and diagnosing mental health and/or substance use disorders. Upon entry into a correctional facility, risk and needs assessments determine the level of danger or security risk individuals pose and the types of rehabilitative programming that will reduce their potential for institutional infractions and for recidivating upon release. Before individuals enter the general prison or jail population, intake staff has to determine:

- The appropriate security level classification;
- Housing unit assignments; and
- The rehabilitation programming and services that should be prioritized.

Although risk and needs assessment and clinical assessments differ in their underlying purpose, they overlap in a very key function. They both can identify treatment needs that must be met to reduce likelihood of recidivism.

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 greatest impact. Risk and needs assessment should tell us the **'who, what, and how'** of rehabilitation programming for each individual (Latessa, 2010). Risk assessments act as preliminary screening tools. They can eliminate low risk/low need individuals who don't require further screening and assessment, while identifying who should move on to the next level of assessment to determine service needs. Responsivity refers to how programming should be delivered and barriers that may need to be addressed before individuals can benefit from services.

This premise is called Risk, Needs and Responsivity (RNR) Theory

Responsivity can be important for those with co-occurring mental health and substance abuse disorders. For example, an individual in need of addiction treatment with active symptoms of psychosis may not do well in RSAT until they are stabilized through mental health counseling and/or they are stabilized on effective anti-psychotic, sometimes in combination with other psychiatric medications. But, they may do very well in RSAT once this has been accomplished. Likewise a risk and needs assessment may indicate an individual is at high risk for self-harm or suicide and may not be appropriate for participation in an RSAT program until the issue is addressed.

Research shows that the same indicators that predict recidivism among individuals without mental health disorders (criminal values, criminal associates, etc.) apply to individuals with mental health diagnoses (Prins & Draper, 2009). If individuals with co-occurring disorders have high levels of criminal thinking and long histories of criminal behavior, interventions to reduce criminogenic risk factors are required, along with mental health and substance abuse treatment to reduce the likelihood of recidivism.

Clinical assessment defines the nature of a problem and informs treatment planning. Assessment is an ongoing process, repeated over time to capture the dynamic status of individuals as they move through recovery.

A number of validated clinical assessment instruments are available. Integrated assessments gather information about mental health and substance use and how one relates to the other. They engage clients in a process that allows a practitioner to:

- Establish a rapport and develop trust with the client
- Determine the presence (or absence) of a co-occurring disorder
- Determine individual readiness for change (motivation for treatment)
- Identify individual strengths and problem areas that may influence treatment and recovery.

Assessment also establishes a baseline for problem severity, symptoms and behaviors. Repeating assessments post-treatment allows results to be compared and tracking of progress over time. Lastly, assessments provide information that the practitioner and client can use to create a treatment plan. It is important to keep in mind, that according to *Section I of RSAT Promising Practices Guidelines*:

Individuals with CODs who require long-term, intensive SUD treatment should have access to RSAT as long as their participation is not disruptive.

Standardized tools are one component of a comprehensive approach to assessment. Since clients entering RSAT programs are likely to have undergone substance abuse and mental health screening upon intake, it is important for RSAT staff to be familiar with the tools used at intake, to review any information captured in the individual's record and to verify self-reported information whenever possible. Effective assessment focuses on individuals' understanding of their problems and their treatment/recovery goals. An integrated assessment should gather detailed information on:

- A chronological history of symptoms, past treatments and any periods of recovery from each disorder
- Current strengths, supports, limitations and any cultural issues that may impact treatment
- Level of functioning, problem severity and duration - to inform level of intensity and duration of treatment
- Family history, work history, significant relationships, religious and cultural beliefs – goals, ambitions and values

- Screening for traumatic histories, current safety and trauma-related mental health symptoms may also be appropriate
- Client care choices and preferences, shared decision making and knowledge of client rights and confidentiality

Integrated CLINICAL ASSESSMENT TOOLS

Assessment tools are generally used to identify the likely presence and severity of co-occurring disorders, but do not ‘diagnose.’ Some of the assessments listed below require significant training to administer; some are proprietary and can have associated costs. The information is usually combined with a comprehensive psychosocial history, a review of administrative files, and an interview with a qualified behavioral health practitioner who makes a diagnosis based on the total picture.

Instrument	Description
The Psychiatric Research Interview for Substance and Mental Disorders (PRISM)	Semi-Structured interview designed to address the problem of diagnosing psychopathology in people who abuse substances. The instrument requires approximately 90 minutes to administer and significant training.
Global Assessment of Individual Needs (GAIN)	An assessment system for substance use and co-occurring mental health disorders. Full version has 99 subscales, requires 60-90 minutes to administer and significant training, but modular versions are also available including a brief screening tool.
The Addiction Severity Index (ASI – V5)	Semi-Structured 60-minute interview; 155 items with 7 subscales, including mental health status. Also reviews indicators of emotional, physical, and sexual abuse. Research validates its use for persons with CODs. Several versions are commonly used in custody settings (public domain).

What are the shortcomings of standardized assessments?

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

- There is no one-size-fits-all risk and needs assessment tool. Agencies often use multiple versions of an assessment at different points of criminal justice involvement, with a special emphasis on pre-release assessment to help determine levels of parole supervision and community service needs.
- Recent research on gender-specific risk factors suggests important predictors of recidivism for women, related to co-occurring disorders, have not been included in generic risk and needs assessments. The Women’s Risk and Needs Assessment (WRNA) is an example of a gender-responsive tool (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 points for scoring low, medium and

high risk. The distribution of scores is predictable, but the numerical values should be calibrated - as soon a large enough number of individuals are assessed within the new population (usually at least 100).

- 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 responsive to all the cultural norms of diverse populations.
- One disadvantage of standardized tools is that some of them don't provide a lot of opportunity to establish a connection with the individual.

There is no substitute for connecting with a client and establishing a good rapport and a therapeutic alliance. This is strongly supported by research (Miller, 1999; Wanberg and Milkman, 2004).

Resource:

Screening and Assessment of CODs in the Justice System, SAMHSA, 2016:
<https://store.samhsa.gov/product/Screening-and-Assessment-of-Co-occurring-Disorders-in-the-Justice-System/SMA15-4930>

EXERCISE 2: Discussion of SIGNS AND SYMPTOMS OF CODs

Now that we have reviewed screening and assessment tools, let's take a look at the profiles in **Exercise I**, from the end of the first module and consider each case for CODs:

Sara - age 22: Convicted of opioid trafficking; a history of violent victimization by partner. Began using prescription opioids in 6th grade; was supplementing them with heroin before arrest. Experienced intense opioid withdrawal in custody. Would not cooperate with state's attorney during her trial; claimed her live-in boyfriend knew nothing about the drug trafficking.

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

Roger - age 54: Convicted of felonious sexual assault on a child. Reports periodic alcohol use, but successfully passed all urine screens for alcohol when paroled for 9 months. He violated his terms of release by moving in with a woman with two young children. He is depressed about having his parole revoked and reports he sometimes feels suicidal.

Many individuals that do not have a depressive disorder may state they are depressed about their situation. There is nothing in Roger's profile that indicates he has a mental disorder; it is also uncertain whether he has a substance use disorder. Screening and assessment, especially with regard to Roger's drinking, is required before determining if he is appropriate for RSAT. He does not appear to have a co-occurring disorder, but screening for risk of suicide is indicated.

Brian - age 33: Convicted of assaulting a police officer. He began heavy cocaine use and binge drinking in college and dropped out of school when he started having violent episodes with his roommates. His family found him living in an abandoned building. He remained homeless between multiple arrests for public nudity, drunk and disorderly, shoplifting, etc. (more than 25). This time he hit an officer because a "dark force" was prompting police to target him.

Brian's profile points to a serious mental disorder and an alcohol use disorder. His hallucinations may be symptoms of schizophrenia or other psychotic disorder. His use of substances 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 mental health diagnosis, level of stability, his drinking problem and his drug use.

Steve - age 29: Convicted of possession of a controlled substance after an attempted suicide by barbiturate overdose. Self-injures, visible scarring on arms and shoulders. Psychiatric medications make it difficult to keep him awake during groups. He attempted suicide during his second week in custody after reporting he was raped by a cell mate.

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

Marsha- age 42: Convicted of theft by deception for passing bad checks. Both her children are in placement. She admits she abuses alcohol, used crack cocaine for several years and speaks of her time on the streets with pride and nostalgia. She cycles through periods of intense moods, rarely seems to be fully present during groups and is either completely withdrawn or talking through the entire group without letting other participants speak.

Marsha shows signs of both types of disorders. She may have a bi-polar disorder. As she undergoes the assessment process, it will be important to monitor her mood changes and to work with a mental health clinician who is qualified to make a diagnosis and help determine if she can benefit from participating in RSAT.

Review

- The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) is the current catalogue of diagnostic criteria and classification of behavioral health disorders used by all mental health professionals to help diagnose co-occurring disorders.
- Screening for mental health and substance use disorders usually occurs at intake into a correctional facility. It is a brief process that flags individuals who may require an assessment to determine if they have one or both types of disorder. Many forensic risk and needs assessments screen for mental health and substance use problems, but often facilities administer separate screening instruments for both.
- Forensic risk and needs assessments determine security levels, housing assignments and prioritize programming needs to reduce future criminal behavior. They do not serve the same purpose as clinical assessments designed to help diagnose substance use and mental health disorders. However, both help identify the types of services that can benefit individuals.
- Information from clinical assessment tools for co-occurring disorders is usually combined with a comprehensive psychosocial history, a review of administrative files, and an interview with a qualified behavioral health practitioner - who makes a diagnosis based on the total picture.
- No standardized assessment tool is perfect. They all offer helpful information and have certain disadvantages. Some do not provide a lot of opportunity to establish a personal connection. There is no substitute for a good rapport and for building a therapeutic alliance with the client. This is strongly supported by research.

(See RSAT Promising Practice Guidelines):

- Section I – Intake, Screening and Assessment
- Section II – Treatment Programming

Module Two Pre/Post

Test Answer key:

1. F
2. T
3. T
4. F
5. T
6. F
7. T

Module III: Best Practices for Implementing Integrated Treatment

- A. Introduction to Integrated Treatment
 - B. Best Practices for Supporting Co-occurring Recovery in RSAT
 - C. Building Integrated Treatment Capacities
- Review

Learning Objectives

After this module, participants will be able to:

- Identify the principles of integrated treatment for COD
- Give examples of modifications RSAT programs make to better accommodate clients with CODs
- Name two evidence-based integrated interventions used in RSAT Programs
- Give two examples of how your program could improve its capacity to serve clients with CODs

Pre/Post-Test

1. Treatment strategies should be tailored to the needs individuals and can only be standardized to a certain extent.
2. Motivational interventions are designed to make clients regret past behavior so they will change.
3. It doesn't matter how long an individual is involved in treatment, as long as the treatment is intensive.
4. Integrated treatment tends to incorporate interventions that promote recovery from both substance use and mental health disorders.
5. Medication-assisted treatment for opioid or alcohol use disorders is not usually recommended for people with co-occurring mental health disorders.
6. People with co-occurring disorders are very difficult to treat and require highly skilled staff with specialized advanced training.
7. Release planning should be a considered when the treatment plan is developed, especially for RSAT clients requiring psychiatric medication management.

INTRODUCTION TO INTEGRATED TREATMENT

Historically, treatment for co-occurring substance use and mental health disorders was rarely accessible - due to separate funding streams, different training, licensing and credentialing requirements for clinicians and eligibility guidelines (Brunette and Mueser, 2006). Treatment philosophies were sometimes at odds. Patients with dual disorders often got conflicting messages when they were treated for both disorders in separate systems of care by different clinicians – each with limited training on the respective accompanying disorder. This led to poor outcomes and to clients with CODs being labeled as hopeless, treatment resistant and lacking in motivation. Labeling is associated with a number of negative outcomes including decreased client motivation (Gambrill, 2006; Poulin, Hand, Boudreau & Santor, 2005). Stigma, shame, and discrimination prevented many people from seeking services for either condition.

Early substance abuse treatment modalities, especially the ones that targeted criminal justice populations, tended to rely on confrontational approaches. Confrontation elicits predictable responses: such as defensiveness and resistance, which were generally met with more confrontation. Counselors were often encouraged to break down clients until they achieved complete ‘surrender’, declaring those who did not still needed to ‘hit bottom.’ Early treatment programs often confused peer support fellowships with professional clinical care, frequently mandating clients to embrace religious or spiritual beliefs that peer recovery fellowships invited members to voluntarily adopt. For many individuals, especially those with CODs, this approach was counterproductive.

By the early 1990s, substance abuse treatment began to shift as research started to inform practice and new counseling techniques were adopted that fostered motivation to change, increased coping skills and helped individuals build on strengths (Sciacca, 1997). But, it was still common for treatment providers to refuse to admit people with a mental health diagnosis, especially if they were prescribed any type of psychiatric medication. Federally-funded substance abuse programs were required to be abstinence-based, and treatment objectives included discontinuing use of all mood-altering substances. Some providers, lacking in mental health training, were adamant that even physician-prescribed psychiatric medications with no or low potential for abuse were also off limits. Erroneous assumptions included the belief that very few substance abuse clients actually had mental health disorders, that symptoms would disappear once they’d been clean and sober for a while, and if they did not – it could be addressed after a significant period of sobriety was achieved.

Conflicts with mental health treatment practices and addictive disorders also posed problems. Approaches to treating serious mental illnesses embraced harm reduction strategies, sometimes without any expectation that clients stop using substances. Treatments often relied heavily on medications to manage symptoms, including drugs some people in recovery could not take safely, and sometimes did not even screen for substance use disorders. Assumptions about clients were often deficit-based and recovery was not yet a guiding concept. Both systems endorsed sequential treatment, and expected clients to put one disorder on hold while addressing the other, but rarely agreed on the sequence.

Integrated approaches recognize interactions between both disorders, barriers recovering individuals must overcome and the holistic shift in identity and lifestyle recovery involves.

Current research on substance abuse treatment that addresses both disorders demonstrates better retention and outcomes when mental health services are integrated onsite (CSAT, 2007). This allows clients to be treated and monitored through various stages of recovery by partnering providers that offer consistent messages about and recovery (CSAT, 1995).

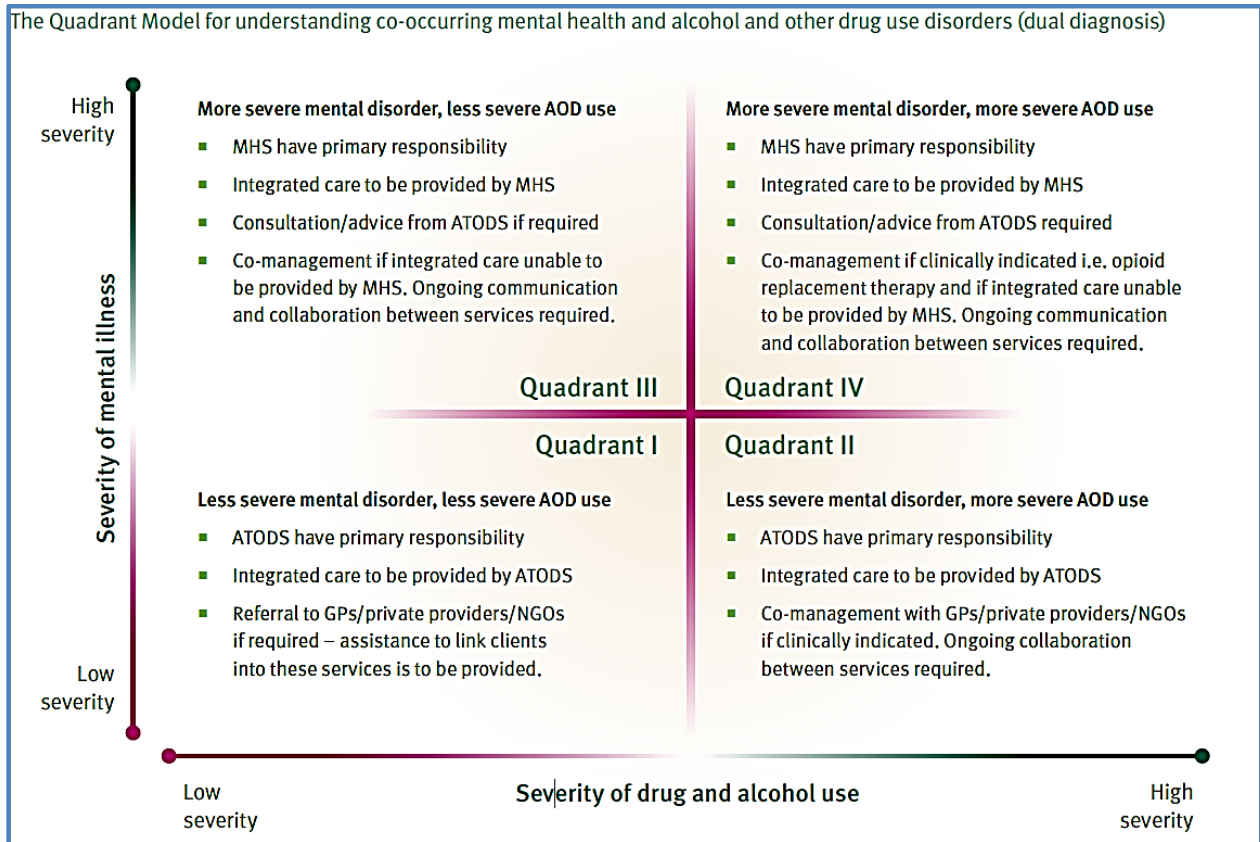
Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. Ideally, clinicians are cross-trained in both mental health and addiction. Unified treatment teams and case management approaches allow coordination of services that address the full range of the client needs more effectively and unify expectations.

Recovery is an individualized process—informed by levels of severity, needs, strengths and preferences of each client. Increased coordination translates into more realistic expectations that recognize there is no point when one treatment should end and the other begins. There are a number of integrated treatment principles on which experts in the field agree (Mueser, Noordsy, & Drake, 2003; SAMHSA, 2010):

- Co-occurring disorders are the expectation; clinical services should incorporate this assumption into screening, assessment, and treatment planning
- Within the treatment context, both disorders are considered primary
- Empathy, respect, and a belief in the individual's capacity for recovery are fundamental provider attitudes
- Treatment should be individualized to accommodate the unique needs and personal goals of individuals at different stages of their recovery
- The role of an individual's community in treatment, post-release reintegration and aftercare is a major factor in recovery.

The Quadrant Model

Wide recognition of many of these clinical issues, coupled with research that confirmed the increased effectiveness of integrated treatment approaches led to the development of ways to manage collaborative care. The 'Quadrant' model is part of the [Comprehensive, Continuous, Integrated System of Care Model](#) (Minkoff and Cline, 2004). It recognizes the diverse needs of clients and has been internationally applied to patient placement and care management for co-occurring disorders. It suggests a way to structure collaboration by assigning primary management of patient care according to the severity of each disorder. Keep in mind that the model is intended to be dynamic, flexible, individualized and to suggest a method for ensuring treatment is integrated. The illustration that follows shows a vertical continuum of severity (high to low) for mental health disorders alongside the quadrant and a horizontal continuum of severity for addictive disorders along the base.



Quadrant I – These individuals are in the ‘low severity’ quadrant for both disorders, but in custody settings they often have a high degree of criminogenic risk factors that combine with their mental health and substance abuse issues to increase the risk of recidivism. They may benefit from RSAT program participation if they meet the criteria for a moderately severe substance use disorder, with RSAT staff coordinating mental health collaboration and post-release referral to appropriate services. Integration of cognitive behavioral approaches that also address mental health issues and criminal thinking is indicated.

Quadrant II – The majority of individuals RSAT programs serve are likely to have severe substance use disorders and less serious mental health problems. They may do well in treatment with RSAT staff monitoring mental health symptoms, addressing them through integrated approaches and collaborating with mental health staff. Some of these individuals may benefit from psychiatric medications for depression or other disorders and may require ongoing medication management.

Quadrant III – Many individuals with severe and persistent mental illness do not have severe substance abuse problems and are not appropriate for RSAT. Their mental health problems, however, may be exacerbated by substance abuse. Mental health staff may refer them to other available substance abuse programming or consult with RSAT staff on release planning.

Quadrant IV - RSAT programs may serve individuals with serious and persistent mental illness who also have severe substance use disorders. Mental health staff usually makes the determination that their mental health symptoms are sufficiently stabilized to allow them to benefit from intensive substance use disorder treatment. RSAT and mental health staffs can engage in collaborative treatment planning and closely monitor progress. Continuity of care is critical for these individuals as they re-enter communities and requires a high level of pre-release planning and integrated care coordination.

Many RSAT programs function in institutions that do not or cannot apply this model. It is by no means the only method of managing services for individuals in custody with CODs, but it may help RSAT staff during pre-release planning to identify the best system of care for primary case management of re-entering clients with CODs.

How is the seriousness and severity of a mental health disorder determined?

It would probably be very helpful to know who and what belongs in which quadrant. Unfortunately, it's not as simple as looking up a diagnosis to see which category it's listed under. A link to a brief SAMHSA document in the resource section below explains the many factors in more detail.

- Different terminology has been used over the years to refer to people gravely affected by mental illness, and recently it has changed...again.
- The term '*severe and persistent mental illness*' (SPMI) is no longer used. For years it was widely understood to refer to people who experience significant impairment for long periods of time due to mental illness. It has been replaced by '*serious mental illness (SMI)*,' which does not necessarily connote the same gravity.
- Legal and clinical definitions differ. Social Security law specifies which impairments may be eligible for disability benefits and the criteria for the severity of each. Insurance companies may also use this list to determine covered levels of care.
- Clinical definitions are based on the impact of a disorder and the "serious functional impairment, which substantially interferes with or limits one or more major life activities." (SAMHSA, 2013).

The law defines the following conditions as a serious mental illness:

- *Schizophrenia*
- *Paranoid and other psychotic disorders*
- *Bipolar disorders (hypomanic, manic, depressive, and mixed)*
- *Major depressive disorders (single episode or recurrent)*
- *Schizoaffective disorders (bipolar or depressive)*
- *Pervasive developmental disorders*
- *Obsessive-compulsive disorders*
- *Depression in childhood and adolescence*
- *Panic disorder*
- *Posttraumatic stress disorders (acute, chronic, or with delayed onset)*
- *Bulimia Nervosa 307.51*
- *Anorexia Nervosa 307.1*

Each way of defining serious mental illness has its flaws. For example, the mental disorder with highest mortality rate is anorexia nervosa, but some people with the disorder may function and remain employed until they suddenly die. Therefore, it would not meet the criteria for impairment or interference with functioning.

In practice, determinations about the seriousness and severity of an incarcerated individual's mental disorder and their appropriateness for RSAT participation are usually made collaboratively, based on multiple factors including clinical assessments, criminogenic risks and needs and the client's motivation for treatment. This brings us to another guideline for managing service integration in custody settings for individuals with CODs - *The Five C's* (Miller, 2010)

The Five C's of Integrated Treatment in Correctional Settings – are essential tasks, guiding objectives and foundational attitudes relevant to integrated SUD treatment for people with CODs. They apply to the service delivery framework and to working with clients on treatment planning, decision-making and recovery self-management.

1. Communication

Staff - Ad hoc contact between mental health services and RSAT programs is not sufficient for the level of bi-directional communication required. Check-ins, team meetings, joint staffing, access to consultation and specialists, sitting-in on appointments with prescribers, and looping in security and other program partners must be built into operations by design. It's simple to back out a non-essential layer of contact for clients who are stable when it's smooth sailing. However, if mechanisms are not in place, averting problems during the early weeks of treatment, trouble shooting, fine-tuning and pre-emptive measures to avoid a crisis will be difficult to facilitate. A pilot in San Diego, based on Assertive Community Treatment, which offered pre-release planning and linkages to mental health and substance abuse services, along with nine months of post-release intensive case management, identified overcoming communication barriers as key to success ([Burke and Keaton, 2004](#)).

Clients -Transparency, trust, shared decision-making and informed consent require simple explanations of complex issues and options. Low health literacy levels, linguistic/cultural and cognitive barriers are challenges. Bi-direction exchanges are critical to confirming comprehension of key points, symptom and medication monitoring and to exploring insights about how mental health problems can trigger the urge to use. This is the heart and soul of relapse prevention for individuals with CODs.

2. Collaboration

Staff – No single discipline can facilitate durable recoveries among people with co-occurring disorders in custody by going it alone. Integration implies holistic strategies beyond rehabilitation, mental health and substance abuse programming that reach out to housing, health care, supported employment, peer recovery services and other. It involves advocating for the needs of a group with a triad of intersecting stigmas - at the outset. RSAT graduates may have valid reasons for avoiding institutions and interactions with service providers, many of whom are eager to reciprocate with skepticism. Collaboration requires everyone to take risks, but also has the potential to negotiate measures to mitigate the unacceptable ones.

With clients – Co-occurring recovery is a process of expanding networks of support and learning how to collaborate with an ever-widening diverse circle of contacts. Clients with multiple needs are more likely to achieve the level of independence they require to remain in the community when they can rely on a number of people, providers and social service agencies. RSAT staff and programs model the collaborative approach client need to learn, beginning with intake and extending beyond re-entry.

3. Coordination

Staff – Making sure the appropriate staff ‘own’ their part of the multitude of components involved in treating individuals with CODs, that efforts aren’t duplicated, tasks don’t fall through the cracks and each party reinforces the work of the other makes it possible to get the job done. Unified treatment and pre-release planning can help to consolidate the work load. Establishing consistent designated contacts at key community agencies can help coordinate post-release care.

Clients – Realistic expectations regarding accessible services upon release are critical. If clients plan to return to work or family duties and transportation is an issue, referrals to a lot of discrete services spread across town are unlikely to result in coordinated care. Follow-up care should also be integrated. Balancing informal networks of support and maximizing natural supports from family and peers can result in better follow through and recovery outcomes.

4. Consultation

Staff – Prescribers, mental health specialist, pain management specialists, psychiatrists and physicians certified in addictions, and psychiatric social workers all have specific areas of expertise. Confering with resources available with your facility on program policies and procedures and on individual cases is essential. There are also resources available through state mental health and substance abuse authorities and local university research centers, and federal resources that support practice improvement.

Clients – Each state has an Office of Consumer Affairs for mental health and a designated Protection and Advocacy agency that helps protect the rights of people with mental illness. Consumer and family mental health networks and peer support centers also operate in most communities; many offer WRAP groups and other self-directed recovery supports. Addiction recovery organizations and support groups offer both online and in-person support.

5. Cross-training

Staff – In service training by mental health and addiction specialists experienced in co-occurring recovery offer training for community mental health and substance abuse service providers in every state. Promoting more knowledge about substances, addiction, trauma, medications and various evidence-based approaches across mental health and treatment staffs can enhance integration.

Clients – The benefits of learning about each disorder are well-established. Clients can take advantage of many printed and web-based resources designed for this purpose. Programs can order printed materials and pamphlets from SAMHSA at no charge for RSAT programs to distribute.

Resources:

GAINS Center for Behavioral Health and Justice Transformation:

<https://www.samhsa.gov/gains-center>

Dual Diagnosis.org: <http://www.dualdiagnosis.org/jail-time-drug-users/>

SAMHSA Advisory, 2016: [An Introduction to Bipolar Disorder and Co-Occurring Substance Use Disorders](#)

[Behind the Term: Serious Mental Illness](#), NREPP, 2016

[National Institute of Mental Health – Pamphlets, Publications and Booklets](#)

[SAMHSA Publications and Resources on Mental and Substance Use Disorders](#)

EXERCISE 3: MYTHS, MISCONCEPTIONS AND FACTS ABOUT CODS

Take a look at these common myths about people with CODs.

- ✓ Put a check mark next to any of these myths that has ever influenced your thinking.
- + Put a plus sign next to any that you think influence others in various service systems.
- ☆ Put a star next to the ones that have the most influence on clients' perceptions of themselves as persons in co-occurring recovery.

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

Fact: Experience and research demonstrate that individuals with untreated co-occurring disorders (COD) are at higher risk for: relapsing, reoffending, homelessness and victimization (BJS, 2008).

Myth: *Stop using and most of your psychological problems will clear up.*

Fact: People with untreated COD's progress more rapidly from initial use to dependence, are less likely to complete treatment and to 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 when they stop using substances upon entry into a prison or jail (Prins & Draper, 2009).

Myth: *People with CODs are high-end consumers of services, and they do not get well.*

Fact: The vast majority of people with CODs do not get any treatment. According to Corbett, Nikkel and Drake, 2010, only 10% of clients with co-occurring disorders receive any treatment, for mental health or substance abuse, and only 4% receive integrated interventions. Many tend to avoid primary health care services. It is impossible to count the numbers of people with 'undetected' CODs who are in long-term recovery.

Myth: *Treating CODs requires highly skilled staff with specialized training.*

Fact: Many practices have been shown to be effective for people with COD's that do not require extensive specialized training. Supporting co-occurring recovery doesn't require staff to treat psychiatric disorders. Responsive case management, motivational approaches and linkages to supported employment, housing first programs and peer support are competencies staff may already possess or can easily acquire (Drake, O'Neal, & Wallach, 2008). Dual licensed clinicians with extensive knowledge of psychiatric interventions are essential team members and can support staff with clinical supervision.

Myth: *You can't do much until people with CODs 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 motivation for change. Ambivalence about treatment and abstaining from drugs and alcohol is a normal part of the change process. Unfortunately, pain is not the central motivator of change. (Walters, Claerk, Gingerich and Metzger, 2007).

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

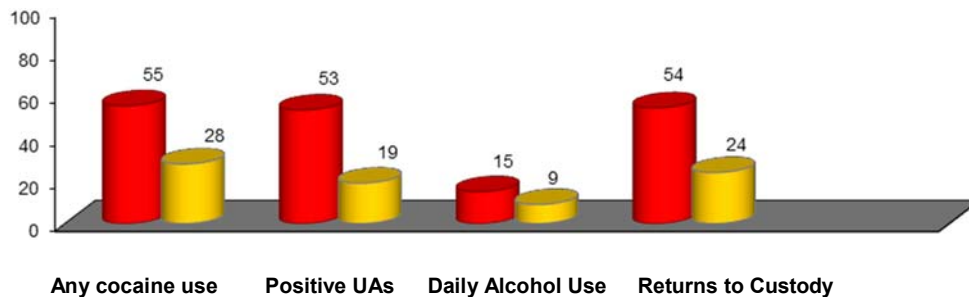
Fact: According to the Bureau of Justice Assistance the rate of violent crimes among those with mental disorders is the same as for others (2008). People with mental health disorders, however, are far more likely to be victims of violence. In 2004, nearly a quarter of people with mental illness were 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.

Best Practices for Supporting Co-occurring Recovery in RSAT

Screening → Assessment → Treatment Plan

Two primary principles regarding in-custody treatment planning that apply, regardless of treatment strategy, are the dosage principle and the importance of pre-release planning for continuing care. These have some specific application to treating individuals with co-occurring disorders.

Dosage: The effectiveness of any strategy is dependent on whether it has been administered with fidelity and for sufficient time to produce an impact. This is called the dosage principle. This is especially relevant for clients with CODs, who have greater needs and face 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 any individual stays engaged with treatment and recovery supports, the more his or her prognosis improves. RSAT clients with CODs are best served by remaining in treatment at least six months whenever possible.



Source: NIDA, 2006. Treatment is Key: Addressing Drug Abuse in Criminal Justice Settings. Treatment is the Key: Addressing Drug Abuse in Criminal Justice Settings. Redonna K. Chandler, Ph.D. Branch Chief Services Research Branch Division of Epidemiology, Services, and Prevention Research National Institute on Drug Abuse September 20, 2006 NIDA Advisory Council Meeting.

The graph above shows the difference in returns to substance use and custody for clients who were followed-up for 40 months post-release who received more than 90 days of treatment (the yellow column). Compared to those who had less than 90 days treatment (red column), the differences are dramatic. The yellow group shows significantly lower returns to custody and fewer positive drug tests (Simpson, Joe, & Brown, 1997).

Individualized stays based on progress toward achieving treatment goals are best. Higher-risk offenders require significantly more structure and services than lower-risk offenders. New research on the threshold of cognitive behavioral therapy required to bring about change in high risk offenders indicates a minimum of 300 hours should be delivered over a period of 6-12 months (Bourgon & Armstrong, 2006; Latessa, 2004; Gendreau & Goggin, 1995).

(See RSAT Promising Practices Guidelines, Section II -Treatment Programming)

“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.”

- NIDA’s Principles of Drug Abuse Treatment for Criminal Justice Populations (2011)

Pre-release Planning: Regardless of the treatment approach while individuals are incarcerated, release planning should begin when the treatment plan is developed. Many resources have long waiting lists and eligibility requirements that involve complicated paperwork, especially for justice-involved populations who are not typically priority clients. For RSAT clients with CODs, continuing care may involve medication management, acquisition of disability benefits and health coverage, hand-offs to mental health and addiction providers experienced with CODs and additional peer support linkages, as well as all the arrangements RSAT clients without mental health disorders require. Without this level of continuing care co-ordination, the transition may be next to impossible for many with serious mental health disorders. (See *RSAT Promising Practices, Section VIII -Transition and Aftercare Planning*)

Resources:

National Institutes on Drug Abuse (2011) *Principles of Effective Drug Abuse Treatment for Criminal Justice Populations: A Research-based Guide*:

https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf

Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide (2017). Council of State Governments Justice Center:

<https://csgjusticecenter.org/mental-health/publications/guidelines-for-successful-transition-of-people-with-mental-or-substance-use-disorders-from-jail-and-prison-implementation-guide/>

Examples of Effective Programs and Practices for RSAT Participants with CODs

There are a number of effective practices for justice-involved clients with substance use and mental health disorders. This manual is not intended to be a comprehensive list of all integrated treatment approaches that may be effective with RSAT clients. The following represents some of the core practices RSAT programs employ to successfully address three central objectives: criminal rehabilitation, improved mental health and addiction recovery.



1. Cognitive-Behavioral Therapy (CBT)

Cognitive approaches target a person’s attitudes and thought processes, teach individuals to recognize thinking errors and to replace them with rational, pro-social thoughts. Behavioral approaches focus on learning and reinforcing new behaviors. Research on cognitive behavioral treatments demonstrates effectiveness with substance use and mental health disorders and for reducing recidivism. A meta-

analysis found CBT programs in custody had the potential to reduce recidivism in the general population by an average of 35% (Landenberger & Lipsey, 2005).

Cognitive -- targets attitudes and thought processes

Behavioral – skills practice, role modeling and reinforcement

Cognitive behavioral strategies focus on changing the individual's thinking patterns in order to change future behavior. They work well in custody settings because they target observable behaviors and, unlike certain insight therapies, they are easily facilitated by trained staff. CBT sessions should include role plays, skill rehearsals and positive reinforcement of target behaviors. There are a variety of cognitive behavioral interventions for criminal thinking and substance use. Some also address specific mental health issues such as trauma or depression and increasing safe coping skills.

Effective interventions have strong behavioral components that require participants to *practice* new behaviors and coping skills in group with feedback from staff and peers. Participants are assigned 'homework' between sessions that reinforces new behavior. CBT is effective with a variety of behavioral disorders, including substance abuse, anti-social, aggressive, delinquent and criminal behavior. Research on CBT has demonstrated it can be more effective than medications for certain anxiety disorders. Of course, it is frequently used in combination with medications for clients with CODs. (See *RSAT Promising Practices, Section III, Treatment Modalities and Structured Program Activities*).

CBT emphasizes personal responsibility, focuses on the present, recognizing distorted or unrealistic thinking and the impact it has on problematic behavior. It increases willingness, readiness and ability to make changes. Most CBT interventions are time-limited and delivered in small groups that incorporate role plays, rehearsals, 'homework' and modeling or demonstrations. Typically, groups for custody populations are facilitated by trained professionals or para-professionals. Training for non-clinician group facilitators usually involves 40 hours or more of preparation. CBT can also be delivered in individual counseling sessions, usually by licensed and certified therapists.

Examples of well-known interventions for justice populations include *Thinking for a Change (T4C)* which is supported by training and technical assistance from the National Institute of Corrections. T4C consists of 25 sessions delivered over 3-5 weeks in groups of 8-10. The chart on the following page lists examples of interventions that are used with various subgroups of the criminal justice population. It summarizes their content, structure and duration. Some of the interventions are proprietary and may have costs associated with implementation. Each intervention listed is linked to an online resource that provides more complete information implementing specific curricula.

Examples of Primary Cognitive-Behavioral Therapy Programs for Justice Populations

Intervention	Approach	Target Clients	Structure
Aggression Replacement Training	<p>Social skills training (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 (cognitive component) is a set of procedures designed to raise the young person's level of fairness and concern with others' needs and rights.</p>	Originally designed to reduce anger and violence in juvenile justice populations; recently adapted for adults.	1 hour classes for 10 weeks.
Criminal Conduct and Substance Abuse Treatment	<p>Phase I: Challenge to Change. Involves the client in a reflective-contemplative process. Assessment builds relationship with provider. A series of lesson experiences help the client develop motivation to change.</p> <p>Phase II: Commitment to Change. Client in an active demonstration of implementing and practicing change. Strengthening basic skills and learning key CBT methods for changing thoughts and behaviors that contribute to substance abuse and criminal conduct.</p> <p>Phase III: Ownership of Change. Stabilization and maintenance involves the client's ownership of change over time. Treatment experiences are designed to reinforce and strengthen commitment to established changes.</p>	Adults with substance abuse.	9-12 months, CBT-community or custody settings. 12 modules in 3 phases, in sequence
Moral Reconciliation Therapy	<p>9 stages of personality growth and recovery are explored by addressing 7 issues:</p> <ol style="list-style-type: none"> 1. Confrontation of beliefs, attitudes and behaviors 2. Assessment of current relationships 3. Reinforcement of positive behaviors and habits 4. Positive identity formation 5. Enhancement of self-concept 6. Decrease in hedonism and development of frustration tolerance 7. Development of higher stages of moral reasoning 	Justice-involved adults and juveniles substance abusers, 'resistant' clients	Open groups up to 5x weekly Custody or community-35 sessions over 8-12 weeks, 6 - 8 per group
Relapse Prevention Therapy	<p>Self-blame and failure after a lapse or relapse is replaced with a view of them as temporary setbacks that may ultimately lead to positive outcomes and become 'prolapses,' defined as mistakes that clients learn from that improve their eventual chances of success.</p> <ul style="list-style-type: none"> ▫ Understanding relapse as a process, not an event. ▫ Identify and cope with high-risk situations. ▫ Cope effectively with urges and cravings. ▫ Implement damage control to minimize consequences; get back on track. ▫ Stay engaged in treatment if relapses occur. ▫ Create a more balanced lifestyle. 	Developed as maintenance program to prevent and manage relapse Addresses questions about relapse as a process and event	Flexible; no prescribed structure.
Thinking for a Change	<p>National Institute of Corrections program to increase offenders' awareness of self and others integrates cognitive restructuring, social skills, and problem solving.</p> <ul style="list-style-type: none"> ▫ A brief 15-minute pre-screening session to reinforce the need for the program and motivate positive participation. ▫ Groups limited to 8-12 to facilitate interactive and productive feedback. ▫ Sessions target criminal thinking, the way thoughts influence behavior and anger ▫ Aimed at increasing empathy for others and problem-solving skills 	Adults, juveniles, males and females in state correctional systems, local jails, community-based corrections programs, and probation or parole.	Twice weekly for 1-2 hrs; 25 sequential lessons, plus added sessions developed by the class.

Adapted from: [Cognitive Behavioral Therapy: A Review and Discussion for Corrections Professionals](#)

Another example of a CBT hybrid specifically developed for veterans and active military is [Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking \(MISSION\)](#). SAMHSA's National Registry of Evidence-based Practices and Programs (NREPP) rates evidence high for outcomes pertaining to substance use/disorders, and promising for outcomes related to: justice involvement, co-occurring disorders/symptoms, employment readiness, alcohol use/disorders, phobia, panic, and generalized anxiety disorders and unspecified serious mental illness and related symptoms. MISSION is a 12-month program that facilitates rapid community engagement in comprehensive outpatient mental health and substance abuse services. It may be a helpful tool for both treatment and for release planning for RSAT clients who have served in the military.

Resources:

[National Institute of Justice Webpage on CBT](#)

[Cognitive Behavioral Therapy: A Review and Discussion for Corrections Professionals Evidence-based CBT Resources & Tools for RSAT Programs](#)

2. Medication-Assisted Treatment and Psychiatric Medication Management

Both mental health and substance use disorders can improve through the appropriate use of medications.

Medication-Assisted Treatment (MAT) – When treatment incorporates the use of medications that are approved for the treatment of opioid or alcohol use disorders, it is referred to as medication-assisted treatment or MAT. MAT can help stabilize and manage withdrawal symptoms, reduce cravings, and decrease the potential for relapse. MAT has been underutilized in community-based treatment, but especially for justice-involved individuals. This is changing inside and outside of custody settings. MAT for alcohol or opioid use disorders can be very effective for individuals with CODs. It is important that clients who are candidates for MAT who may also be taking psychiatric medications (or medications for physical health conditions) are monitored by the prescribing physician to avoid medication interactions, preferably by one experienced in addiction medicine and psychiatric medication management.

In the case of HIV positive individuals with and co-occurring mental health and substance use disorders, many patients can be treated with common psychiatric medications. Physicians generally use a graduated approach that employs minimum doses of safer medications first, and closely monitors the effects. Then the type and amount of medication may be increased as needed, slowly, a step at a time.

Medications used to treat opioid use disorders can be also be effective for these individuals. Some research has shown clients with HIV can benefit from the structure that methadone maintenance treatment provides. The Opioid Treatment Outpatient Program (OTOP) at San Francisco General Hospital is an example of a program that specializes in treating HIV-positive patients with opioid use disorders. The majority of its

250-patient methadone treatment program serves clients who are HIV positive. The program offers substance abuse treatment combined with onsite psychiatric care and HIV/AIDS primary care. For more information on meeting the needs of substance abuse clients with HIV or AIDS, see:

[Substance Abuse Treatment for Persons with HIV/AIDS. SAMHSA Treatment Improvement Protocol Series, No. 37](#)

[RSAT Training Tool: HIV Prevention and the Treatment Needs of Offenders at risk for or Living with HIV/AIDS](#)

Opioid Replacement Therapy (ORT) – ORT is a type of MAT for opioid addictions that uses approved long-acting opioid agonist medications that do not have the euphoric effects of heroin and other short-acting opioids. This helps individuals discontinue illicit opioid use by satisfying certain parts of the brain affected by habitual opioid use. Methadone and buprenorphine formulations are approved medications for ORT. The principle behind ORT is that individuals may be treated and maintained in outpatient settings, are quickly able to regain a normal life and can continue to work at a job while they reduce criminal activities and high risk behaviors associated with opioid use. These medications have been shown to relieve withdrawal symptoms, cravings and reduce criminal behaviors among opioid dependent individuals.

RSAT staff needs to be aware of the potential benefits of MAT for substance use disorders, psychiatric medications for mental health disorders and of the potential for drug interactions among clients who may be prescribed both.

The transitional period from incarceration to community supervision is a high risk period for overdose among opioid dependent individuals, especially if they have been abstinent from opioids in custody (Binswanger et al., 2007). Although use of opioid replacement therapies inside correctional facilities has traditionally been limited to methadone treatment for pregnant women, access is increasing. Many RSAT programs refer re-entering individuals for opioid replacement therapy upon release. Research studies have shown that beginning opioid replacement therapy prior to release substantially increases the likelihood of post-release participation in community based treatment and aftercare and can drastically reduce post-release drug overdose fatalities (Kinlock, Gordon, Schwartz, Fitzgerald, & O'Grady, 2009).

Long-acting Injectable Naltrexone - Naltrexone is an opioid antagonist or blocker that is also used to treat opioid addiction. It can help discourage continued opioid use when combined with counseling and recovery support. It works by blocking the reinforcing effects of opioids (the pain-relieving and euphoric effects). Naltrexone can also help relieve cravings, but it does not relieve withdrawal symptoms. Opioid-dependent individuals must wait 7-10 from their last use to begin taking naltrexone. This means they must be able to get through the period of acute opioid withdrawal before they can begin treatment with naltrexone. The drug is also approved for treatment of alcohol use disorders and may be effective for people with alcohol problems or for those who have a problem with both opioids and alcohol.

Naltrexone was only available in an oral pill form until 2006, when an extended release

injectable form with effects that last up to 28 days was approved for treating alcohol use disorders (brand name: Vivitrol). In 2010, it was also approved for treatment of opioid use disorders. State correctional systems in at least 29 states now have programs that offer the long-acting injectable form of naltrexone as part of treatment for opioid use disorders to individuals who are about to be released. It is well-suited for custody environments since many people are already through the acute withdrawal period and since naltrexone has no potential for abuse or diversion and contraband is not a problem. (See *RSAT Promising Practices Guidelines, Section III*)

Use of Psychiatric Medications - A variety of anti-depressant, anti-anxiety, anticonvulsant, anti-psychotic, and mood-stabilizing medications are used to treat mental health disorders. They can be very effective and are often used in conjunction with psychotherapy. According to the American Correctional Association, 73% of correctional facilities prescribe psychotropic medications. On the average, one out of ten individuals in custody take medications while incarcerated as part of their treatment for mental health disorders (BJS, 2000).

It is important to keep in mind individuals in custody have the right to make health care decisions. Medications are an option, but generally coercion is not. It is within the scope of a prisoner's constitutional rights to refuse medication for a medical condition.

There are mechanisms to override this right for people in custody with serious mental illness. One mechanism is a court order. Courts have upheld forced medication of justice-involved individuals with mental health disorders in some cases under certain conditions. Many state correctional systems have authorized treatment review committees that can override refusal of treatment by a person in custody with mental illness. Other states still require a judicial review and/or a transfer to a state psychiatric hospital. These mechanisms make it possible to force a mentally ill individual to take psychiatric medications while in custody, but it is not a common practice (Felthous, 2014).

Mental health advocates have raised concerns that some state prisons overmedicate people with mental health disorders. One study found that over 40% of those in custody were prescribed anti-psychotic medications for off-label uses (Felner, 2006), meaning the medication was prescribed for another reason besides its FDA approved use as a treatment for psychosis.

For many individuals with mental health disorders, including those in RSAT programs, medications can provide tremendous relief, minimize symptoms and improve quality of life. It is also common for individuals in addiction recovery who also have a co-occurring mental health disorder to report that it was difficult to achieve long-term sobriety until they received integrated treatment that addressed a long-standing mental health condition with an effective medication.

However, some individuals resist medications and have low rates of compliance with treatment recommendations. Non-adherence with anti-psychotic medications is associated with higher rates of relapse and re-hospitalization in people with schizophrenia (Kishimoto et al., 2013). All medications have side effects that must be weighed against the benefits. In some cases, side effects can be very troubling.

Not all individuals respond to psychiatric medications. Some respond to certain medications while others do not. Sometimes a medication works well for an individual for a period of time, and then stops working. The reasons for this are not clear in all cases, but genetics can play a part in an individual's response to some medications.

More commonly, psychiatric medications administered in custody are discontinued upon release due to lack of continuity of care. Individuals are routinely released with a limited supply of meds and may not have a way to pay for their prescriptions or linkages in place with prescribers for follow-up care. RSAT staff should work with facility and community mental health providers to ensure re-entering clients are able to continue effective medication regimes and are linked to case management services upon release.

One promising innovation currently being piloted in a few re-entry programs and mental health courts is a new generation of anti-psychotic drugs that are administered in long-acting injectable form, with effects that continue for 30 days or more. Injectable anti-psychotic agents can be helpful if medication adherence is poor or uncertain (Bosanac and Castle, 2015). These long-acting injectable anti-psychotics must be initiated in advance of release to allow time to achieve the desired steady therapeutic dosage. Providing injectable, long-acting anti-psychotic medications to individuals in custody who benefit from them can help treatment to continue without interruption during re-entry as they transition to the community.

Psychopharmacology is a specialized field that requires a high level of advanced training. There are still a lot of unknowns when it comes to use of psychiatric medications. Research suggests that certain medications for people with serious mental health disorders such as bi-polar and psychotic disorders also have therapeutic benefits for various addictive disorders. For example, one study of patients receiving clozapine for treatment of schizophrenia showed that 85% of those who were actively using substances when they started the medication decreased their substance use while they were taking it (Zimmet, Strous, Burgess, Kohnstamm and Green, 2000). A study of the effects of the anticonvulsant drug, Lamotrigine, which is used to treat bipolar disorder, was conducted with bipolar patients who were also cocaine dependent. Cocaine cravings decrease significantly, along with bipolar symptoms after they began the medication (Brown, Nejtek, Perantie, Orsulak and Bobadilla (2003).

Resources:

[MAT for RSAT Programs and for Clients Transitioning to and from Community-based Treatment](#)

Federal Bureau of Prisons: [Treatment and Care of Inmates with Mental Illness](#);

National Commission on Correctional Health Care: [Psychotropic Medications](#)

Mid-Atlantic Addiction Technology Transfer Center: [Behavioral Health Medications](#)

[General Principles for the Use of Pharmacological Agents to Treat Individuals with Co-occurring Mental and Substance Use Disorders – 2012](#)

[Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders](#)

KAP Keys for Clinicians Based on TIP 54- 2013. [Treating sleep problems of People in Recovery](#)

[From Substance Use Disorders](#)

3. Motivational Approaches

Three practices designed to motivate justice-involved individuals to engage in treatment and comply with supervision requirements have demonstrated promise in research studies. These include: *Motivational Interviewing*, *Motivational Enhancement Therapy*, and *Contingency Management*.

Motivational Interviewing (MI) - Although there are not many studies on MI for incarcerated individuals, it has been demonstrated effective in both community corrections and in SUD intervention and treatment (Walters, Clark, Gingerich and Meltzer, 2007). Motivation is seen as a dynamic factor that can be shaped and changed. MI reframes responses that are often viewed as resistant as *ambivalence*, which is considered a normal part of the change process. MI is a brief, directive counseling approach for exploring and resolving ambivalence that employs a consistent set of principles and techniques. They include open-ended questions, supportive listening and affirmations that reinforce a client's commitment to change and increase internal motivators.

Motivational Enhancement Therapy (MET) - This evidence-based practice has been successful with adults in the NIDA Blending Initiative (Martino et al., 2010) and with adolescents in the Cannabis Youth Treatment Study (Dennis et al., 2004). It combines the use of MI during two or three individual sessions that build motivation, review assessment results, and prepare clients for group. CBT group sessions follow and also use motivation interviewing; hence, MET/CBT is the name of the central manualized intervention. MET/CBT is regarded as one of the most evidence-based approaches to treating substance abuse in juveniles involved with the justice system.

Contingency Management (CM) – CM is a program of pre-determined rewards used to acknowledge and reinforce target behaviors. In community-based programs, target behaviors are reinforced through the use of incentives, awards or prizes. For example, an individual may be awarded a raffle ticket for each clean drug screen and additional small prizes for consecutive clean screening results. At the end of the month, a drawing is held for a significant prize such as a bus pass or a gym membership.

According to NIDA, when providing correctional supervision to individuals participating in drug abuse treatment, it is important to reinforce positive behavior. Contingency management in institutional settings may confer certain privileges or increased 'good time' sentencing reductions for achieving treatment objectives and target behaviors (Gendreau, Listwan and Kuhns, 2011). Incentivizing an entire unit has been extremely effective in correctional treatment settings that serve people with serious mental illness (for example, no disciplinary reports for 90 days and the unit gets a VCR). Nonmonetary, social reinforcers such as recognition for progress and formal promotions to advanced phases of treatment can also be effective (NIDA, 2006). Tips for Implementation:

1. Rewards should outnumber punishments 4:1
2. Reinforcers should be clearly defined in advance and immediately conferred when target behaviors are achieved.

3. If punishments are used, graduated sanctions are best, with minimal consequences for first offenses to allow for corrective action, but increasing in severity each time the behavior is repeated.

(See *RSAT Promising Practice Guidelines, Section VII*)

Resources:

NIC Annotated Bibliography: [Motivational Interviewing with a Criminal Justice Focus, 2011](#)

NIDA Blending Initiative: [Promoting Awareness of Motivational Incentives](#)

4. *Strength-based Recovery Management Approaches* - These approaches are often referred to as *Wellness and Recovery Self-Management* or *Illness Management and Recovery Self-Management*. They are a set of related but distinct practices that empower people with mental illness and/or CODs to actively take responsibility for sustaining recovery. This can include programs that inform people about their disorder(s) and help them develop individualized strategies that help them manage and cope. Approaches are often self-directed and/or peer-led, affording recovering people greater control over their care and their lives. They can help increase community recovery support and enlist support from family members, improve patient communication and collaboration with providers, and result in more effective coping strategies for dealing with setbacks or distressing symptoms. Although these interventions are designed for individuals living with serious mental illnesses, they also align with approaches that support ongoing addiction recovery.

There are not a lot of sophisticated studies on recovery management approaches in custody settings. However, evidence supports their effectiveness in jail diversion programs and for people with mental health and/or co-occurring disorders who under community supervision (Mueser & MacKain, 2008). They are also employed in a variety of institutional settings. The four practices listed below are examples of recovery management approaches with significant research that demonstrates their effectiveness.

Psychoeducation Programs – These programs are aimed at educating people about their mental health disorder and treatment options. They employ primarily didactic approaches to improve understanding of the nature of a disorder and to enhance the capacity to make informed treatment decisions. These types of programs may also be offered to family members and others close to individuals in co-occurring recovery. They have been shown to increase treatment adherence, improve management of subsequent relapses and lower hospitalization rates (Xia et al., 2011). Related practices include ‘Shared Decision Making,’ which provides tools to patients and providers to help them collaborate on informed decisions about treatment options, websites or apps that offer electronic modules that educate people about specific mental health disorders and/or recovery resources or help them with ongoing self-management of their conditions(s).

Social and Independent Living Skills (SILS) - This program consists of a series of teaching modules, based on the principles of social skills training, that teach people 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 and recreation. Life skills training is frequently part of correctional treatment programs. SILS is a form of life skills training tailored to people recovering from behavioral health disorders to help them manage their conditions.

Behavioral Tailoring – This approach helps people adhere to medication regimes by developing daily routines that build in natural reminders (such as putting one's toothbrush by one's medication dispenser). It improves medication adherence and can help prevent relapses and psychiatric hospitalizations.

Wellness Recovery Action Planning (WRAP) and *Illness Management and Recovery (IMR)* are both evidence-based approaches that have been effective for justice populations. WRAP, however, is more widely available in many communities and is available in criminal justice settings (Cook et al., 2012; Mueser and Gingerich, 2006). Related relapse prevention training approaches also teaches people to identify early warning signs that indicate a need to pay attention to their daily routines for maintaining wellness and recovery. They also help people to develop a plan in advance to respond to signs that indicate a relapse could be likely so they can take action before things get worse.

Wellness Recovery and Action Planning (WRAP) - NREPP lists promising evidence of WRAP's effectiveness for outcomes in the following areas: anxiety disorders/symptoms; depression; general functioning and well-being; non-specific mental disorders/symptoms; receipt of mental health and/or substance use treatment; social competence and social connectedness. Small groups are facilitated by trained peers that guide participants through the process of creating a personalized plan for maintaining recovery and wellness. The plan includes a crisis component that functions like an advanced directive. It can be activated during a relapse or upon admission to inpatient care. It designates a support team to act on behalf of individuals dealing with relapse and to advocate for the treatment preferences the plan outlines. The list below highlights some criminal justice programs that offer WRAP:

- Wellness Recovery Action Plans are part of re-entry planning for participants in the Georgia Department of Corrections Integrated Treatment Program.
- WRAP has been a component of the Kalamazoo Michigan Mental Health Recovery Court program since 2008, serving individuals with severe and persistent mental illness, mostly with co-occurring substance use disorders. Peer staff with past criminal justice involvement who are in co-occurring recovery coach participants as they develop their plans.
- In Virginia, two regional behavioral health staff members contribute 20 hours a week to facilitating WRAP groups in jail-based Therapeutic Communities.
- WRAP is delivered to men in the Maguire Correctional Facility in Redwood City, CA and is being piloted as part of the Choices Program at the San Mateo County Men's Correctional Facility through a partnership with the Sheriff's Department.
- [One New Heart Beat](#) is a community organization that delivers pre and post release WRAP groups to incarcerated and re-entering individuals.

Resources:

[WRAP books, information and tools](#) are owned and distributed by AHP and available online, along with related resources and articles. WRAP has been applied to a number of different issues, including addiction, trauma recovery and re-entry.

[Copeland Center](#) is the source for WRAP facilitator training.

[National Alliance for the Mentally Ill \(NAMI\)](#) offers a Fact Sheet on illness and recovery management for people with mental illness.

5. Integrated Trauma and Substance Abuse Interventions

Histories of traumatic experiences and exposure to violence are common among individuals with substance use disorders. An estimated two thirds of men and women in publically-funded community substance abuse treatment report a history of childhood physical or sexual abuse (Clark, 2001). Incarcerated men, and especially incarcerated women and juveniles, have unusually high rates of lifetime exposure to violence and victimization (Miller and Najavits, 2011). It is critical to understand that a diagnosis of posttraumatic stress disorder (PTSD) means the effects of past trauma are experienced **in the present**, and often involve physiological symptoms and autonomic nervous system dysregulation. When these individuals stop using drugs and alcohol they generally have an urgent need to learn to manage these symptoms/responses without resorting to substance use. Integrated trauma and substance abuse interventions address trauma issues concurrently, recognizing that sequential treatment approaches may not work for these individuals, especially in custody environments, which are rife with unavoidable trauma triggers (Miller, 2012; Miller and Najavits, 2011, Miller and MacDonald, 2009).

Research confirms the dual diagnosis of substance use disorders and PTSD is extremely common, especially among women, people who have been incarcerated, veterans and the justice-involved juveniles. Addiction treatment outcomes are far less favorable for such individuals than for those without PTSD (Najavits, 2002). RSAT programs can take steps to ensure the principles of trauma-informed care are applied to all aspects of treatment, even if they do not offer trauma-specific interventions. (See *RSAT Promising Practices Guidelines, Sections III*)

Resource: RSAT Training Tool: [Trauma-informed Approaches in Correctional Settings](#)

Several integrated interventions for trauma and substance abuse have strong research that supports their effectiveness with justice populations (Miller and Najavits, 2012; Miller, 2011). Examples listed below are present-day approaches that employ cognitive-behavioral techniques to increase drug and alcohol-free coping skills and offer alternative strategies for dealing with the effects of trauma. They are not aimed at delving into past traumatic events and can be delivered without extensive specialized clinical training. Feedback on the benefits of these interventions from RSAT staff and clients, along with outcome data from evaluation studies, suggests they improve SUD treatment engagement and emotional stability.

[Trauma Recovery and Empowerment Model \(TREM\)](#) – TREM is a manualized integrated group intervention for women with substance abuse and histories of exposure to sexual and physical abuse. Its 18-29 sessions draw on cognitive restructuring and psychoeducational skills-training techniques to help increase coping skills and increase recovery support. TREM is listed on NREPP with at least one study that evaluated its use with justice-involved women supervised in the community. Outcomes are rated promising for the following areas: alcohol use/disorders; anxiety disorders/symptoms; coping; depression; disruptive disorders/behaviors; general functioning and well-being; general substance use non-specific mental health disorders/symptoms; trauma and stress-related disorders/symptoms and victimization and maltreatment. (Note: M-TREM is a version for men that is also available)

[Helping Women Recover and Beyond Trauma](#) – Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women are manual-driven treatments that can be combined and delivered to groups of 8-12 women in criminal justice or correctional settings who have substance use disorders and may have traumatic histories. NREPP rates outcomes promising in the following areas: substance use; aftercare retention and completion and re-incarceration. At least one study was conducted in a prison.

[Seeking Safety](#) – Is focused on psychoeducation and coping skills and has five key principles: (1) safety as the overarching goal (2) integrated treatment for both posttraumatic stress and substance abuse (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) helping clinicians with the challenges of working with trauma survivors. It is designed for flexible use and offers 25 sessions that can be delivered in any order, in group or individual sessions, and to male or female clients in a variety of settings. A minimum of 6 sessions have been shown to result in positive outcomes. It is listed on NREPP, with at least one study that evaluated its use with women in a prison setting. More recent studies have included justice-involved men and SUD clients supervised in the community. Outcomes are rated promising for the following areas: drug use; symptom severity of psychological distress; employment; PTSD symptoms; perceived social support; substance use; trauma-related symptoms; psychopathology and treatment retention. [Seeking Safety for Incarcerated Women](#) is also listed on **Crime Solutions**, the National Institute of Justice clearinghouse of programs and practices that rates evidence of effectiveness. It is rated as promising, with one recent study that showed it significantly reduced PTSD and depression scores among incarcerated women.

[Trauma Affect Regulation: Guide for Education and Therapy \(TARGET\)](#) This manualized, trauma-focused psychotherapy is geared to adolescents with PTSD involved in the juvenile justice system. It also addresses substance abuse. **Crime Solutions** rates evidence of evidence of effectiveness as high with research that showed significant reductions in measures of PTSD symptoms and anxiety for the treatment group compared to the control group. TARGET consists of 12 group or individual sessions, which can be expanded to be delivered over several months to teach a set of steps for regulating intense emotions and solving social problems while maintaining sobriety.

6. Intensive Case Management Models/Assertive Community Treatment

Intensive Case Management (ICM) for people with severe mental illness evolved from *Assertive Community Treatment (ACT)*, a model which relies on team-based approach to supporting individuals with complex behavioral health needs rather than individual caseloads. Although these interventions are more applicable to re-entry, the principles

can help ensure RSAT participants maintain treatment gains when they transition to community-based care. Both models include frequent service contact, mobile outreach and low staff/client ratios. They are ideal for those with addiction and severe mental illness who are leaving custody-based treatment programs and re-entering the community. Compared with standard care, people receiving ICM are significantly more likely to stay in contact with providers, have lower rates of psychiatric hospitalization, a higher rate of stable housing and better overall functioning.

[Assertive community treatment](#) offers highly specialized teams that are available every day of the year. Teams are comprised of social workers, nurses, psychiatrists, substance abuse counselors, case managers and/or peer recovery specialists. Team members help in all areas of life. Studies have shown that there have been significant decreases in jail time and the length of psychiatric hospital stays in states that have implemented ACT programs. Teams that support justice-involved individuals in co-occurring recovery are sometime referred to as FACT Teams (forensic assertive community treatment teams) and may include probation/parole officers. Patient Centered Medical Homes and other integrated care models that help consolidate services for individuals with complex behavioral health and social service needs have similar objectives.

Integrated treatment models are not mutually exclusive. RSAT clients with CODs can benefit from multiple approaches that are part of an individualized comprehensive treatment plan.

Resources:

[Effective Clinical Practices in Treating Clients in the Criminal Justice System](#), 2008. Authored by Scott, W. for the National Institute of Corrections:

[Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison](#), 2013 – Council of State Governments/GAINS Center:

See RSAT Promising Practice Guidelines:

- Section III – Treatment Modalities and Structured Program Activities
- Section VIII – Transition and Aftercare Planning

Building Integrated Treatment Capacities in RSAT Programs

Integrated programs coordinate all elements of treatment and rehabilitation to ensure everyone works collaboratively toward the same goals. An important ingredient of success is program fidelity, ensuring that staff understands how to consistently apply integrated treatment principles, practices and interventions as intended. Many RSAT programs use a Modified Therapeutic Community (MTC) model that retains the effective elements of the TC approach, but are tailored to correctional settings.

TCs offer an alcohol and drug free environment that supports participants as they progress through phases of treatment and learn, practice and adopt new behaviors.

Staff and peers also support efforts to eliminate counter-productive habits associated with substance abuse and criminal activities. When the community works towards a unified set of goals and adheres to common principles, it becomes a healing agent. TC core principles and methods can generally benefit participants with co-occurring disorders, but some further modifications may be helpful:

- RSAT programs highly structured daily routine can benefit individuals with CODs; however, additional prompting, coaching, visual aids, shorter sessions and repeat reminders can help with adherence to program schedules.
- RSAT programs foster personal responsibility, but some individuals with certain co-occurring disorders may require checklists, check-ins or a peer mentors to help them organize, prioritize and stay on task with responsibilities.
- Informal pro-social networks help sustain recovery, but some mental disorders contribute to isolation and make it hard to interact with peers and pick up on social cues. Structured recreational activities, social skills guidance, rehearsal and practice may be required.
- Medication difficulties and side effects can interfere with sleep and wakefulness. Allowing people to stand in group or to ask a buddy to nudge them if they doze are reasonable accommodations. Some meds have serious side effects such as involuntary movements and severe agitation. RSAT staff may need to confer with prescribers and other mental health staff when serious side effects persist.
- Building self-efficacy is important for most people in recovery, but people with CODs may require explicit and repeated reinforcement for incremental progress.
- Individuals with anxiety and trauma-related disorders may benefit from learning self-soothing strategies, grounding and ways to maintain 'serenity' when they become agitated or fearful.
- Finally, people with CODs are the best resource of information about what they find difficult, triggering or upsetting. They should be encouraged to let staff know what upsets them and what others can do to help.

Modifications for individuals with co-occurring disorders may involve making programs more flexible, less intense, and more individualized.

Increased flexibility, reduction in the duration of some activities, less confrontation, increased emphasis on coaching and instruction, fewer sanctions, more explicit affirmation for achievements and greater sensitivity to individual differences client needs can maximize treatment engagement. Programs should strongly encourage participants to become involved in the workings of the community. Despite the high level of needs some individuals with CODs have, they also appreciate opportunities to maintain autonomy over the course of their recovery. Upon release from custody, individuals with CODs should receive supportive services in the community for both disorders,

including linkages to mental health and addiction recovery peer support. This is essential to community re-integration and to connecting with the larger recovery community. (See *RSAT Promising Practices Guidelines, Section VI – Sanctions and Rewards*)

DEVELOPING STAFF COMPETENCIES

This manual is intended to introduce RSAT staff to the basic principles and practices of integrated SUD treatment for programs that serve participants with CODs. Specifically, as discussed in Module I, basic competencies include a working knowledge of:

- Prevalence, course, signs, and symptoms of co-occurring disorders
- Interaction of symptoms of mental health and substance use disorders
- Strategies for ongoing screening and assessment for co-occurring disorders
- Integrated treatment interventions and other evidence-based practices
- Specialized integrated release planning/case management approaches
- Familiarity with services available in the community and appropriate benefit programs

[The Dual Diagnosis Capability in Addiction Treatment \(DDCAT\) Index and Toolkit](#)

Community-based substance abuse treatment programs fall into different categories with regard to their capacity to serve clients with co-occurring disorders. DDCAT is a system of standards that has been developed for rating SUD treatment programs on a continuum that spans *addiction only programs, dual diagnosis capable* and *dual diagnosis enhanced*. The DDCAT index and the implementation toolkit are available online at the link above. Highlights include minimum recommendations for staff training, credentialing and supervision for each category.

Staffing Recommendations: RSAT programs that serve individuals with CODs require support from mental health specialists and addiction treatment providers experienced in treatment of co-occurring disorders, a framework for collaboration and consultation, and a supervision structure that employs qualified clinical supervisors. Dual diagnosis capable programs at minimum have:

- Experienced and competent prescribers for medications for mental health disorders and for SUDs as consultants or contractors that prescribe to patients and confer with staff on medication issues.
- Onsite clinical staff with mental health licensure or dual disorder licensed substance abuse clinicians with doctoral or masters level training.
- Access to regular formal mental health supervision by a licensed professional (for example: licensed clinical social worker, psychologist, psychiatrist or psychiatric nurse practitioner).

SAMHSA offers a five module training toolkit on the core elements of integrated treatment that uses vignettes, discussion, exercises and examples from experts in the field. Although it is not specific to justice populations, it includes relevant topics:

- Mechanisms to cross-train professionals and continuously develop the skill base of non-credentialed workers
- Regular clinical supervision by credentialed professions with specialized training
- Ensuring fidelity is considered to help maintain adherence to evidenced-based approaches.

[Five Modules in the COD Training Toolkit, SAMHSA, 2009](#)

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
5. Service Formats

Many other links to resources are listed throughout this manual, but below are a few additional websites, national centers and tools aimed at increases the RSAT staff knowledge and skills relevant to CODs.

Resources:

[National Association of State Mental Health Program Directors](#)

[National Institute of Mental Health](#)

[National Center for PTSD](#) (VHA)

[Institute for Research, Education and Training – COD Toolkit](#)

[Council of State Governments Justice Center - Mental Health](#)

- ◆ No-cost Online Trainings:

[Co-Occurring Mental Health and Substance Use Disorders](#)

[Treatment Competencies](#) - Community Support and Treatment Services (Michigan)

[The Department of Mental Health Law & Policy, University of South Florida](#)

[COD Training Series](#) – Includes a module on treating CODs in justice populations

EXERCISE 4: Program Integration INVENTORY

The questions below will help guide RSAT program administrators and allied staffs as they implement evidence-based integrated treatment practices and program components (SAMHSA, 2009).

Consider your program or institution as you answer the questions below. When you are finished, rate your RSAT program's capacity to treat clients with CODs on a scale of 1 to 5 (with 1 being the least). Check off any areas that you feel you need improvement. Pick two of those areas and for each of them write down any steps you could take to make improvements.

- Which staff are at least masters level practitioner(s) who can serve as onsite clinicians for your integrated treatment program? (licensed mental health or a dual diagnosis certified alcohol and drug counselor)
- Who provides clinical supervision to staff? (psychologist or licensed mental health clinician with experience and competencies re: CODs)
- What is the supervision structure? (group, individual, both and how often)
- Who prescribes medications for mental health disorders; how much of the time are they onsite?
- What procedures are in place for consultation with prescribers, psychiatric services or mental health staff?
- How do you monitor RSAT participants for mental health symptoms and report progress and/or concerns to institutional mental health staff?
- How do you collaborate on treatment, case management and release planning with mental health staff?
- Which community mental health agencies do you work with on coordinating post-release care? Do you have designated contacts at each agency?
- What steps do your prescribers take to ensure clients with addictive disorders are prescribed alternative medications that have low abuse potential?
- What integrated evidence-based programs and interventions do you offer?
- How do you educate RSAT program participants about their mental health diagnosis?

- What types of mental health and/or addiction recovery peer support and recovery self-management components do you integrate?
- How do you measure your program's fidelity to the evidence-based practices/model it employs?
- What community partners can you contact to help with in-reach, evaluation, supervision and staff training?
- How do you train program and security staff?
- How do you reward and reinforce target behaviors and recognize progress?

OVERALL RATING: **1** **2** **3** **4** **5**

Two areas in need of improvement:

1. _____

Steps:

2. _____

Steps:

WRAP UP AND CONCLUSION

This tool aims to provide foundational support to RSAT programs and staffs who are likely to already be working with many clients with CODs. It is designed to help both clinical and non-clinical staff attain a sufficient level of knowledge and skills to identify possible signs and symptoms of co-occurring disorders and to access the resources and clinical expertise they require. Justice professionals with responsibilities relative to RSAT program delivery are encouraged to become familiar with the fundamentals of integrated screening and assessment and to develop and utilize procedures that ensure collaboration with mental health services.

Although RSAT staffs do not practice outside of the scope of their training and experience, the basic principles that guide integration are relevant to everyone who works with RSAT participants - program and security staff alike. RSAT programs by federal mandate are established to provide substance use disorder treatment. Therefore, they cannot help but include individuals with co-occurring disorders, whether diagnosed or not. The overlap between substance use and mental health disorders makes isolating individuals with only the former impractical if not impossible. It also is a disservice to deprive someone in need of SUD treatment just because they have co-occurring mental health disorder. As described, this population most likely to recidivate without targeted assistance.

However, effectively serving individuals with co-occurring disorders requires more than simply adding another group to the standard RSAT treatment regime. Integrated approaches coordinate all elements of treatment and rehabilitation to ensure everyone works collaboratively toward the same goals. Close and continued collaboration between RSAT and mental health services is required.

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, prison and aftercare programs in order to improve chances of re-entry success and ongoing recovery. Requests for further information are welcome as are examples of what RSAT programs have put into place to meet the needs of individuals in substance use treatment who are also dealing with mental health disorders.

Module Three
Pre/Post Test Answers

1. T
2. F
3. F
4. T
5. F
6. F
7. T

Appendix - BENEFIT PROGRAMS – Highlights

The information below is a brief summary of potential resources for coverage and services for individuals with CODs. For complete information, including Medicaid eligibility and enrollment resources, see: RSAT Training Tool: [Health and Recovery Self-Management Tools for RSAT Participants](#)

(See *RSAT Promising Practices Guidelines, Section V.*)

SOCIAL SECURITY

Supplement Social Security Income (SSI) and Social Security Disability Insurance (SSDI) are both programs that provide disability benefit payments. They are not paid while beneficiaries are incarcerated (this includes detention centers, halfway houses, work release centers, boot camps, etc. - but not necessarily home confinement).

If people were receiving SSI before entering prison or jail: benefits are suspended after one full calendar month in custody and terminated after 12 full months in custody. If incarcerated for more than 12 consecutive calendar months, they must reapply upon release.

If people were receiving SSDI before entering prison or jail: they can continue receiving benefits until they are convicted of a criminal offense. If they are in jail awaiting trial, SSDI continues until they are convicted. Then benefits are suspended after they have served 30 continuous days. They can be reinstated the month following release by contacting the local Social Security office with official release papers and requesting reinstatement.

Applying for SSI benefits before release - People in custody can apply for SSI benefits before their expected release date from prison or jail. Applications are processed under the pre-release procedure for people in jails or prison if they are likely to meet the SSI eligibility criteria upon release.

Many correctional systems have pre-release agreements with local Social Security offices. Under these agreements, institutions notify local SS offices when an individual who is likely to be eligible for SSI is approaching release, sends relevant medical records and keeps the office informed about release plans. Social Security processes these claims or reinstatements as quickly as possible and notifies the institution regarding eligibility determinations, with the applicant's permission. The details of the procedure are available online at: [Prerelease Procedure](#). There is also a pamphlet available on benefits and incarceration from Social Security that can be ordered or viewed online: ['What Prisoners Need to Know.'](#)

Information on other relevant Social Security programs: Social Security also provides benefits to eligible individuals with HIV/AIDS. Information on SS for HIV is available at the link: <https://www.ssa.gov/pubs/EN-05-10019.pdf>

SOAR Resources - The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the [SSI/SSDI Outreach, Access and Recovery](#) (SOAR) Technical Assistance Center. SOAR is dedicated to ensuring eligible individuals with disabilities apply for

and obtain benefits. Applying for disability benefits is a difficult and complicated process. Nationally, only about 28% of applications are approved when they are initially submitted. The approval rate of initial applications from individuals experiencing homelessness who have no one to assist them is even lower – only 10-15%. The remaining applicants have to appeal the initial decision and obtain approval of their application for benefits through a lengthy appeals process that can take more than a year and sometimes involves retaining an attorney.

The SOAR program provides technical assistance to criminal justice agencies and accepts applications for the Criminal Justice Technical Assistance Program from agencies that have not already participated in the federally sponsored initiative. The SOAR website offers information and resources such as those listed below:

[SOAR Technical Assistance Application for Criminal Justice Programs](#)

[Living Arrangements: Residing in an Institution](#)

[Working With Justice-Involved Persons](#)

VETERANS' BENEFITS

The VA provides specific assistance and health care for veterans re-entering after incarceration and for justice-involved veterans.

If people were receiving VA disability benefits before entering jail or prison: VA benefits could be limited or even suspended during incarceration. VA disability compensation payments are reduced if a Veteran is convicted of a felony and imprisoned for more than 60 days. Veterans who are rated as 20% or more disabled are limited to the 10% disability rate. For a Veteran whose disability rating is 10%, the payment is reduced by one-half. Once a Veteran is released from prison, payments may be reinstated. All or part of the compensation not paid to an incarcerated Veteran may be apportioned to the Veteran's spouse, child or children, and dependent parents based on individual need.

Disability benefits are not reduced for Veterans in work release programs, residing in halfway houses (also known as "residential re-entry centers") or for those under community supervision. People can apply to restart benefits when they are 30 days or less from release. They should inform the VA of their scheduled release date. The VA must be notified within one year of actual release. If there was an overpayment (full benefits paid for more than 60 days after date of incarceration), the recipient will have to repay the amount of the overpayment before benefits can begin again.

VA Programs for Justice-Involved Veterans:

- [Health Care for Re-entering Veterans](#) (HCRV) is designed to help incarcerated Veterans successfully reintegrate back into the community after release. A list of regional HCRV specialists is available at: <https://www.va.gov/homeless/reentry.asp#contacts>. The program offers:

- Outreach and pre-release assessment services for Veterans in prison;
- Referrals and linkages to services, including substance use, mental health and employment services upon release; and
- Short-term case management assistance after release.
- The [Veterans Justice Outreach](https://www.va.gov/homeless/vjo.asp#contacts) (VJO) initiative is designed to help by ensuring eligible justice-involved Veterans receive timely access to VA health care, specifically mental health and substance use services (if clinically indicated) and other VA services and benefits as appropriate. A list of regional VJO specialists is available at the following link: <https://www.va.gov/homeless/vjo.asp#contacts>

MEDICARE - Re-entering individuals, without any type of disability who are approaching age 65 may be eligible for Medicare Part A and/or Part B. Medicare Part A covers in-patient hospital care, and Medicare Part B covers most outpatient treatments. People approaching age 65 will have a seven-month *Initial Enrollment Period* to sign up for these benefits. They should sign up to avoid gaps in coverage or late enrollment fees. They will not be automatically enrolled in Medicare. The initial enrollment period:

- Begins three months before the month they turn 65;
- Includes the month they turn 65; and
- Ends three months after the month they turn 65

If people become eligible for Medicare while they are in jail or prison: It is best to enroll in Medicare Parts A and B while they are incarcerated – even if they remain in prison for a while. Although Medicare won't cover care costs while they are incarcerated, signing up when they become eligible ensures Medicare will pay for care immediately upon release. There is not usually a premium required for Part A, but to keep Part B coverage they need to continue paying Part B premiums (\$134 per month in 2017) while in custody. It may be worth it to do this since coverage will be effective the day of release. Also, missing the initial enrollment period can result in a long waiting period after release until they can re-enroll and before coverage takes effect. It can mean fees or lifelong higher premiums.

To enroll in Part A and Part B while incarcerated they should send a signed and dated letter to Social Security that includes name, Social Security number, a clear statement that they want to enroll, and the date coverage should be effective. They should keep a copy of the letter and a copy of the envelope or send the letter by certified mail with return receipt.

If people were on Medicare before entering jail or prison: Medicare Part A will be suspended during incarceration but will resume upon release. Medicare Part B may be affected by incarceration. If premiums are paid during incarceration, benefits resume upon release. If they don't continue paying part B premiums, they must reapply for Medicare Part B. Before benefits can start, they must pay back all the premiums they missed while incarcerated. People who were receiving Social Security Disability payments prior to incarceration may have had Medicare premiums deducted from their check. They will have to pay premiums themselves while in custody. If they do not and have to re-enroll upon release, it can mean long waiting

periods and higher premiums. People should not pay for a Medicare Advantage or Medicare Part D while incarcerated. Visit www.ssa.gov or call (800) 772-1213 for more details.

[State Health Insurance Assistance Programs \(SHIPs\)](#) SHIPs help Medicare beneficiaries with one-on-one insurance counseling and operate in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands. Older justice-involved individuals who are nearing Medicare eligibility can take advantage of these services. The SHIP website includes a locator to find state SHIP programs that can help: <https://www.shiptacenter.org/>

Federally Qualified Health Centers (FQHCs)

[FQHCs are a](#) particularly important re-entry resource in states that have not expanded Medicaid eligibility. The Health Resources and Services Administration (HRSA) [FQHC locator](#) identifies the nearest health center anywhere in the United States. FQHCs provide primary health care services to uninsured and medically underserved individuals and areas regardless of ability to pay. They may also offer dental services, pharmacy services, behavioral health care, transportation, and case management. Since the passage of the Affordable Care Act, FQHCs have been encouraged to integrate behavioral health services. Most now provide mental health services and at least half of all FQHCs offer substance use disorder treatment.

There are many different types of Community Health Centers that are certified as federally qualified health centers. They include rural health centers, migrant health centers and health care centers for the homeless. FQHCs not only accept Medicaid and Medicare, they are also eligible to receive funding that offsets the cost of care for the uninsured and can apply for funds to hire enrollment assistors. Some community health centers are eligible to accept Medicaid and Medicare reimbursement but do not receive other grants to offset caring for the uninsured. These are known as federally qualified health center 'look alike.'

All FQHCs and look alike are an important resource for re-entering individuals in need of health care services. They are required to include 50% consumer representation on their board of directors and to deliver culturally appropriate services to the communities they serve. Since they operate in rural and medically underserved areas, they are sometimes the only comprehensive health care providers in certain communities. RSAT staff can use the FQHC locator to find centers that serve the communities of re-entry for RSAT graduates.

Examples of Federal Health Care Resources

[Health Care for the Homeless Program](#) - The Health Care for the Homeless Program is a major source of care for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing. These programs are a specific type FQHC that are required to direct outreach efforts and provide services to meet the needs of this population. They are also required to offer substance use services.

[Indian Health Service](#) coordinates federal health services to American Indians and Alaska Natives. The website offers information about the specific provisions of the Affordable Care Act that apply to Native Americans and Alaska Natives and other targeted health programs.

[Contact list of Federal CMS and Tribal Affairs staff and regional CMS Indian Health Contacts](#)

Health Homes - The “Health Home” model uses a care manager to coordinate communication among interdisciplinary providers serving patients with multiple conditions, especially those dealing with chronic physical and behavioral health problems. Their networks must include mental health and substance use disorder treatment capacities. The link takes you to a list of [Health Homes that address care coordination for justice-involved individuals](#).

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