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Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders

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One of the biggest challenges for drug courts is effectively working with participants with *co-occurring disorders*. By definition, persons with the dual diagnosis of both substance use disorders and mental illnesses have co-occurring disorders. All mental disorders, such as schizophrenia, bipolar disorder, posttraumatic stress disorder (PTSD), or severe depression, increase the chances of having a drug- or alcohol-use disorder, leading to a co-occurring disorder (Kessler et al., 2005; Grant et al., 2004). While some people with profound impairments related to their mental illnesses will be inappropriately referred to adult drug courts and need other options, these participants will be a *small minority* of persons with mental illnesses (Kessler et al., 1996). The National Drug Court Institute and Substance Abuse and Mental Health Services Administration's (SAMHSA's) GAINS Center believe that every adult drug court can achieve positive outcomes for persons with co-occurring disorders—*if* the court is committed to doing so. With some creativity and thoughtful planning, most persons with co-occurring disorders can successfully participate in drug courts.

Treatment Court Models

Adult treatment courts generally comprise three main types: drug courts, mental health courts, and co-occurring courts. Drug courts are the most abundant and standardized because of federal funding and regulation. Mental health courts and co-occurring courts are alternatives to incarceration and are more varied as a result of evolving independently in their jurisdictions. Table 1 on page 2 highlights some major differences between these treatment courts.

Flexibility

No matter which type of court you have, the key to treating participants with co-occurring disorders is flexibility. People with difficulty thinking, concentrating, or controlling emotions are not able to successfully participate in standard therapeutic groups or 12-step programs (Mueser et al., 2003). However, remaining flexible and using individualized criteria does not mean the participant faces no rules or expectations for change. Courts might need to apply a different paradigm to

TABLE 1 Differences between Three Types of Treatment Courts

	Drug Court	Mental Health Court	Co-Occurring Court
Participants Charges	Drug or alcohol related misdemeanors & felonies	Misdemeanors or felonies except serious violent & sex offenses	Variable
Primary Clinical Criterion	Addictions	SMI*	Addiction & SMI*
Service Delivery	Often have independent drug treatment programs within the court	Typically contract with community agencies for treatment & supports	Blend of court-sponsored & community interventions
Graduation Criterion	Sobriety, employment, & education	Individualized criteria	Individualized criteria
No. of Courts Nationally†	1,438	349	37

* Serious Mental Illness † As of June 30, 2012

participants with co-occurring disorders to achieve best outcomes, revisiting standardized responses to participant failures.

Overlapping Populations

Persons with co-occurring mental illnesses and substance use disorders are in all three types of adult treatment courts. Best estimates are that 30%–40% of current drug court participants have diagnosable mental illnesses, 75%–80% of mental health court enrollees have substance use disorders, and, by definition, all co-occurring court participants have both disorders (Blenko, 2001; Almquist & Dodd, 2009). All of these courts share the goal of reducing the unnecessary penetration into the criminal justice system of persons with mental illnesses, substance use disorders, or both by integrating court supervision with effective treatment services. Drug treatment courts can do this for participants with co-occurring disorders if they are willing and know how.

The Big Six

To effectively work with persons with mental illnesses co-occurring with substance use disorders, your court will need to understand and implement the six keys to success. Each step in this document addresses one of these keys:

Step 1: Know Who Your Participants Are and What They Need

Step 2: Adapt Your Court Structure

Step 3: Expand Your Treatment Options

Step 4: Target Your Case Management and Community Supervision

Step 5: Expand Mechanisms for Collaboration

Step 6: Educate Your Team

Step 1
Who Your Participants Are and What They Need

The first thing your court needs to do to improve outcomes is identify participants who have co-occurring disorders. This is not necessarily a simple task to codify. Those with co-occurring disorders in the justice system have tremendous heterogeneity across several dimensions: (1) the *type* of mental and substance use disorders, (2) the *presence* of multiple mental disorders and multiple

substance use disorders, (3) the *severity* of mental and substance use disorders, including the degree of functional impairment, (4) criminal justice *history* and risk for criminal recidivism, and (5) *prior involvement* in behavioral health treatment services. Few persons with co-occurring disorders have received specialized (i.e., integrated) behavioral health services either in the general community (SAMHSA, 2009) or in the criminal justice system (Chandler et al., 2004).

Rates of Co-Occurring Disorders in the Criminal Justice System

Persons in the criminal justice system have rates of mental, substance use, and co-occurring disorders that greatly exceed those found in the general population. For example, a recent study conducted in jails (Steadman et al., 2009) found that 17% of males and 34% of females have either a major depressive disorder, a bipolar disorder, a schizophrenic spectrum disorder, or PTSD. Among prisoners in substance abuse treatment programs, one-third were found to have either a major mood disorder (e.g., bipolar disorder, depression) and 3% were found to have psychotic disorders (Grella et al., 2008). From 70%–74% of persons in the justice system who have mental disorders also have co-occurring substance use disorders (Baillargeon et al., 2010; James & Glaze, 2006). Many others in the criminal justice system have less serious, mental disorders, including approximately 25% who have anxiety disorders (Grella et al., 2008; Zlotnick et al., 2008). Extrapolating from these studies, approximately 12% of males and 24% of females in the criminal justice system have co-occurring disorders.

Trauma and Mental Illness

People with co-occurring disorders are much more likely than the general population to be exposed to a range of traumatic events (such as physical or sexual abuse, the unexpected loss of a loved one, or witnessing violence) both before and after the onset of their disorders. Individuals who have been traumatized as children or adolescents are at increased vulnerability to subsequent retraumatization, which can destabilize both psychiatric and substance use disorders. Therefore courts must have an understanding of the effect of trauma on participants with co-occurring disorders to properly address treatment needs and avoid inadvertent retraumatization.

The most common consequences of exposure to significant trauma are acute stress disorders, and adjustment disorders. Another consequence of significant trauma is PTSD, a disorder characterized by symptoms such as reexperiencing the traumatic event (e.g., intense memories, flashbacks, nightmares), avoidance of trauma-related stimuli (e.g., avoidance of people, places, or things that remind them of traumatic events), and physiological overarousal (e.g., exaggerated startle response, increased heart rate and perspiration, anger). PTSD is common in people with a serious mental illness, an addiction, or co-occurring disorders. Most estimates of current PTSD within the co-occurring disorders population range between 20%–40% compared with the lifetime prevalence of PTSD in the general population of 10%. Untreated PTSD can lead to worse outcomes for people with co-occurring disorders, including dropout from treatment, relapse of substance abuse or mental health symptoms, and reoffending.

Despite the high prevalence of PTSD in people with co-occurring disorders, it is not routinely screened for or evaluated in most treatment settings. To make matters worse, people with PTSD usually avoid talking about their traumatic experiences and their PTSD symptoms unless directly asked. Some mental health and addiction specialists have been taught not to inquire about trauma history for fear of opening Pandora's box and retraumatizing the individual. However, research and modern practices show that trauma and PTSD can safely and effectively be evaluated in people with co-occurring disorders without risking destabilizing their mental illness or addiction. Accurate and routine screening for and assessment of trauma exposure and PTSD is important in people with co-occurring disorders to ensure they receive the treatment they need. Cognitive-behavioral treatments for PTSD such as desensitization and cognitive restructuring have been shown to be effective in the general population, and these approaches can be successfully adapted for people with co-occurring disorders in the criminal justice system.

Identifying Appropriate Candidates for Drug Courts

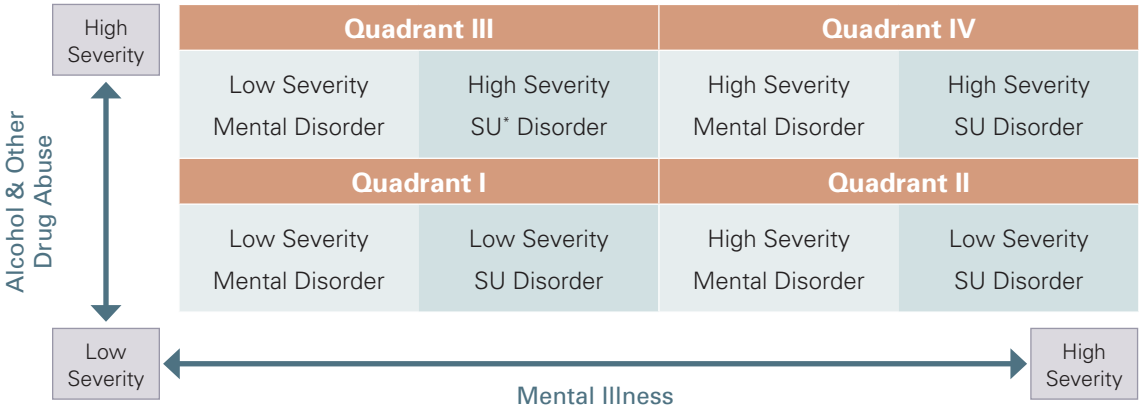
Research clearly indicates that intensive behavioral health treatment services in the criminal justice system should be prioritized for those who are at high risk for criminal recidivism (e.g., new crimes or technical violations;

Andrews, Bonta, & Wormith, 2006; Lowenkamp & Latessa, E.J. 2005; Osher, D'Amora, & Plotkin, 2012). According to the risk-need-responsivity (RNR) model that is derived from this research, the risks of recidivism and the needs of the offender should drive selection of offender treatment and supervision services. These services should be reserved for persons who have high *criminogenic needs* (Andrews & Bonta, 2010), or areas that independently contribute to the risk of recidivism, including antisocial attitudes, personality, and peers; substance abuse; family and marital problems; education and employment deficits; and lack of prosocial leisure activities. Although mental disorders are not an independent risk factor for recidivism, persons with these disorders in the justice system have elevated criminal risk and criminogenic needs (Skeem, Nicholson, & Kregg, 2008). Thus, persons with greater mental health and substance abuse needs are appropriate targets for drug court programs.

Based on research related to the RNR model, the best outcomes are achieved when drug courts target participants who are at a greater risk for criminal recidivism *and* have greater criminogenic needs (Marlowe, 2012b). This includes persons who have a history of prior felony arrests and who have high needs related to substance abuse, criminal attitudes and beliefs, education, employment, family or social support, and leisure activities. Screening and assessment instruments used in drug courts should therefore address the risk of recidivism and the severity of various criminogenic needs linked to recidivism.

The quadrant model in Figure 1 describes four subgroups of potential drug court participants with co-occurring disorders, each requiring different levels of treatment and supervision. Persons in quadrant I, who have low needs related to both disorders, are not appropriate for drug courts and should be processed through traditional courts. Persons in quadrant II, who have low severity substance use disorders but high needs for mental disorders, are best suited for placement in a mental health court or similar mental health diversion program. Persons in quadrant III, who have high substance use needs but low mental disorder needs, are best suited for traditional drug court services or intensive community-based substance abuse treatment. Finally, persons in quadrant IV have high needs for both mental and substance use disorders. As drug court participants, they

FIGURE 1 Quadrant Model: Participants in Adult Drug Courts with Co-Occurring Disorders



* Substance Use

Adapted from a figure developed by the NASADAD & NASMHPD Council of State Government Justice Center, 2012

will require specialized interventions such as integrated cognitive-behavioral treatment, co-occurring disorders tracks or groups, adaptations to status hearings, and specifically trained supervision teams (Peters et al., 2012).

Participants with co-occurring disorders may have specialized needs that interfere with their engagement at court. Your drug court might have to address not only the more obvious need for treatment of mental disorders such as PTSD, but also more mundane needs such as better literacy skills, housing, medical care, and transportation.

The court should also consider the criminal history of the participant and the nature and severity of the current charge. A violent history or offense is subject to scrutiny before admission but should not be an automatic disqualifier.

Finally, determining motivation level of participants may not be useful as it is a subjective analysis and may vary widely over time with this population. Being inclusive should be a goal of the court.

Screening and Assessment for Co-Occurring Disorders

Purpose of behavioral health screening and assessment is to identify, diagnosis, and determine appropriate level of care. Integrated screening and assessment for mental and substance use disorders and criminogenic risk should be conducted for all drug court participants early in the admissions process. Such evaluations provide the foundation to accurately identify persons with co-occurring disorders, determine if they are eligible for the program, and aid in directing them into proper areas and levels of services in a timely manner.

Screening

Screening is used to determine if a person is eligibility for drug court and identify any special needs. Drug courts should look for symptoms of mental disorders (bipolar disorder, depression, psychotic spectrum disorders); trauma and PTSD; and cognitive, intellectual, and other functional impairments. The instruments that screen for these disorders contain brief sets of questions, which do not typically require staff with advanced degrees or certifications to administer, score, or interpret. All drug courts should screen for mental and substance use disorders using standardized, validated screening instruments that have proven psychometric properties (reliability, criterion validity, etc.) for your target population. Validated screening instruments are not always available to examine areas of functional impairment affecting participation in drug courts, such as ability to handle stress in group treatment settings or in status hearings and ability to interact with drug court staff without excessive anxiety, agitation, or aggressive behavior (Peters & Osher, 2004). Interview and observation should be used to address these areas, and findings should be shared with the drug court team.

Several evidence-based screening instruments for mental disorders are listed on page 21 under *Instruments*.

Assessment

Drug court participants who have been screened as having co-occurring disorders should subsequently be assessed by a licensed mental health professional. Assessment provides a more comprehensive review of psychosocial issues that may affect participant engagement in drug court. It also reveals what types of treatment and supervision services will best serve a participant's needs. Although clinical assessments do address issues pertaining to criminal justice contact, most are not designed to determine outcomes for criminal justice programs.

Assessment of co-occurring disorders is provided through a clinical interview, which should be supplemented by use of evidence-based and validated instruments, including structured diagnostic interviews, psychosocial assessment instruments, psychological tests, laboratory, or other types of testing, and by collateral information (e.g., from family members). Findings should be shared with the drug court team. Assessment of co-occurring disorders should include the below components:

- Mental health and substance use diagnoses using criteria from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*
- Comprehensive history of mental health disorders and treatment services (including symptom history, use of psychotropic medications, previous treatment episodes, hospitalizations), response to treatment, history of trauma and PTSD, and family history of mental disorder

- Comprehensive history of substance use disorders and treatment services, including types of drugs used, frequency of use, major consequences of use, response to treatment, and substance abuse by family members and peers
- Interaction between mental and substance use disorders, including patterns of mental health symptoms during periods of abstinence and relapse precursors involving both mental and substance use disorders
- Functional assessment to describe the role that substance use plays in the person's life and factors that would interfere with achieving abstinence and other recovery goals
- Comprehensive examination of functional impairment that could affect participation in drug court, including cognitive deficits (e.g., attention and concentration), stress tolerance, and requisite interpersonal skills
- Other psychosocial areas that are likely to affect engagement and participation in drug court services, including criminogenic needs, motivation for treatment, literacy, transportation, and major medical problems

A wide variety of assessment instruments are available to assist in co-occurring disorders assessment (see *Instruments* on page 21 of this document).

Step 2 Adapt Your Court Structure

As previously mentioned, one of the principal components necessary for treating participants with co-occurring disorders is flexibility, but within a defined framework. With that in mind, customizing your court's structure, processes, and treatment is necessary to modify behavior and achieve successful outcomes.

Court Adaptation: Team Members

Gaining access to records of treatment history, prior diagnoses, and knowledge of any ongoing treatment may bring new team members onboard and is critical to addressing co-occurring disorders in drug court participants. Community treatment agencies and individual practitioners can enhance the resources available to the court. Adding a psychiatrist or psychologist to the team will help the court with obtaining the correct diagnoses and ensure participants obtain the proper medications. In addition to psychiatrists and psychologists, the inclusion of individual caseworkers is encouraged. The participant with co-occurring disorders may require a higher staff-to-participant ratio with caseworkers who are deeply involved with the participants and who are capable of bringing great insight to the team as a result of frequent home visits and other contacts (Prins & Draper, 2009; Skeem, Emke-Francis, Louden, 2006; Louden et al., 2008).

All team members should receive cross-training. The difference in expectations between the criminal justice professional and the mental health treatment professional is sometimes profound, and all team members should have a general understanding of the needs and contributions of other team members in order to focus on the common goal.

Court Adaptation: Process

Standard court processes and approaches may not be the most appropriate for participants with co-occurring disorders. For instance, in drug court, less frequent court attendance is considered a reward. The participant with co-occurring disorders may not consider court visits in the same way. The court visit is a time for the participant to receive recognition from the judge and a stable event around which to build the week's schedule. Maintaining a predictable schedule of weekly or twice weekly court appearances enhances the effect of treatment on improving the life skills of attendance, promptness, and planning ahead (Peters & Osher, 2004). Frequent court appearances may also help the judge and the team assess the participant's status and quickly respond to problems or needs.

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Support Groups

Courts that look to the traditional recommendation that their participants join Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) as part of the support network may need to rethink this process. Since participants in co-occurring disorders programs may not be able to handle stress in a group setting or feel comfortable contributing to a group discussion, AA or NA might not be as appropriate for participants with co-occurring disorders as they are for the traditional drug court participants.

The team should identify appropriate support groups, such as Double Trouble in Recovery, that address both the substance abuse and mental illness. Any support group referrals, such as to 12-step programs like AA, should be preceded by some preparation of the participant as to what he or she will encounter. Programs such as Project Match's Twelve-Step Facilitation are a valuable resource for that preparation. Participants with co-occurring disorders should also be reassured that just listening is acceptable participation.

Working with the Family

The family of the participant can be an invaluable asset and support to the court, the team, and the participant. Unfortunately, many individuals with co-occurring disorders may have arrived in the criminal justice system at the end of a long trail of behavior that has alienated all or part of their family. Court processes should include attempting to engage the family. The history and insight provided by the family may be helpful to the team. The education about the illness, the nature of co-occurring disorders, and treatment provided by the court may go far toward bringing the family back in a supportive role. Attempts by the court to engage the family in the participant's recovery process often succeed in reuniting the participant with family. The National Alliance on Mental Illness (NAMI) and other support groups may be a valuable resource for support for both the participant and his or her family.

Developing Tracks

The initial steps necessary to determine the appropriate track or treatment plan include screening for both mental illness and substance abuse and determining the severity of each diagnosis. The quadrant model (see Figure 1 in Step 1) defines the four different tracks to consider establishing when resources are available. Participants with low severity for both disorders (quadrant I) may fit well into a more traditional diversion program, which does not include intensive treatment. Participants with high-severity mental health issues and low-severity substance abuse problems (quadrant II) are most suited to a mental health court track. Those with a high severity of substance abuse and low mental health problems (quadrant III) are best-suited to a drug court or intensive community-based substance abuse treatment. Finally, individuals with high severity of both co-occurring disorders (quadrant IV) may be best served in a co-occurring disorders treatment program from within a drug court.

A co-occurring disorders treatment program should include the following strategies:

- Cross-train all members of your multidisciplinary team, including the judge
- Provide intensive supervision, monitoring, and participant contact with smaller caseloads for therapists and caseworkers
- Consider the size of court and audience and the frequency of participant appearances and adjust to comport with mental health symptoms such as discomfort with environment or large groups of people
- Provide clear and concrete directives regarding targeted behaviors using a supportive rather than confrontational approach with realistic expectations that consider a participant's ability to accomplish the set goals
- Identify and apply flexible responses for noncompliance that are realistic to the participant's ability to accomplish
- Emphasize medication compliance including monitoring the ability to obtain medications and provide supervision in taking as prescribed
- Educate participants on the impact that good and poor diet and sleep habits have on recovery and health
- Conduct frequent, random, and observed drug testing
- Ensure the team is familiar with community treatment services and can aid the participant in utilizing ancillary services as needed

Court Adaptation: Integrated Treatment Approach

Axis I disorders (the most widely-recognized of the disorders, which include major depressive episodes, schizophrenic episodes, PTSD, panic attacks, etc.) combined with the effects of multiple drugs of abuse result in a widely diverse group. Substance abuse may cause psychiatric symptoms, exacerbate them, or mask them. Psychiatric disorders may mimic substance abuse symptoms. This makes treatment and court needs very different not only from the standard drug court program, but also within the specific co-occurring disorders track. Best practices require integrated treatment to address co-occurring disorders, not sequential or parallel treatment. Treatment should be individually tailored to the participant's needs and should be expected to be a long-term engagement that continues after the participant's involvement with court. Providing integrated treatment may include addressing the following:

- Medications (commonly prescribed psychotropic medications may create a need for access and compliance monitoring)
- Mental health care
- Housing
- Cleanliness and hygiene
- Family and peer support
- Medical and dental care
- Nutrition and sleep habits
- Social services

Court Adaptation: Progress and Completion of Goals

Because the structure and expectations of a typical drug court may need to be adjusted to accommodate the co-occurring disorders participant, the court may need to revisit what goals to consider *proximal*, those that participants are already capable of performing and are necessary for long-term objectives, and what to consider *distal*, those that are ultimately desired, but will take some time to accomplish. Goals that are proximal for the drug court participant may not be the same for participants with co-occurring disorders. Attendance, timeliness, stability, insight into treatment, and other expectations may be distal goals for some members of this population depending on their level or type of impairment. As with drug court, keeping the participant engaged in treatment is a desired goal but may be more difficult to achieve in this track and thus require a longer time in the court program.

With this in mind, the designation of phases as used in a traditional drug court sense may need to be modified in a co-occurring court. It is still the goal of the court to move clients through a process of orientation, treatment, relapse prevention, and gradual transition to less supervision. A co-occurring disorders program may consider breaking down the traditional drug court phases into more specific goal-oriented segments and allowing more time to accomplish the goals of orientation, engagement, compliance, maintenance, transition, relapse prevention, and aftercare. These phases should include the individual treatment plan, comprising proximal and distal goals specific to each participant. Presenting the client with a concrete list of goals that are tied to the treatment plan, and recognizing when each goal is met will emphasize progress. The movement between phases may take a longer time to complete. Combining these two approaches will encourage continued engagement in treatment. The approach to supervision and treatment should be slower and more intensive for a longer period of time to address the co-occurring symptoms. Rather than universal requirements for what determines ability to graduate, it is more realistic for this population to complete the program when each client has achieved specifically determined goals that have been mutually agreed upon by the participant and the team (Peters & Osher, 2004).

These goals may include the following:

- A determined period of sobriety and medication compliance
- Reduction in mental health symptoms

- Continued engagement and progress in treatment
- Stable home plan
- Establishment of a support network
- Completion of special probation terms such as paying program costs, making restitution, or participating in community service

The goal of adapting expectations within a phase system is to allow each participant progress at a pace appropriate to his or her abilities and achieve goals that may be unique to his or her needs by creating individualized criteria for graduation. As stated previously, flexibility within a defined framework is the key to success with the co-occurring disorders population.

Step 3
Expand Your Treatment Options

Serious mental illnesses greatly complicate the treatment of substance use disorders. If not treated, co-occurring disorders can lead to high rates of dropout and poor outcomes. Successful treatment of people with these co-occurring disorders requires expanding treatment options in order to fully address the serious mental illness and its interactions with drug or alcohol use. The goals of expanded treatment are as follows:

- Engage, motivate, and actively involve the participant in his or her own treatment, including setting treatment goals
- Reach out to family members and other social supports to encourage and reinforce the participant's treatment efforts and goals
- Reduce mental health symptoms and substance abuse, relapses of both disorders, and hospitalizations
- Improve role functioning at work, school, or parenting
- Improve quality of peer relationships and promote healthy and legal recreational activities
- Increase independent living skills

Understanding Co-Occurring Disorders in People with Serious Mental Illness

About 50% of all people with serious mental illness experience a drug or alcohol use disorder at some point in their lives compared with only 15% of the general population. This leads to two questions:

1. Why are people with serious mental illness so vulnerable to developing substance use problems?

There is no single explanation for the high rates of drug and alcohol abuse in people with serious mental illness. Rather, the increased vulnerability can be explained by the confluence of different factors related to serious mental illness:

- Biological factors related to serious mental illnesses increase sensitivity to the effects of even small amounts of drugs and alcohol
- Efforts to cope with mental health symptoms and distress (or 'self-medication')
- Facilitation of relationships with other people including addressing the stigma of mental illness and social needs such as acceptance, friendship, and intimacy
- Lack of structured, meaningful roles and activities leading to boredom and susceptibility to using substances

2. What are the implications of these factors for treating co-occurring disorders?

The treatment of co-occurring disorders is most effective when it directly addresses the reasons underlying the high rates of substance abuse in serious mental illness. Therefore, the implication of the above factors related to serious mental illness is that the following should be addressed in treatment approaches:

- Educate people about their mental illness including its biological nature and their increased sensitivity to substances
- Teach more effective strategies for coping with symptoms and distress
- Improve social skills and identify alternative social outlets to meet social needs
- Help people develop meaningful roles in life, such as student, worker, or parent

Effective Treatment for Serious Mental Illnesses

Remarkable progress has been made in recent years in effective treatments for serious mental illness, including co-occurring disorders. In addition, numerous promising practices continue to be developed, further increasing the range of effective treatment options. Similar to the

importance of engaging people with an addiction in long-term substance abuse recovery, people with a serious mental illness benefit most from long-term mental health treatment and rehabilitation addressing the broad range of their needs.

Connecting people with co-occurring disorders to the services they most need is facilitated by knowledge of which treatments research has demonstrated as effective or promising for serious mental illness. Medication is a mainstay in such treatment, but for most people, medication alone is insufficient. Other services are needed to help them cope more effectively with their illness and to function better in their lives. Table 2 provides a summary of evidence-based and promising treatments for people with serious mental illness, including the focus of each intervention and a summary of how it works. While not every intervention will be available to people in a particular area, many services should be available, and the more needed interventions that an individual can access, the more effective their treatment will be.

Recovery and Mental Illness

People with a serious mental illness have often been told that recovery is impossible and that they should lower their expectations of what they can expect from life. These messages can be discouraging and contribute to problems with motivation that are already characteristics of the illnesses themselves. However, in recent years, the traditional medical concept of *recovery*, defined as no longer experiencing any symptoms or impairments related to an illness, has been replaced by a more meaningful and hopeful definition that is akin to recovering one's life. Recovery is defined as an intensely personal experience in which people strive to develop a meaningful and purposeful life, despite having a mental illness. This change in focus is evidenced in the President's New Freedom Commission on Mental Health, which states: "Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities" (2003). Such a recovery-oriented approach is achieved through services that strive to do the following:

- Be optimistic and future-oriented
- Concentrate on the person rather than the illness
- Actively-involve the person in their own treatment and treatment planning
- Focus on real-world functioning including work, school, and social relationships

This newer approach recognizes that recovery is not a linear process. People with a serious mental illness can improve in one area without necessarily improving in another area. Or progress in one area can itself lead to improvement in other areas. For example, many people with a serious mental illness are able to work despite having significant symptoms, and such work may even decrease the severity of symptoms. This new vision of recovery provides hope and motivation to people with co-occurring disorders that they can regain control over their lives and become accepted, contributing members of society.

Individualized Treatment Plans

To be as effective as possible, treatment for co-occurring disorders must be individualized to the specific needs of the person, including setting individual goals, identifying the specific services required to meet those goals, and establishing the intensity and duration of specific treatments and modifying over time as needed. Dealing with relapses, including both relapses of substance use and mental illness symptoms, should be a part of that recovery plan, for they are common and natural in the recovery process, However, despite this, relapses can be demoralizing. Therefore, while consequences for relapses of substance use (but not mental illness) may be imposed, rather than viewing relapses strictly as a setback, they should be more fruitfully reframed as part of the process of recovery from co-occurring substance use and psychiatric disorders. The team should determine if the behaviors that lead to relapse are proximal or distal behaviors and assign higher magnitude sanctions for easy proximal behaviors and lower

magnitude sanctions for difficult distal behaviors (Marlowe 2012a).

All individuals with a co-occurring substance use and psychiatric disorder should have an individualized relapse prevention plan developed as part of their treatment. Despite developing such a plan, relapses may occur. A relapse is an opportunity to reevaluate and modify the participant's treatment plan, including their relapse prevention plan, based on an understanding of the possible factors that may have contributed to the relapse (e.g., increased levels of stress or exposure to substances). Life improvements, such as working at a new job, resuming an educational program, or developing new relationships, naturally involve change, which can open the door for a mild increase or relapse in symptoms or a relapse of substance use. However, relapses can often be prevented or minimized through collaboration on treatment and by developing or modifying a relapse prevention plan as needed. All efforts by the participant to move forward and improve his or her life should be reinforced. Furthermore, *not* making efforts to change and improve life has its own hazards, including excessive unstructured time and lack of meaningful roles, which can worsen mental health symptoms and contribute to substance abuse.

In line with the need to individualize treatment plans, the plan for supervision must also be specific to the individual's circumstances and needs. Some participants require closer supervision (e.g., more frequent status hearings, home visits by probation, anklet monitoring, or more frequent drug tests) to ensure they are following through on their co-occurring disorders treatment plans and to identify problems as soon as they appear. Close supervision is especially important in individuals with serious mental illness and co-occurring substance abuse, and it provides more opportunities to help individuals get back on their personal road to recovery.

TABLE 2 Evidence-Based & Promising Services for Serious Mental Illness

Intervention	Goals	Additional Information
Medications	• Symptom reduction • Prevention of relapses and hospitalizations	• Medications are provided by psychiatrist, other doctor, or other licensed prescriber, and monitored monthly or more often. • Antipsychotic medications reduce psychotic symptoms and mood swings (mania). • Antidepressants reduce depression and anxiety. • Mood stabilizers reduce mood swings (mania). • Long-acting ('depot') antipsychotic medications are available by injection every 2–4 weeks.
Integrated Treatment for Co-Occurring Disorders	• Reduction of substance abuse • Prevention of relapses	• Mental health and substance abuse are treated concurrently by clinician or treatment team. • Treatment of both disorders is integrated. • Treatment is low-stress and motivation-based. • Outreach and close monitoring are provided as needed.

TABLE 2 Evidence-Based & Promising Services for Serious Mental Illness *(continued)*

Intervention	Goals	Additional Information
Supported Employment	• Competitive jobs paying competitive wages in the community	• Include all participants who want to work in the supported employment program. • Aid participants with rapid job search without requiring prevocational training. • Pay attention to individual preferences regarding preferred type of work and disclosure of mental illness. • Provide follow-along supports after job acquisition to facilitate maintenance. • Integrate vocational and clinical services. • Provide counseling on employment benefits such as SSI, SSDI, and insurance.
Illness Management & Recovery	• Improved capacity for shared decision-making about treatment options • Reduction of symptom severity & distress • Reduction of relapses & hospitalizations	• Provide psychoeducation about mental illness and its treatment. • Teach medication adherence strategies. • Build social support. • Improve self-management of stress and persistent symptoms. • Develop a relapse prevention plan.
Family Psychoeducation	• Improved understanding by family & participant of mental illness • Reduction of stress & tension in family • Improved monitoring of mental illness & prevention of relapses & hospitalizations • Increased support for participant's treatment goals	• Mental health professionals lead single-family or multiple-family group psychoeducation sessions. • Develop a collaborative relationship between family and treatment team. • Provide psychoeducation about mental illness and its treatment. • Teach communication and problem solving skills to reduce family stress. • Develop a relapse prevention plan with the family.
Supported Housing	• Stable, independent housing in community	• Help provide access to independent, stable housing regardless of individual's clinical status. • Set up or work with supports in community to sustain stable housing. • Provide practical help with paying bills, apartment maintenance, and solving everyday problems.

TABLE 2 Evidence-Based & Promising Services for Serious Mental Illness *(continued)*

Intervention	Goals	Additional Information
Cognitive Behavior Therapy	• Reduction of symptom severity or distress related to the following: ➢ Hallucinations or delusions ➢ Depression or suicidal thinking ➢ Anxiety, including PTSD ➢ Urges to use substances ➢ Criminogenic thinking	• Conduct 10–25 time-limited individual or group psychotherapy sessions aimed at helping people recognize and change inaccurate thoughts and beliefs that lead to negative feelings and maladaptive behaviors. • Help participant evaluate evidence supporting upsetting thoughts, and change self-defeating thinking (such as catastrophizing) to more helpful thinking. • Teach how to gather more information about upsetting thoughts and beliefs to better evaluate their accuracy. • Problem solve how to handle challenging situations not due to inaccurate, self-defeated thinking.
Social Skills Training	• Improved social relationships & independent living skills • Development of healthy & legal leisure & recreational activities • Improved social skills regarding the following: ➢ Refusing offers of alcohol or drugs ➢ Resolving interpersonal conflict ➢ Self-assertion & expression of feelings ➢ Job performance	• Conduct group-based training of social skills based on role playing to practice appropriate skills in social situations. • Break down complex skills into smaller steps to facilitate gradual shaping of skills through multiple role plays. • Assign homework for the practice of skills, including trips out into the community. • Elicit natural supports (such as family) who can prompt appropriate use of skills in natural situations.
Case Management	• Engagement & retention of individuals in treatment • Identification & coordination of treatment & living needs • Address needs relating to other systems, such as criminal justice, medical, & protective services	• Individual case manager or team helps the participant perform these goals and the tasks needed to accomplish them. • Meet regularly with the participant. • Evaluate needs, referrals to treatment, and maintenance of outcomes. • Coordinate services between different treatment providers. • Assist with applying for medical and other benefits. • Set up more intensive community approaches (e.g., assertive community treatment, intensive case management) for people with multiple hospitalizations or homelessness.

Step 4 Target Your Case Management and Community Supervision

Case Management

The philosophy statement of the Case Management Society of America describes case management as a means for achieving participant wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.

Case management in the drug court setting involves multiple team members sharing responsibilities and coordinating activities with and on behalf of participants. In an effective drug court, these responsibilities are clearly defined and understood by all team members. Fundamentally, helpful case management relies on *teamwork* to design and oversee the case management plan as well as to implement and revise it as the participants progress.

Case Management is a major element of engaging a participant, planning to address his or her individual barriers to recovery, and assisting the participant to surmount those barriers and learn to negotiate the community support system on an ongoing basis.

For the drug court participant with co-occurring substance use and mental disorders, the case management plan is likely to be more complex than a plan for a participant without such co-occurring disorders. Typical elements that such a plan needs to consider are described in this step.

Medication Assessment and Management

Persons with serious mental illnesses, as well as some having less severe mental health issues, are likely to require psychiatric assessment for psychotropic medications. If prescribed, such medications will require monitoring and subsequent reassessment. Assistance with arranging and keeping all appointments, filling prescriptions, and monitoring adherence to the prescribed medication regimen, including observing clients taking medication, are common case management needs. Supporting the participant in articulating his or her response to the medications as well as helping him or her to understand side effects and accept both the costs and the benefits of prescribed medication may be case management tasks.

Housing

Participants with serious mental illnesses may require aid to arrange for sober and supportive housing. Within the mental health system, housing options may be available to such participants that are not routinely available to the drug court participant with only a substance use disorder. Beyond arranging for initial housing placement, the team should continue to monitor housing stability as a component of the case management plan.

Financial Management

While the drug court participant is not likely to require a designated payee for benefit payments or other financial resources, assistance with budgeting for participants with co-occurring disorders is a common need. These participants frequently fall at the lowest end of the income spectrum and will be challenged to meet basic needs within their available resources. Direct assistance with applications for various benefit programs such as Social Security, Medicaid, food stamps, or other government low-income assistance programs will be a frequent need. In some cases, the participant may have a mental health services case manager to assist with such needs. Where this is not the case, the drug court team will need to assign one team member or an appropriate responsible party to perform this role. Many communities have implemented SAMHSA's SSI/SSDI Outreach, Access, and Recovery program, (SOAR). This national project is designed to expedite access to income supports and entitlements administered by the Social Security Administration for eligible

adults who are homeless (or at risk) and have a mental illness or a co-occurring substance use disorder. SOAR-trained case managers can dramatically reduce delays in receiving SSI/SSDI benefits.

Vocational and Educational Services

One of the most positive contributions of drug courts has been achieving long-term rehabilitation of participants' employment and educational status. For participants with co-occurring disorders, the services of vocational rehabilitation programs have been invaluable. From employability assessment and identification of needed job skills to vocational training or job placement and direct assistance in removing barriers, vocational rehabilitation programs are a major resource that should be tapped. Other community resources, such as high school educational programs (e.g., GED), vocational programs at community colleges, and other educational services, are also important resources. Finally some participants may be eligible for mental-health-supported employment. Case management is key to the connection and advocacy that will enable many participants to find meaningful and economically beneficial work.

Primary Health Care

While attention to both substance use and mental health issues will be the initial and primary focus of the case management plan, health and nutrition should not be overlooked. As recently reported in a Dartmouth study:

> People with serious mental illnesses are at risk of premature death, largely due to cardiovascular and metabolic disorders associated with obesity, sedentary lifestyle, and smoking. Until very recently, mental health services have neglected prevention and health promotion as a core service need for people with serious mental illnesses. (Bartels & Desilets 2012)

Obtaining primary, and in some cases specialist, health care with effective referral and follow-up is a very important long-term recovery strategy for participants with co-occurring disorders. Dental needs should not be neglected since participants with co-occurring disorders frequently have chronic or acute dental pain and related ongoing systemic infections.

Case management can be the critical bridge to the more traditional community health care resources such as the network of federally qualified health centers across the nation.

Community Supervision

Treatment and supervision needs of participants with co-occurring disorders are beyond those of the general drug court population, but much has been learned in recent years about effective rehabilitation and supervision. Lessons learned include such practices as the following:

- The level of supervision should be dictated according to the assessed risk for recidivism, with more intensive supervision provided to those individuals assessed as being high risk and less intensive supervision for those with lower risk. In addition, supervision of persons with mental illness should emphasize the development of a helping relationship rather than solely a surveillance approach.
- Interventions should target specific criminogenic needs as identified through a validated risk and needs assessment. In the case of a participant assessed as having significant antisocial attitudes and values, cognitive restructuring, which addresses criminal thinking, should be included among the interventions used. If procriminal associates are an identified risk factor, efforts should be made to redirect the participant to prosocial peer activities and recover support groups. Basic living needs must be addressed such as income assistance, housing, and employment services. Poor problem solving skills or limited self-regulation skills should be addressed through specific life skills training.
- Supervision should take into consideration the abilities of the participant and function within that framework. (Skeem & Petrila, 2004; Skeem, Encandela, & Louden, 2003).

However, applying these practices within the traditional drug court framework can be challenging. Often there is a one-size-fits-all regimen of supervision. Supervision personnel may lack knowledge of the limitations or cognitive impairments experienced by persons with certain diagnoses. In addition, the agencies delivering the needed services are generally overburdened and underfunded. The result of such factors is that gaining access to needed services can be daunting and delays in receiving services are common—delays that can severely compromise fragile states of psychiatric stability.

Probation officers or other community supervision agents can be a first line of defense in seeing that this does not happen. As field agents, they are sometimes the first to encounter issues that confront participants engaged in the drug court program. Probation officers are in a position to respond, which can potentially counteract the delays that might adversely affect participants with co-occurring disorders. Therefore it is important for the probation officer to develop a close working relationship with key treatment providers as a means of assisting participants in accessing treatment as quickly as possible. Ongoing contact with treatment staff also ensures continued treatment engagement and promotes quick problem-solving of barriers to treatment participation.

Offender functional limitations frequently interfere with compliance with complex and demanding drug court and related probation requirements. Memory deficits, self-regulation, time management challenges, and ambivalence to medication adherence can become threats to the necessary follow-through expected of drug court participants. Probation officers are an important resource to the team's understanding and ability to address such limitations before they become serious noncompliance issues. To this end, special training of supervision agents along with other drug court team members about mental illness and mental health treatment is particularly important when creating and enforcing a supervision plan for the participant with co-occurring disorders.

Monitoring treatment compliance is a significant responsibility of the probation member of the drug court team. A close working relationship with the treatment provider and a respectful and helpful relationship with the offender is essential to carry out this responsibility. Only with a perceived supportive relationship is the offender likely to be forthcoming about his or her treatment experiences and participation. If issues of noncompliance arise, they should be brought quickly to the team for a broad-based problem-solving discussion, backed up by the authority of the judge in court.

Probation officers need to understand not only the issues posed by the offender's mental illness but also the complexity resulting from the presence of a co-occurring substance use disorder. The interplay of these co-occurring disorders often results in challenges to abstinence, compliance with court-ordered conditions, and symptom management. As a result considerable patience and understanding must accompany the equally important enforced accountability.

The relationship between probation officer and offender has a significant impact on successful probation and drug court participation. Research has shown (Skeem, 2003; Andrews & Kiessling, 1980; Trotter, 1999) that two relationship qualities are important. The first is referred to as *alliance*. Alliance is achieving a bond, a sense of partnership, and a perceived commitment to the participant's success. The second is taking a *firm but fair* approach, which emphasizes considerate respect and flexible consistency.

The final consideration in the effective practice of supervision is a problem-solving approach to noncompliance that considers a balanced set of responses rather than an exclusively sanction-oriented or punitive approach. Threats of sanctions may be less effective for the participant with co-occurring disorders than a serious effort to both understand the reasons behind the noncompliance and to seek solutions. However, for all participants, accountability remains a key part of the drug court aimed at addressing those behaviors over which the participant has reasonable control through the use of both sanctions and rewards.

Step 5
Expand Mechanisms for Collaboration

Collaboration is fundamental to team efforts to reduce criminal recidivism and foster individual recovery and prosocial integration into the community. A defining characteristic of

collaboration is that the efforts of all are directed toward a common goal. This is such an important element of drug courts that it is sixth of the Ten Key Components, which states that "a coordinated strategy governs court response to participant compliance" (Bureau of Justice Assistance & NADCP, 1997). However it is not safe to assume that the goals of each partner to the enterprise are mutually understood and held in common. The individual agencies involved in drug courts frequently see their mission and goals differently. An effective coordinated strategy depends on explicitly clarifying the goals of the drug court. Only from clearly articulated and *shared* goals and collectively agreed-upon objectives and behavior-changing strategies will true collaboration take place. Court goals and objectives should be codified in the initial planning effort when a drug court is established, but it must be revisited as new members join the team. In many courts, mental health professionals will be relatively new team members with knowledge to impart and knowledge to learn in order to help the team understand and address participants' co-occurring disorders.

Developing a Common Understanding

In working toward shared goals and a coordinated approach, team members must come to a common understanding of fundamental knowledge. Each member of the team contributes a professional knowledge base from which key pieces must become commonly understood. For this reason interdisciplinary training is an important and ongoing team responsibility. In the press of time, this interdisciplinary training is often sacrificed. While mutual respect and common civility may facilitate a superficial level of team work, only real understanding will support true collaboration and lead to establishing court goals and objectives that work well. Each team member must think through and identify the fundamental knowledge that the team needs in order to create an optimally functioning program. Drug court coordinators and judges must ensure that such training and knowledge sharing occurs. Such collaboration is the only way for drug courts to understand mental disorders and treatment.

As drug courts become more attentive to the needs of participants with co-occurring disorders, the need for understanding of mental disorders and treatment approaches grows. Collaboration is the key to filling that need.

Maintaining Collaborative Partnerships

One operational focus of collaboration rests among individual drug court team members, while another level of collaboration depends on explicit agreements among drug courts, public agencies, and community-based organizations. For individuals with co-occurring disorders, intensive and regular communication between a broad set of mental health and addiction providers is necessary to ensure coordinated, collaborative, and integrated efforts are appropriate to the needs of the court participant. As the drug court expands its target population to persons with co-occurring disorders, it will interact with new partners, some of which will be less familiar with the drug court model and less experienced in working with the criminal justice system. Some will be skeptical about the ability to hold the participant with co-occurring disorders accountable for following drug court requirements. While developing organizational agreements will take time, such agreements will assure that an organizational foundation exists to support meaningful collaboration that can extend beyond the tenure of individual team members. One effective approach to formally institutionalizing drug court collaboration is through written memoranda of understanding. Such memoranda commit the parties to agreed-upon support for the drug court and articulate the specific roles, responsibilities, and contributions assumed by each party. Through developing such written agreements, each entity may come to understand the expectations of the other partners as well as describe his or her own. This makes the drug court processes much clearer to all involved and avoids the disappointments and conflicts resulting from untested assumptions.

Mapping the Relevant Resources

A systematic effort to identify specialized mental health resources in the community will identify potential partners who may be available for a collaborative relationship. Common examples include specialized police-based responses such as crisis intervention teams, other specialty courts within the jurisdiction, hospital emergency departments and hospital behavioral health units, behavioral health agencies that have integrated mental health and substance abuse treatment, substance abuse or behavioral health residential treatment programs, specialized mental-health-supportive housing agencies,

and the local chapter of the National Alliance on Mental Illness. These resources can be located by contacting the state mental health or behavioral health authority (see the National Association of State Mental Health Program Directors Web site at www.nasmhpd.org). The local chapter of the National Alliance on Mental Illness (see www.NAMI.org) can also help identify local resources and provide additional support to drug court participants with co-occurring disorders and to their families. A growing service element is the consumer-run service such as psychosocial clubhouses, peer support programs, and consumer advocacy organizations. These peer support resources can greatly enhance opportunities for ongoing community support after graduation. Three additional areas of support are important to efforts to strengthen ongoing recovery: vocational rehabilitation, supported employment, and primary health care services. Providers of these services should become key partners for the drug court serving participants with co-occurring disorders.

A Key Foundation of Drug Courts

While effective interpersonal and communication skills, trust, and positive drug court outcomes all play a role in strengthening collaboration, the following actions can and should be taken to build a firm foundation for effective collaboration. A drug court that will serve participants with co-occurring disorders should develop statements of inclusiveness for participants with co-occurring disorders, create a process for routine screening and assessment of co-occurring mental disorders, clarify and establish agreed upon behavioral and clinical goals and objectives, determine the approach to sanctions and rewards, assure ongoing interdisciplinary training, and develop interagency memoranda of understanding with justice organizations and the comprehensive array of treatment and recovery support agencies. The court should systematically map and reach out to engage the specialized mental health resources that are available in the community. This is a basic blueprint for building a solid foundation for collaboration, and collaboration is a foundation for a functioning team and effective drug court.

Step 6
Educate Your Team

Education of the treatment court team is a cornerstone in the foundation for success. Treatment, service, and supervision needs of participants with co-occurring disorders are beyond those of the general drug court population. Even the most practiced drug court professional can benefit from education on the complexity that co-occurring disorders bring into the court. Following are some of the educational topics that teams should consider.

Nature of Co-occurring Disorders

Team members need a basic understanding of mental health and the types of disorders that co-occur with substance abuse and the symptoms thereof. This, along with screening instruments (see *Instruments* on page 21), will aid your team in identifying candidates and participants with co-occurring disorders.

Treatment

While treatment of co-occurring disorders has much in common with treatment of substance abuse alone, it differs in critical ways that can influence outcomes. Teams will need to understand where standard treatment differs from typical drug court practices. Participants with co-occurring disorders will likely be on medication; therefore, team members will need an understanding of some common medications and how they affect mental illness. Finally, team members should understand what stage of treatment a participant is in and the ramifications on a participant's ability to engage in the drug court program.

Trauma

Since participants with co-occurring disorders are very likely to have experienced traumatic events,

team members need to understand how trauma contributes to co-occurring disorders. A better understanding of the effect of trauma will allow team members to more effectively meet treatment needs and avoid inadvertent retraumatization.

Supports

Team members may need to aid co-occurring disorders participants with supports that are unnecessary for other participants. Members should have a basic understanding of mental health needs, medication, and how to assist participants with attaining and maximizing benefits of medication. For example, team members may need to help participants articulate their responses to medications, understand side effects, and accept costs and benefits of medication.

Necessary supports for participants with co-occurring disorders also overlap with those needed by the typical drug court participant. While participants may share a need for aid with literacy skills, housing, employment, transportation, family and peer support, social services, and nutrition, the resources available to address the needs differ. Some supports (for instance, SOAR) are not available to the typical drug court participant, but are potentially available to those with co-occurring disorders. Team members will need to know what additional resources they can draw upon and how to help participants in accessing them.

Response

Participants with co-occurring disorders often face functional limitations that interfere with complying with the complex and demanding drug court requirements. These limitations need to be considered when the court is sanctioning or rewarding their behaviors. As stated earlier, flexibility is key, but individualizing a coherent and consistent program for the specific needs of participants with different psychiatric components of co-occurring disorders can be a challenge. Team members need to not only rely on mental health providers, but they may also have to modify their own standard responses when sanctioning or rewarding participants. The only way to accomplish this is through up-front education and continued sharing and feedback among team members.

Cultural Issues

Just as outcomes in your court can be affected by cultural issues associated with race, gender, and age, so, too, can outcomes be affected by sensitivities the participant has concerning his or her mental disability. Understanding the participants view of his illness will help teams avoid inadvertently alienating these participants, and sensitivity to participants' situations will promote better rapport with the team and thus outcomes. It will also allow team members to support participants in navigating cultural barriers in real world situation.

Working with an Extended Team

A participant with co-occurring disorders likely will require the addition of new team members. Your team may include mental health professionals, deputies, or courtroom personnel who are not always identified as team members. As stated previously, individual agencies see their missions and goals differently. New team members may have specific educational needs; for instance, mental health providers may need a basic understanding of the principles of evidence-based practices (SAMHSA, 2009). Only through education can the different team members share interdisciplinary knowledge, understand the needs of fellow members, and support the collaboration necessary to achieve successful outcomes. A fundamental understanding and knowledge of what each discipline contributes will allow the team to best utilize the skills of each member and minimize disruptions to accomplishing shared goals.

Finding Educational Resources

This list of educational needs is long and varied. To address them, drug court teams will have to seek out educational opportunities. Courts can consult professional organizations to arrange for classes and training. A lot of research has been conducted in this field in the last few years and is available through publications and the internet. The internet also offers sites, webinars, workbooks, articles, and videos that can help your court keep up to date with education. The following are some places to start looking for more on where and how to look for your drug courts specific educational needs.

Educational Resources

Trainings

- Improving Your Drug Court Outcomes for Individuals with Co-Occurring Disorders: www.ndci.org

Web Sites

For up-to-date information on Co-Occurring disorders

- SAMHSA Co-Occurring Disorders: http://www.samhsa.gov/co-occurring/
- Mental Health America, Co-Occurring Disorders: http://www.mentalhealthamerica.net/go/co-occurring-disorders

For information on finding local support

- Behavioral Health Evolution, Double Trouble in Recovery: http://www.bhevolution.org/public/doubletroubleinrecovery.page
- National Alliance on Mental Illness: www.NAMI.org
- National Association of State Mental Health Program Directors: www.nasmhpd.org

For online articles and publications

- Policy Research Associates, Publications: http://www.prainc.com/projects-services/projects-national-centers/publications/
- SAMHSA's GAINS Center: http://gainscenter.samhsa.gov/topical_resources/cooccurring.asp

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Instruments

Screening

Mental Health

- Brief Jail Mental Health Screen
- GAIN-SS
- MHSF-III
- MINI-Screen

Trauma and PTSD

- Primary Care PTSD Screen (PC-PTSD)
- PTSD Checklist—Civilian Version (PCL-C)
- Stressful Life Events Screening Questionnaire—Revised (SLESQ-R)—This can help identify previous traumatic events, and the PTSD screens (e.g., PC-PTSD, PCL-C) can then be used to examine the current level of impairment related to each of these events.

Cognitive, Intellectual, and Other Areas of Functional Impairment

- Beta-III or the WAIS-Abbreviated Scale of Intelligence (WASI)
- Montreal Cognitive Assessment (MOCA) and the Mini-Mental State Examination, 2nd Edition (MMSE-2)
- Role Functioning Scale—This examines four areas of adult functioning: work productivity, independent living and self-care, immediate social-network relationships, and extended social-network relationships.

Screening for Substance Use Disorders

A number of substance abuse screening instruments are available at nominal cost, free of charge, or are in the public domain. Several evidence-based substance abuse screening instruments are listed below:

- Addiction Severity Index (ASI)—Alcohol and Drug Abuse sections
- GAIN-SS
- Simple Screening Instrument (SSI)
- Texas Christian University Drug Screen—II (TCUDS-2)

Assessment

Diagnosis and Assessment of Mental Disorders

- Millon Clinical Multiaxial Inventory—III (MCMI-III)
- Minnesota Multiphasic Personality Inventory—2 (MMPI-2)
- Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)
- Personality Assessment Inventory (PAI)
- Assessment of Substance Abuse and Related Psychosocial Areas
- Addiction Severity Index—5th Edition (ASI)
- Global Appraisal of Needs (GAIN-Q and GAINI instruments)
- Texas Christian University, Institute of Behavioral Research (Brief Intake Interview, Comprehensive Intake)

Assessment of Criminal Risk (e.g., risk for criminal recidivism)

- Historical-Clinical-Risk Management—20 (HCR-20)
- Lifestyle Criminality Screening Form (LCSF)
- Level of Service Inventory—Revised (LSI-R)
- Psychopathy Checklist—Screening Version (PCL-SV)
- Risk and Needs Triage (RANT)
- Short-Term Assessment of Risk and Treatability (START)

Web Sites

SAMHSA's GAINS Center

Monograph—*Screening and Assessment of Co-Occurring Disorders in the Justice System* by Peters, Bartoi, and Sherman, 2008: http://gainscenter.samhsa.gov/pdfs/disorders/ScreeningAndAssessment.pdf

United States Department of Veterans Affairs

This site provides a range of useful information on different instruments that can be deployed for this purpose: http://www.ptsd.va.gov/professional/pages/assessments/list-screening-instruments.asp

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Improving Drug Court Outcomes for Adults with Co-Occurring Disorders

Table 3 summarizes considerations and recommendations for drug courts when they work with individuals with co-occurring disorders. Some items are recommended practices for all drug courts, whether or not they accept participants with co-occurring disorders, but they are highlighted here because of their significance in achieving positive outcomes for these participants.

TABLE 3 Keys to Success

Know Who Your Participants Are & What They Need	
DC Component or Process*	**Adaptations & Considerations for Participants with COD†**
• Screening & assessment • Assignment to specialized court or diversion program *Key Components 3 & 4*	1. Prioritize for court participation individuals who are at high risk for reoffending, based on a validated assessment instrument. 2. Screen candidates for both mental health and substance abuse treatment needs. 3. Follow up screening with in-depth assessment for co-occurring disorders: ➢ Requires specialized training in both mental disorders and drug and alcohol disorders. Co-occurring disorders assessment should be done, whenever possible, by a licensed mental health professional. ➢ Requires a clinical interview. Validated instruments can assist the process but, by themselves, are insufficient. ➢ Domains to consider include symptoms of mental disorders; trauma; and cognitive, intellectual and other functional impairments. Functional limitations are more important for treatment court outcomes than diagnosis. 4. Match individuals to a court program based on service needs: ➢ Low mental health needs & low substance abuse needs: traditional court process ➢ Low mental health needs, & high substance abuse needs: traditional drug court ➢ High mental health needs, & low substance abuse needs: mental health court or diversion program ➢ High mental health needs & high substance abuse needs: Specialized co-occurring disorder adaptations to drug court

*DC: drug court †COD: co-occurring disorders

TABLE 3 Keys to Success *(continued)*

Adapt Your Court Structure

DC Component or Process*	Adaptations & Considerations for Participants with COD†
• Court team • Terms of participation ➢ Status hearings ➢ Graduated rewards & sanctions ➢ Graduation requirements • Case management *Key Components 1, 2, 5, 6, & 7*	1. Adjust your expectations of participants with co-occurring disorders ➢ Each individual with co-occurring disorders has unique needs based on mental health issues, substance abuse, functional impairment, medical issues and psychosocial factors. ➢ Abstinence is always an important goal, but progress toward that goal may need to be measured individually, based on factors such as degree of functional impairment and insight. ➢ Other goals should also be individualized, based on functional impairment and risk of reoffending. Goals that may be proximal (achievable in the short term) for most drug court participants may be distal (long-term) for individuals with co-occurring disorders. ➢ Treatment goals should emphasize secure, long-term treatment engagement. Many psychiatric disabilities require lifelong treatment, in contrast to drug treatment modalities with a beginning, middle, and end. ➢ Standards for graduation and termination should be both individualized and clear-cut. 2. Expand your court team to include people with expertise in co-occurring disorders. 3. Provide peer support for participants. 4. Engage families in the court process. 5. Tailor frequency of court status hearings to support engagement. Many co-occurring disorders participants prefer frequent court appearances or request a voice in determining the frequency of court appearances. 6. Create a separate court or track for participants with high co-occurring disorders needs to better respond to their needs and preserve the integrity of the drug court structure for participants with low mental health needs.

Expand Your Treatment Options

DC Component or Process*	Adaptations & Considerations for Participants with COD†
• Treatment & other supports *Key Component 4*	1. Base treatment goals on principles of recovery, defined as the process in which people are able to live, work, learn and participate fully in their communities. 2. Treatment plans must be highly individualized. 3. Evidence-based and promising practices include the following: ➢ Medications. These are critical for addressing many psychiatric disabilities, but it is inappropriate to expect that medications can cure mental illness. A medical focus on symptom improvement is insufficient to address the behavioral and public safety goals of a treatment court. ➢ Integrated treatment for co-occurring mental illness & substance abuse ➢ Supported employment ➢ Illness management & recovery ➢ Family psychoeducation ➢ Cognitive behavioral therapy ➢ Social skills training ➢ Supported housing ➢ Case management Trauma histories are extremely common among people with co-occurring disorders and should be addressed through trauma-informed treatment.

*DC: drug court †COD: co-occurring disorders

TABLE 3 Keys to Success *(continued)*

Target Your Case Management & Supervision	
DC Component or Process*	**Adaptations & Considerations for Participants with COD†**
• Coordination of services • Monitoring • Graduated rewards & sanctions *Key Components 1, 2, 5, 6, & 7*	1. People with co-occurring disorders have more complex case management needs than typical drug court participants. Elements of a case management plan may include the following: ➢ Assisting with access to treatment ➢ Medication assessment and management ➢ Housing ➢ Financial management ➢ Vocational & educational services ➢ Primary health care 2. Adjust case management structure to maintain lower participant/staff ratios. 3. Functional limitations may interfere with a participant's ability to comply with the court's requirements. 4. A supportive relationship between a participant and the person providing supervision (probation officer or other court team member) will facilitate compliance with court requirements. Three qualities are especially important: ➢ Alliance, or achieving a sense of partnership so that the participant perceives that the supervision officer is committed to his or her success ➢ "Firm but fair" approach, which emphasizes respect and flexible consistency ➢ Problem-solving, rather than punitive, approach to noncompliance
Expand Mechanisms for Collaboration	
DC Component or Process*	**Adaptations & Considerations for Participants with COD†**
• Court team • Partnerships *Key Components 3, 6, 9, & 10*	1. Standard principles of collaboration in drug courts are especially important as new team members and stakeholders join in to support participants with co-occurring disorders. 2. Potential mental health partners include the following: ➢ Crisis intervention teams at local law enforcement ➢ Mobile crisis teams ➢ Hospital emergency departments & behavioral health units ➢ Community mental health treatment & psychiatric rehabilitation agencies ➢ Assertive community treatment teams ➢ Behavioral health agencies that offer integrated mental health and substance abuse treatment or residential behavioral health treatment ➢ Supportive housing providers ➢ Advocacy and peer/family support organizations

*DC: drug court †COD: co-occurring disorders

TABLE 3 Keys to Success *(continued)*

Educate Your Team	
DC Component or Process*	**Adaptations & Considerations for Participants with COD†**
• Interdisciplinary education *Key Component 9*	1. Interdisciplinary co-occurring disorders education efforts should include personnel who are not members of the court team, especially people who are often the first points of contact with the justice system for individuals with co-occurring disorders: police officers, jail personnel, and first appearance courtroom staff. 2. Team members should understand: ➢ Signs and symptoms of the most commons co-occurring disorders ➢ Behaviors associated with co-occurring disorders that might bring people into contact with the criminal justice system ➢ Treatments and related services for co-occurring disorders ➢ Common medications, their side effects, & reasons that participants might resist taking them ➢ Principles of trauma-informed care

*DC: drug court †COD: co-occurring disorders

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