Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders

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The National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness May, 2006

Even the highest estimates of co-occurring disorders (COD) in the general population are small compared to COD prevalence in jails and prisons. The factors that contribute to overrepresentation of COD in justice-involved persons include:

- high rates of substance use, abuse, and dependence among persons with mental illnesses (Grant et al., 2004) coupled with increased enforcement of illegal drug use, possession, and/or sales statutes leading to arrest;
- increased application of mandatory minimum sentencing guidelines for drug-related offenses resulting in longer jail and prison periods of incarceration;
- association of COD and homelessness (Drake et al., 1991) and homelessness and incarceration (Michaels et al., 1992) that brings a subset of impoverished persons with COD in contact with the justice system who often become "revolving door" clients; and
- destabilizing effects of two sets of interacting disorders that impair cognition, lead to behavioral disturbances, and result in both the commission of crimes and the inability to avoid arrest and subsequent sentencing.

The History and State of COD Treatment

The history of treatment approaches to persons with COD reflects the division of mental health and substance abuse treatment systems. Separate regulations, financing, provider education, licensing and credentialing, and eligibility for services have existed for decades. Service delivery mirrors the separation in administration and funding. As a result, persons with COD are often barred from service and shuffled between providers, seldom receiving comprehensive screening and assessment, let alone an effective package of integrated services. Compounding the administrative barriers, the stigma, shame, and discrimination experienced by some consumers can prevent them from seeking care.

These factors are reflected in the finding of the National Survey on Drug Use and Health that almost one-half of persons with COD received neither mental health nor substance abuse services in the year preceding the survey (SAMHSA, 2004). For those that do get service, the majority do not receive integrated care, but rather receive treatment within sequential and parallel treatment models (Mueser et al., 2003) that appear to have little positive effect on outcomes (Havassy et al., 2000).

Services Integration for COD as an EBP

Services integration occurs at two distinct levels — integrated treatment and integrated programs. Critical components of integrated programs consist of both structural elements (e.g., multi-disciplinary teams) and treatment elements (e.g., medications), each of which may have its own body of research evidence to support its effectiveness for specific populations to achieve specific outcomes (Mueser et al., 2003). It is not the use of these components that makes a program integrated, but rather the coordination of appropriate components within a single program that determines the degree of program integration.

Integrated treatment occurs at the interface of providers and the persons with COD. It is the application of knowledge, skills, and techniques by providers to comprehensively address both mental health and substance abuse issues in persons with COD. It is not the use of specific treatment techniques that make a treatment integrated, but the selection and blending of these techniques by the provider and the manner in which they are presented to the consumer that defines integration. Ideally, the providers of integrated treatment would have access to all relevant mental health and substance abuse interventions to blend in an individualized treatment plan.

Treatment planning is a collaborative process that requires an individual and his or her service team to consider the assessment information, to establish individual goals, and to specify the means by which treatment can help the individual reach those goals. Treatment for people with dual disorders is more effective if the same clinician or clinical team helps the individual with both substance abuse and mental illness; that way the individual gets one consistent, integrated message about treatment and recovery (SAMHSA, 2003).

Integrated Treatment Programs for Justice-Involved Persons with COD

While coercion is a consideration in the application of all EBPs to justice-involved persons, its role in COD services is critical. Approaches to the effective use of coercive interventions within the context of integrated treatment have been proposed (CSAT, 2005; Mueser et al., 2003). The appropriate application of coercive strategies by providers is one of the adaptations to COD integrated services required to work with justice-involved persons. Ultimately, the challenge for the client will be to move beyond coercion as the external motivating factor for change to other internal and voluntary motivations.

Several program models such as modified therapeutic community, integrated dual disorder treatment, and assertive community treatment have the potential to achieve positive outcomes with justice-involved persons with COD:

- The modified therapeutic community (MTC) is an integrated residential treatment program with a specific focus on public safety outcomes for persons with COD (DeLeon, 1993). It is a derivative of the therapeutic community and has demonstrated lower rates of

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reincarceration and a reduction in criminal activity in MTC participants (Sacks et al., 2004).

- The Integrated Dual Disorder Treatment (IDDT) model combines program components and treatment elements to assure that persons with COD receive integrated treatment for substance abuse and mental illness from the same team of providers (SAMHSA, 2003). While routinely applied to justice-involved persons with COD, the model has not yet been studied for its specific effects on criminal justice outcomes.
- Assertive Community Treatment (ACT) and its adaptations for justice-involved persons has been previously reviewed (Morrissey & Piper, 2005). As an evidence-based program (EBP), ACT is a blend of program components and treatment elements of which several are specific to COD.

COD Across the Continuum of Criminal Justice Settings

It is important to remember that in applying service integration strategies for justice-involved persons with COD, it is necessary to look at both the program modifications that are required within the various points of contact with the justice system, and the unique aspects of linking justice-involved persons from a point of contact to community providers. Tailored responses within police, court, jail, prison, and community corrections contexts are required.

- The earliest point of contact with the justice system is typically at the point of arrest. Innovation in police responses has led to the development of numerous models (Reuland & Cheney, 2005) aimed at reducing the number of persons with mental illness going to jail, improving officer and civilian safety, and increasing the officers understanding of behavioral disorders.
- A growing number of persons with co-occurring mental and substance use disorders appear before the court. It is critical that court staff understands, identifies, and accommodates the court process to the unique features of defendants with co-occurring disorders. For the courts, further efforts are required to establish the relationship between these clinical disorders and the criminal charges.
- Jails and prisons are constitutionally obligated to provide general and mental health care (Cohen, 2003). In fact, incarcerated individuals are the only U.S. citizens with legally protected access to health care. Jails may be the first opportunity for COD problem identification, treatment, and community referral (Peters & Matthews, 2002).
- The inadequacy of discharge or transition planning activities for inmates released from jail and prison have been well documented (Steadman & Veysey, 1997). Clearly the identification of COD within the inmate population is a critical step to release planning and community linkage. For persons without conditions of release, access to integrated services will be at least as difficult as that of other citizens. For people with probation or parole terms, community supervision affords an opportunity to engage and monitor the person with COD in integrated settings.

Future Directions

The majority of care is likely to be delivered in less structured programs and by clinicians who will hopefully embrace the principles of integrated care. As recommended by SAMHSA in the 2002 Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders, sustained attention should be paid to the development of training the workforce and keeping specific clinical competencies in the forefront.

It is important to provide incentives to address COD in the criminal justice system. This can be achieved in part by documenting the high prevalence of COD within justice settings and the consequences, in terms of poor outcomes, of not providing optimal care.

Justice settings should provide routine screening for CODs (Peters & Bartoi, 1997). Law enforcement, court, and corrections personnel should receive training in the application of effective EBPs to respond to the needs of persons with COD. In addition, behavioral health providers should become familiar with the goals and objectives of these criminal justice programs.

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