

INTEGRATING MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES FOR JUSTICE-INVOLVED PERSONS WITH CO-OCCURRING DISORDERS

Fred C. Osher, M.D.

The prevalence of co-occurring mental and addictive disorders (COD) among persons in jails and prisons is exceedingly high (Baillargeon et al., 2009b; James & Glaze, 2006). The factors that contribute to this overrepresentation of persons with COD in justice settings 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 and prosecution;
- the association of COD with homelessness (Drake et al., 1991) and homelessness with incarceration (Michaels et al., 1992), which results in a subset of impoverished persons with COD in frequent contact with the justice system; these people often become “revolving door” clients (Baillargeon et al., 2009a);
- increased criminogenic risk factors with a return to custody (Balyakina et al., 2013, Osher et al., 2012); and
- increased rates of recidivism when released from jail (Wilson et al., 2011) or when on probation (Balyakina et al., 2013) or parole (Baillargeon et al., 2009b).

The History and Status of COD Treatment

The history of treatment approaches for 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 excluded from treatment or 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 accessing (Hoge, 2007) or seeking care.

These factors are reflected in the finding of the National Survey on Drug Use and Health that over one-half of persons with COD received neither mental health nor substance abuse services in the year preceding the survey (SAMHSA, 2010). For those who do get service, the majority do not receive integrated care (Watkins et al., 2001), 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).

Service Integration for COD as an Evidence-based Practice (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 with a single program that determines the degree of program integration. Without integrated treatment separate programs have little capacity to effectively individualize care (Baillargeon et al., 2009b).

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 and effective 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 providers to use assessment information to establish individual goals and to match treatment to identified needs to help the individual reach those goals. Treatment for people with COD 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

When an individual with COD is also under correctional supervision, the coordination of EBPs within each discipline is required to achieve positive outcomes. The appropriate application of coercion within treatment and supervision is one of the adaptations to COD integrated services required to work with justice-involved persons (CSAT, 2005; Mueser et al., 2003). Ultimately, the challenge for the client is to move beyond coercion as the external motivating factor for change to internal and voluntary motivations.

- The modified therapeutic community (MTC) is an integrated residential treatment program with a specific focus on public safety outcomes that can be adapted to treat persons with COD and include a focus on criminogenic needs (Sacks et al., 2003). It is a derivative of the therapeutic community and has demonstrated lower rates of reincarceration and a reduction in criminal activity in participants (Sacks et al., 2012). Successful transition from residential settings to less intensive levels of care is key to long-term success, and adding MTC components to outpatient treatment can improve criminal justice outcomes (Sacks et al., 2008).
- 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). Application of this approach has been associated with reductions in arrest (Mangrum et al., 2006).

- Assertive Community Treatment (ACT) and its adaptations for justice-involved persons has been previously reviewed (Morrissey & Piper, 2005; Morrissey, 2013). As an evidence-based program, ACT is a blend of program components and treatment elements of which several are specific to COD. To date, the impact of ACT interventions on criminal justice outcomes has been mixed. Modifications to ACT to incorporate forensic expertise have shown promise.

COD Across the Continuum of Criminal Justice Settings

Applying service integration strategies for justice-involved persons with COD are possible at each of the unique points of contact with the justice system.

- The earliest point of contact with the justice system is typically local law enforcement. Specialized police-based responses have reduced the number of persons with COD going to jail, improved officer and civilian safety, and increased the officers' understanding of behavioral disorders (Reuland & Cheney, 2005).
- Large numbers of persons with COD appear before the court. Adaptations to drug and mental health court processes are required to address the needs of defendants with COD (Peters et. al., 2012). It is critical that court staff and community providers understand, identify, and expand treatment options and use case management strategies to coordinate treatment and supervision for defendants with COD. (NADCP, 2013).
- 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 to identify CODs, initiate treatment, and develop reentry plans that address individual risks and needs.
- The inadequacy of discharge or transition planning activities for inmates released from jail and prison have been well documented (Steadman & Veysey, 1997; Brad H. v. City of New York, 2003). Early assessment of CODs is critical to planning for risks and needs and the identification of appropriate resources in the community (Osher et. al., 2003). In addition, pre-release engagement

can improve post-release engagement in services (Lehman Held, Brown, Frost, Hickey, & Buck, 2012). For people with probation or parole terms, community supervision affords an opportunity to engage and monitor the person while coordinating with community providers.

Future Directions

The overrepresentation of persons with COD in the justice system is not a new phenomenon, and despite innovative community efforts to divert persons with mental and/or addictive disorders from jail and prison, it remains a significant issue of concern to policymakers, providers, and families. Persons with COD are a heterogeneous group with complex strengths, needs, and risks.

When individuals are taken into custody, they must be routinely screened and assessed for COD (Peters et al., 2008) and other factors associated with their risk of recidivism (Osher et al. 2012). Understanding the extent to which persons with COD have an increased risk of committing new criminal offenses or violating conditions of probation or parole is important for the criminal justice and behavioral health fields. In particular, such information may serve as the basis for the development of targeted interventions to reduce the rate of recidivism among persons with COD.

Law enforcement, court, and corrections personnel must receive training in the application of effective EBPs to respond to the needs of persons with COD. In parallel, behavioral health staffs require training on correctional EBPs and the interventions that are associated with reducing the risk of recidivism while promoting recovery. Access to integrated care for persons with COD has been associated with these desired outcomes. Unfortunately these EBPs are not sufficiently available.

The passage of the Affordable Care and Mental Health Parity and Addiction Parity Acts holds out the promise of increased service access for impoverished individuals with criminal justice histories. Yet we will only be able to reverse the overrepresentation of persons with COD in the justice system if new and existing resources are used to provide the relevant EBPs.

References

- Baillargeon, J., Binswanger, I.A., Penn, J.V., Williams, B.A., & Murray, O.J., (2009a). Psychiatric disorders and repeat incarcerations; the revolving door. *American Journal of Psychiatry*, 166, 103-109.
- Baillargeon, J., Williams, B.A., Mellow, J., Harzke, A.J., Hoge, S.K., Baillargeon, G., Greifinger, R.B. (2009b). Parole revocation among prison inmates with psychiatric and substance use disorders. *Psychiatric Services*, 60 (11), 1516-d1521.
- Balyakina, E., Mann, C., Ellison, M., Sivernell, R., Fulda, K.G., Sarai, S.K, Cardarelli, R. (2013). Risk of future offense among probationers with co-occurring substance use and mental health disorders. *Community Mental Health Journal*, published online: 14 June.
- Brad H. et al. v. The City of New York et al., stipulation of settlement of the Supreme Court of the State of New York (January 8, 2003).
- Center for Substance Abuse Treatment. (2005b). *Substance abuse treatment for adults in the criminal justice system*. Treatment Improvement Protocol (TIP) Series, No. 42. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Cohen F. (2003). *The mentally disordered inmate and the law: 2003 cumulative supplement*. Kingston, NJ: Civic Research Institute.
- Drake R.E., Osher, F.C., & Wallach, M.A. (1991). Homelessness and dual diagnosis. *American Psychologist*, 46 (11), 1149-1158.
- Grant, B.F., Stinson, F.S., Dawson, D.A., Chou, S.P., Dufour, M.C., Compton, W., Pickering, R.P. & Kaplan, D. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry*, 61, 891-896.
- Havassy, B.E., Shopshire, M.S., & Quigley, L.A. (2000). Effects of substance dependence on outcomes of patients in randomized trial of two case management models. *Psychiatric Services*, 51, 639-644.
- Hoge, S. K. (2007). Providing transition and outpatient services to the mentally ill released from correctional institutions. In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities* (pp. 461-477). New York: Springer.

- James, D.J. & Glaze, L.E. (2006). *Mental health problems of prison and jail inmates [Special Report]*. Bureau of Justice Statistics (Publication no. NCJ213600), Washington, DC; US Department of Justice.
- Lehman Held, M., Brown, C. A., Frost, L. E., Hickey, J. S., & Buck, D. S. (2012). Integrated primary and behavioral health care in patient-centered medical homes for jail releases with mental illness. *Criminal Justice and Behavior*. Advance online publication. doi: 10.1177/0093854811433709
- Mangrum, L.F., Spence, R.T., & Lopez, M. (2006). Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment* 30, 79-84.
- Michaels, D., Zoloth, S., Alcabes, P., Braslow, C., & Safyer, S. (1992). Homelessness and indicators of mental illness among inmates in New York City's correctional system. *Hospital and Community Psychiatry*, 43(2):150-155.
- Morrissey, J. P. (2013). *Evidence update: Forensic Assertive Community Treatment*. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation.
- Morrissey, J. & Piper, P. (2005). *Extending ACT to criminal justice settings: Applications, evidence, and options*. Delmar, NY: National GAINS Center.
- Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.
- Osher, F.C., D'Amora, D.A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery. New York: Council of State Governments Justice Center.
- Osher F, Steadman H.J., & Barr, H. (2003). A best practice approach to community reentry from jails for inmates with co-occurring disorders: the APIC model. *Crime and Delinquency*, 49, 79-96.
- Peters, R.H., Bartoi, M.G., & Sherman, P.B. (2008). *Screening and assessment of co-occurring disorders in the justice system*. Delmar, NY: CMHS National GAINS Center.
- Peters, R.H., Kremling, J., Bekman, N.M., & Caudy, M.S. (2012). Co-Occurring disorders in treatment-based courts: Results of a national survey. *Behavioral Sciences and the Law*, 60, 800 – 812.
- Reuland, M. & Cheney, J. (2005). *Enhancing success of police-based diversion programs for people with mental illness*. Delmar, New York: GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.
- Sacks, S., Sacks, J., & Stommel, J. (2003). Modified TC for MICA inmates in correctional setting: A program description. *Corrections Today*, 10, 90 – 99.
- Sacks, S., McKendrick, K., Sacks, J., Banks, S., & Harle, M. (2008). Enhanced outpatient treatment for co-occurring disorders: Main outcomes. *Journal of Substance Abuse Treatment*, 34, 48-60.
- Sacks, S., Chaple, M., Sacks, J., McKendrick, K., & Cleland, C.M. (2012). Randomized trial of a reentry modified therapeutic community for offenders with co-occurring disorders: Crime outcomes. *Journal of Substance Abuse Treatment*, 42, 247 -259.
- Steadman, H. J, Peters, R. H., Carpenter, C., Mueser, K. T., et al. (2013). *Six steps to improve your drug court outcomes for adults with co-occurring disorders*. Drug Court Practitioner Fact Sheet, 8(1), Alexandria, VA: National Drug Court Institute & SAMHSA's GAINS Center for Behavioral Health and Justice Transformation.
- Steadman, H.J. & Veysey, B. (1997). Providing services for jail inmates with mental disorders, National Institute of Justice: *Research in Brief*, January.
- Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental health findings* (Center for Behavioral Health Statistics and Quality, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.
- Watkins, K. E., Burnam, A., Kung, F.-Y., & Paddock, S. (2001). A national survey of care for persons with co-occurring mental and substance use disorders. *Psychiatric Services*, 52, 1062-1068.
- Wilson, A.B., Draine, J., Hadley, T., Mettraux, S., & Evans, A. (2011). Examining the impact of mental illness and substance use on recidivism in a county jail. *International Journal of Law and Psychiatry*, 34, 264-268.