Mental Health

Mental Health (*included in workbook)

1. **Co-occurring Disorders and Specialty Courts* Roger H. Peters and Fred C. Osher. National GAINS Center July 2003
   This document looks at the inevitable inclusion of drug court participants with a mental health diagnosis and offers recommendations for program design modifications to meet their needs.

2. *The Essential Elements of a Mental Health Court* (2nd ed. draft) Council of State Governments. April 2005
   This publication looks at this emerging number of mental health courts across the country and shows the similarities in design. It identifies ten essential elements of a mental health court.

3. *A Guide to Mental Health Court Design and Implementation* Council of State Governments. May 2005
   This comprehensive publication defines mental health courts and offers specific recommendations for program planning and implementation.

4. **Rethinking the Revolving Door: A Look at Mental Illness in the Courts.* Denckla, D. and Berman, G. Center for Court Innovation. 2001
   This document defines the mental health court model and raises issues to be addressed by the planning team.

5. *Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?* Roger H. Peters and Holly A. Hills. National GAINS Center 2003
   Covering a range of important topics related to serving individuals with a mental health diagnosis, this publication discusses best practices that can applied in a mental health court.

6. *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage* Goldkamp, John and Cheryl Irons-Guynn Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. 2000
   An overview of select mental health courts.

7. *The Use of Criminal Charges and Sanctions in Mental Health Courts* Griffin, Patricia, Henry J. Steadman, and John Petrila Psychiatric Services 53: 1285–1289. 2002
   This publication documents a study of three mental health courts and the application of sanctions. It can provide insight for mental health courts that are addressing the need for specialized approaches to responding to client non-compliance.

8. *Mental Health Courts Program* Council of State Governments 2003
This is a two-page brochure that provides a brief but informational look at mental health courts.

9. *Mental Health Courts: A National Snapshot* Council of State Governments 2005
This brochure offers some information about the state of mental health courts in the United States, and provides a resource list specifically for this type of collaborative justice program.

10. *Family Members: A Key Component of the Mental Health Court Team* Family Justice. Carol Shapiro June 2005
A useful guide designed to highlight the importance of including and involving participants' family members in the program process.

11. *Navigating the Mental Health Maze: A Guide for Court Practitioners.* Fred C. Osher and Irene S. Levine. Council of State Governments May 2005
This publication provides a comprehensive overview of the mental health care system for non-clinicians. It can become part of the initial and on-going cross training necessary for mental health professionals and court personnel to work together effectively.

12. *A Guide to Collecting Mental Health Court Outcome Data.* Henry J. Steadman. Council of State Governments May 2005
A practical guide to developing a data collection plan.

13. *The Special Needs of Women with Co-occurring Disorders Diverted from the Criminal Judicial System* Holly A. Hills. National GAINS Center. July 2003
This publication addresses the unique needs of women with mental health diagnoses and offers recommendations for effective service delivery.

14. *Mental Health Courts Satellite Broadcast, November 14, 2002
Broadcast materials and additional resources

15. *Psychopharmacology, Jeff Gould, M.D.
Materials from Mental Health Courts Satellite Broadcast, November 14, 2002

Co-Occurring Disorders and Specialty Courts

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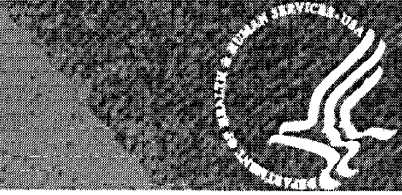

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Co-Occurring Disorders and Specialty Courts

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Abstract

A growing number of persons with co-occurring mental and substance use disorders are involved in the criminal justice system, with an associated rise in the number of these individuals appearing before the court. Increasingly, "problem-solving courts" or "specialty courts" (e.g., drug courts, mental health courts, domestic violence courts, community courts, re-entry courts) have been implemented to move beyond case processing to address the underlying issues that brought the defendant to court in the first place. In linking participants with co-occurring disorders to treatment alternatives, judges are testing the ways in which the specialty courts can serve as a therapeutic agent. This source document is intended to provide specialty court staff an overview of the characteristics and needs of individuals with co-occurring disorders, as well as to describe best practices associated with positive outcomes both in treatment settings and the court.

Background

A growing number of persons with co-occurring mental and substance use disorders are involved in the criminal justice system, with an associated increase in the number of these individuals appearing before the court. In most cases, the co-occurring disorders either directly resulted in their arrest (e.g., drug possession or sales) or contributed to it (e.g., severe disability, homelessness).

Mental disorders include DSM IV Axis I disorders (e.g., major depressive disorder, bipolar disorder, schizophrenia) that are often accompanied by one or more Axis II (personality) disorders. Substance abuse refers to substance use disorders, both abuse of and dependence on psychoactive substances, including alcohol. It is critical that court staff understands, identifies, and accommodates the court process to the unique features of defendants with co-occurring disorders. The effective handling of individuals with co-occurring disorders will improve both public safety and public health outcomes.

Research provides compelling reasons for the importance of this issue. On any given day, there are over two million adults in U.S. jails and prisons, and the cost of housing these inmates exceeds $40 billion per year (Justice Policy Institute, 2000). Persons with mental illnesses are arrested at disproportionately higher rates than persons without such disorders (Lamb & Weinberger, 1998). Over 11 million adults are booked into U.S. jails each year (Stephen, 2001). The prevalence of serious mental illness (SMI) among jail inmates is estimated at over 7 percent (Steadman et al., 1999), which is two to three times higher than rates found in the general population (Lamb & Weinberger, 1998). The majority of these individuals—approximately 75 percent—have co-occurring substance use disorders (National GAINS Center, 2001).

Traditionally, cases involving persons with co-occurring disorders in court settings have included competency evaluations, pleas of "not guilty by reason of insanity," and "guilty but mentally ill." These outcomes are employed in a relatively few cases. Increasingly, "problem-solving courts" or "specialty courts" (e.g., drug courts, mental health courts, domestic violence courts, community courts, re-entry courts) have been implemented to move beyond case processing to address the underlying issues that brought the defendant to court in the first place. In linking participants with co-occurring disorders to treatment alternatives, judges are testing the ways in which the specialty courts can serve as a therapeutic agent. Individuals

Persons with mental illnesses are arrested at disproportionately higher rates than persons without such disorders.

The majority of these individuals—approximately 75 percent—have co-occurring substance use disorders.

with co-occurring mental and substance use disorders pose unique challenges for specialty courts, in particular, as these courts must develop their own strategies for addressing public safety while engaging participants in programs outside of jail. For example, drug court judges have found that participants with co-occurring disorders are harder to place in treatment than other participants (Denckla & Berman, 2001).

This source document is intended to provide specialty court staff an overview of the characteristics and needs of individuals with co-occurring disorders, as well as to describe best practices associated with positive outcomes both in treatment settings and the court. Section 1 of the document will highlight the potential negative outcomes associated with co-occurring disorders, the need for screening and assessment, the heterogeneity of the population, evidence-based practices and treatment principles associated with positive outcomes, barriers to service delivery, and implications for specialty court programs addressing the needs of participants with co-occurring disorders. Subsequent sections will address: (1) eligibility considerations for specialty courts; (2) evidence-based treatment and management approaches and related "principles of care"; (3) modified services that should be provided by all specialty court programs; and (4) enhancements to treatment, judicial and supervision strategies for specialty court participants with co-occurring disorders.

Specialty courts must develop their own strategies for addressing public safety while engaging participants in programs outside of jail.

Overview of Clinical Issues

The mental health and substance abuse fields have had a growing awareness of the prevalence of co-occurring disorders and the challenges presented by this population. The lack of success within traditional treatment settings for individuals with co-occurring disorders is well documented and has stimulated innovative and specialized service approaches. Despite increasing evidence that outcomes for persons with co-occurring mental and substance use disorders improve when care is provided in a comprehensive and integrated fashion (Drake et al., 2001; Drake et al., 1998), access to effective service remains elusive to most individuals with these conditions (U.S. DHHS, 1999). It is estimated that up to 10 million people in the United States meet criteria for co-occurring disorders in any given year (CMHS, 1997). Without adequate treatment we can predict a continuation of significant disability, poor adjustment, suboptimal quality of life, and increased court appearances among persons with co-occurring disorders (Osher & Kofoed, 1989).

Clinicians, health care administrators, families, and consumers articulate a sense of frustration that not enough is being done to address the needs of persons with co-occurring disorders. More recently judges and court advocates have shared concerns that new court processing approaches are required. These groups witness the way these individuals cycle in and out of costly and inappropriate treatment settings, such as emergency rooms and jails, and are consistently over-represented in surveys of homeless populations. Many of these individuals become the "revolving-door" defendants within the court.

Negative Outcomes

Substance abuse among persons with mental illness has been associated with negative outcomes including increased vulnerability to relapse and rehospitalization (Caton et. al, 1993; Haywood et al., 1995; Seibel et al., 1993); more psychotic symptoms (Carey et al.; 1991; Drake et al., 1989; Osher et al., 1994); greater depression and suicidality (Bartels et al., 1992); violence (Cuffel et al., 1994); incarceration (Abram & Teplin, 1991; Bureau of Justice Statistics, 1999); inability to manage finances and daily needs (Drake & Wallach, 1989); housing instability and homelessness (Caton et al., 1994; Drake & Wallach, 1989; Osher et al., 1994); noncompliance with medications and other treatments (Drake et al., 1989; Owen et al., 1996); increased risk behavior and vulnerability to HIV infection (Cournos & McKinnon, 1997; Cournos et al., 1991) and hepatitis (Rosenberg et al., 2000); lower satisfaction with familial relationships (Dixon et al., 1995); increased family burden (Clark, 1994); and higher service utilization and costs (Bartels et al., 1993; Dickey & Azeni, 1996).

Negative outcomes associated with co-occurring disorders may include:

- *relapse and hospitalization*
- *increase in psychotic symptoms*
- *greater depression and suicidality*
- *episodic violence*
- *contact with the criminal justice system*
- *diminished functioning*
- *housing instability/ homelessness*
- *noncompliance with medication and treatment*
- *increased risk behavior and vulnerability to HIV/ hepatitis infection*
- *familial disfunction/strain*
- *increased service utilization/costs*

The Relationship Between Substance Use and Mental Disorders and the Role of Assessment

It is important to recognize the complex interaction of substance use and psychiatric disorders. Sorting out the interaction is a sophisticated assessment task that may lead to classification as outlined by Lehman et al. (1989) in which six possible relationships were identified:

1. **Acute and chronic substance abuse may produce psychiatric symptoms.** Smoking a stimulant such

as crack cocaine will cause paranoid symptoms in a significant percentage of users. Prolonged alcohol use and its negative effects on sleep and nutrition can produce profound depressive symptoms.

2. **Substance withdrawal can cause psychiatric symptoms.** A person who is physically dependant on heroin will demonstrate extreme anxiety if they lose access to the drug for over a day.

3. **Substance use can mask psychiatric symptoms.** A person with social anxiety and an inability to interact with others, might be capable of completing a job interview after using minor tranquilizers.

4. **Psychiatric disorders can mimic symptoms associated with substance use.** A college student with schizophrenia may have hallucinations that seem similar to those of their friends who use LSD.

5. **Acute and chronic substance abuse can exacerbate psychiatric disorders.** A person with schizophrenia who regularly smokes marijuana may not get relief from auditory hallucinations despite taking medication.

6. **Acute and chronic psychiatric disorders can exacerbate the recovery process from substance use disorders.** A person with cocaine addiction and depression may not be able to get to treatment/ support groups or understand the lessons being taught.

In this classification scheme, the first two relationships do not qualify as co-occurring disorders but will require substance abuse interventions. These are individuals for whom abstinence will allow for an elimination of psychiatric symptoms. The third and fourth relationships do not represent bona fide examples of co-occurring disorders either. Individuals with psychiatric illnesses can be effectively treated with existing forms of mental health treatment. It is only the last two categories that qualify as co-occurring disorders. Persons within these categories require integrated treatment strategies. Accurate classification of persons with co-occurring disorders is somewhat difficult, especially at, or near, the time of arrest. In many cases, the most effective strategy is to assume that co-occurring disorders exist. In clinical terms, this approach is often represented as a notation to "rule/out" the co-occurring condition.

The interaction of substance use and psychiatric disorders is complex ... two reciprocal relationships qualify as co-occurring disorders:

- *Acute and chronic substance abuse can exacerbate psychiatric disorders.*
- *Acute and chronic psychiatric disorders can exacerbate the recovery process from substance use disorders.*

For the courts, further efforts are required to establish the relationship between these clinical disorders and the criminal charges.

- Did these conditions affect the defendants understanding of the crime?
- Did the conditions influence the commission of the crime?
- Do these conditions affect the defendant's capacity to participate in their own defense?

Determining the nature of the relationship between substance use, mental illness, and abnormalities in mood, thinking, and behavior is a complex, yet critical, task. It is predicated on the expectation that clinicians, supervision staff, or court personnel actively search for the relationship. This is not a routine practice in most behavioral health treatment settings or in pre-trial evaluation services. Specialized staff available to the court for assessment purposes must be familiar with the interactions between mental and substance use disorders.

Heterogeneity of the Population with Co-Occurring Disorders

Court orders and treatment planning require an accurate description of the problems to be addressed. Despite considerable progress in assessment tools and strategies, the identification and characterization of persons with co-occurring disorders remains a difficult task (Lehman et al., 1996). While the assessment process is complex and can be protracted, the identification of individuals with co-occurring disorders is simply a preliminary step in designing an appropriate response to their needs. Having determined that the defendant has two simultaneous, interacting conditions–a mental illness and a substance use disorder–does not allow a simple template or formula for court processing. It is critical that the *heterogeneity* of the population be acknowledged. Some defendants will have thought disorders like schizophrenia, while others will have mood disorders such as major depression or bipolar disorder. Their treatment and court needs will be very different. Any substance of abuse can be combined with any mental disorder to meet criteria under the umbrella term of co-occurring disorder. These two dimensions–mental illness and substance abuse–can be crossed with any set of demographic variables (age, gender, and/or culture) to create additional subgroups with special needs. Add the frequent presence of other medical co-morbidities, and the classification of co-occurring disorders gains additional complexity. Lastly, the nature of the crime and criminal history will vary substantially. These interacting variables underline the importance of the adage: *if you've seen one person with co-occurring disorders, you've seen one person with co-occurring disorders.*

For clinical and organizational purposes, the separation of persons with co-occurring disorders into subgroups based solely on diagnosis or demographics will not lead to effective matching to treatment and supervision services. Arguably the most important dimension to consider is the degree of disfunction the two disorders produce in an individual. One useful model was developed in New York and endorsed by both the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors (NASMHPD & NASADAD, 1999). (See Figure 1.)

Rather than focus on diagnoses, the model uses two dimensions–the severity of the mental illness and the severity of the substance abuse problem–to define four sub-groups of individuals with co-occurring disorders in a two-by-two matrix. The advantages of this model are that it encompasses the heterogeneity of the population with co-occurring disorders, it assigns responsibility for providing some degree of care to these individuals to every system, and it is flexible enough to be adapted to most service settings. Significant overlap between systems is inherent in the model, and it more realistically corresponds to the multiple pathways used by persons with co-occurring disorders to access care. With this conceptual framework, court personnel do not need to be as facile with technical behavioral health terms nor understand subtle differences in differential diagnostics. These differences in severity are important in deciding conditions of release as is discussed later in this document.

Using this type of organizational model, individuals who are assessed as having high severity of mental

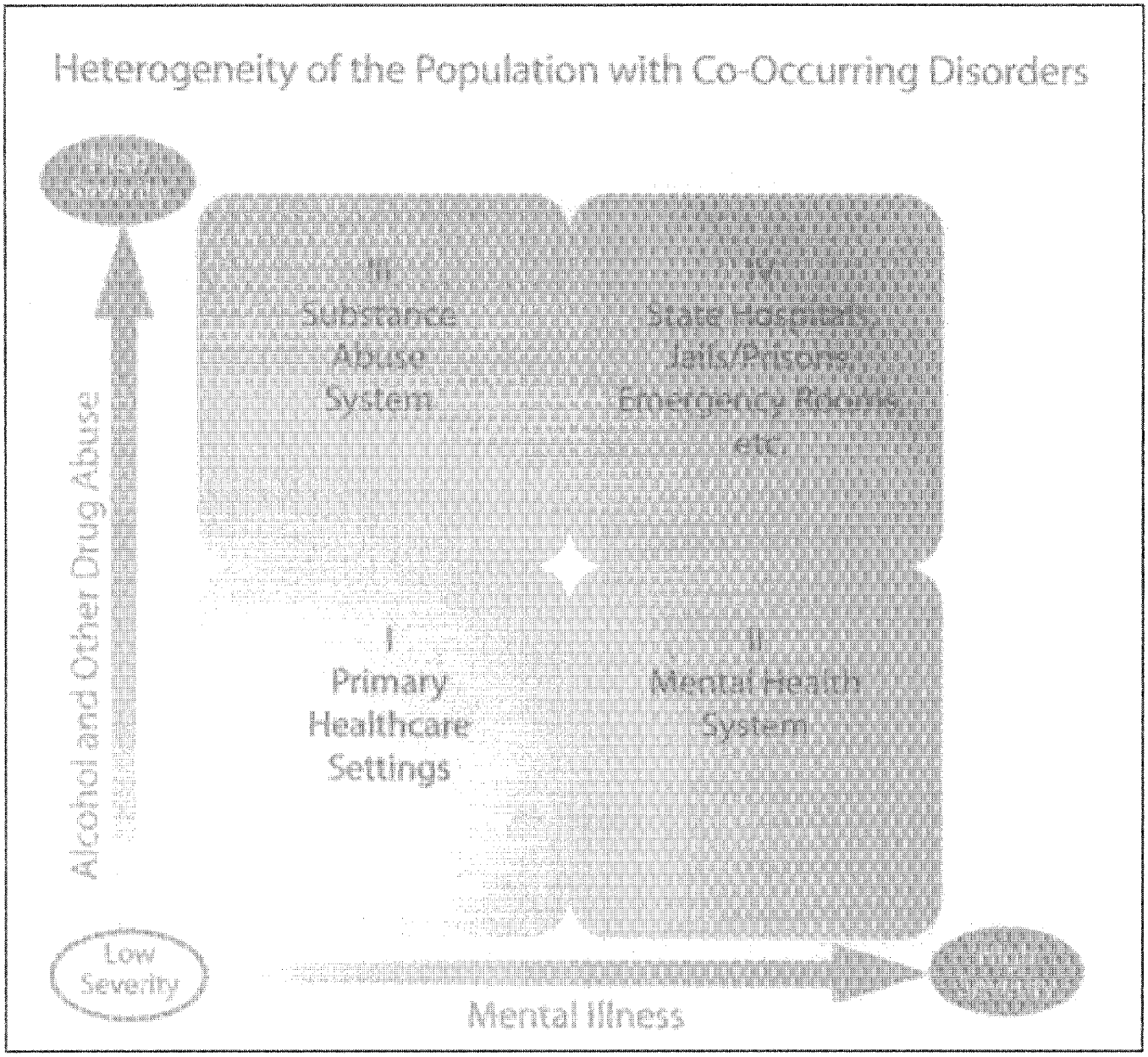

Figure 1.

health problems and low substance abuse problems may be most productively placed in mental health court programs or similar diversion programs. Individuals who have high severity of substance abuse problems and low mental health problems may be matched most effectively to drug court programs. Individuals who have high severity of both co-occurring disorders would be good candidates for specialized court-supervised co-occurring disorder treatment programs, or enhancement of existing specialty court programs to create unique "tracks" or components that address co-occurring disorders. Individuals who have low severity of both co-occurring disorders may be best suited for traditional diversion programs that do not include intensive treatment programming. This treatment matching approach assumes that individuals assessed for treatment have low public safety risk, and meet other program eligibility criteria.

Section 2

Specialty Courts and Individuals with Co-Occurring Disorders

Overview of Court Issues Courts will need to determine which defendants are eligible for specialty services. Specialty courts have sometimes attempted to screen out individuals with co-occurring mental disorders during the admission process. For example, in some drug courts, participants have been discharged due to their use of psychotropic medication, and several of the more recently developed mental health courts have indicated a reluctance to provide services to defendants with severe substance abuse problems. However, most specialty courts have successfully involved participants with both mental and substance use disorders, and have adapted relationships with community behavioral health agencies to accommodate participants' broad range of need. Even in programs that attempt to exclude individuals with co-occurring disorders, there are many successful graduates with co-occurring disorders who were not detected at the time of admission.

Specialty courts have sometimes attempted to screen out individuals with co-occurring mental disorders during the admission process.

Clearly, some participants with co-occurring disorders may not ultimately complete the specialty court program, just as many other problems (e.g., health conditions, housing, employment, transportation) experienced by participants may interfere with, or slow their progress in the program. Specialty courts can anticipate a pattern of variability in functioning and symptom severity among many participants with co-occurring disorders and need to adapt a flexible approach in working with these individuals. Some programs may not have the resources to work effectively with participants who have co-occurring disorders, and may choose not to work with this population. However, exclusion of these individuals is clearly not a satisfactory solution. Given the high frequency of co-occurring disorders among criminal defendants, this approach would exclude a large number of potential specialty court participants, and would deprive those with the greatest needs from receiving effective services.

Specialty courts should not restrict admission solely on the basis of co-occurring disorders, past mental health or substance abuse diagnoses, or a history of treatment for behavioral disorders, but should instead consider the degree to which these disorders lead to functional impairment that inhibits effective program participation (see Figure 1). In many cases, the precise nature and effects of functional impairment (e.g., difficulties in attention/concentration) are difficult to gauge until an individual is placed in a specialty court treatment setting and it can be determined how they respond to staff

directives, group treatment experiences, and supports that are provided by the program. Separate specialty court tracks for persons with co-occurring disorders may not be required unless participants exhibit significant impairment in psychological or social functioning. The symptom picture and functioning level of specialty court participants who have mental disorders can be expected to change over time and is influenced by use of medication, stress at home or work, and use of drugs and alcohol. Specialty court staff should follow-up on any observations of even small changes in mental health symptoms or functioning level to determine if there are issues related to treatment and supervision that need to be addressed.

Five Critical Domains that Affect Specialty Court Participation

Severity of Mental Illness The severity and associated level of psychosocial impairment of mental disorders varies significantly across individuals. Those seen in specialty courts vary between having few strengths and major mental health symptoms to being self-sufficient with few mental health symptoms. Specialty court programs should carefully assess the level of severity of mental disorders and areas of functioning that are affected, in addition to the mental health diagnosis.

Evidence of delusions, hallucinations, or paranoia may make it difficult for the individual to participate in certain types of treatment (e.g., group counseling), although other approaches (e.g., individual counseling) may be available to address these mental health needs. It is particularly important to identify periods of relatively high functioning and to assess whether adherence to prescribed medications, involvement in structured treatment programs, social and family supports, or other factors contributed to these outcomes.

The impact of substance abuse on mental disorders should be examined to determine if these disorders improve substantially during periods of abstinence. Recovery potential related to mental disorders should also be assessed. Specialized training related to co-occurring disorders and reduced staff caseloads should be considered, particularly when there are a significant number of participants who have major mental disorders and who have personality disorders.

Critical Domains that Affect Specialty Court Participation:

- *Severity of mental illness*
- *Severity of substance use disorder*
- *Severity of criminal charges and criminal history*
- *Motivation for recovery and stages of change*
- *Program resources*

Mental Health Indicators that Affect Specialty Court Participation

Key *mental health indicators* that suggest potential difficulties in traditional community treatment (Peters & Hills, 1997) such as specialty court programs, include the following:

- Delusions, hallucinations, severe depression, paranoia, or mania (i.e., hyperactivity and agitation) that occurs frequently, is obvious to others, is disruptive to status hearings or group treatment activities, or that otherwise prevents constructive interaction with specialty court staff or participants. Many participants with unusual thoughts and odd or eccentric behaviors can be tolerated within specialty court programs and may be responsive to community treatment. In order to manage these persons effectively, it is often useful to provide staff training and education to specialty court participants regarding the nature and cause of mental health symptoms.
- A historical lack of stabilization on psychotropic medication, or failure to adhere to medication. It is important to note that use of medications is not a violation of abstinence policies and does not conflict with other principles of substance abuse treatment. Orders that improve treatment compliance may be sufficient to allow for participation in court ordered programs.
- Presence of suicidal thoughts or other dangerous behavior.
- Inability to handle stress in group treatment settings.
- Impaired cognitive functioning. This includes difficulties in attention, concentration, memory, and abstract thinking that impair an individual's ability to communicate his or her needs and understand treatment-related materials.
- Inability to interact effectively with specialty court staff without excessive anxiety, agitation, or aggressive behavior. In some cases, anxiety and agitation can result from withdrawal from alcohol, cocaine, methamphetamine, or other drugs.
- The presence of a co-occurring personality disorder. A significant number of individuals with substance abuse problems have an Axis II (personality) disorder, and may be noncompliant with program directives or guidelines. Personality disorders that may be particularly problematic in specialty courts include Borderline Personality Disorder with associated suicidal and manipulative behaviors, and Antisocial Personality Disorder with associated features of psychopathy such as callousness towards others and inability to develop reciprocal interpersonal relationships.

critical domain

Severity of Substance Abuse Disorder

Even small to moderate levels of alcohol and drug use can produce significant difficulties–including enhanced stress, return of major mental health symptoms, loss of housing and social supports, and unemployment–for specialty court participants who have mental disorders. It is particularly problematic in specialty courts when these individuals are unable to achieve sustained abstinence from drugs or alcohol, even when involved in progressively more intensive treatment services. For some individuals who do not have a history of sustained abstinence, more intensive services (e.g., residential treatment) may be needed prior to placement in a specialty court program. Specialty court programs should examine the severity of substance abuse problems, and determine whether current use patterns are aggravating mental health problems. Assessment should also consider whether use of psychotropic medications (e.g., antidepressants, mood stabilizers, anti-psychotic medications)

concurrently with alcohol or illicit drug use present a threat to the participant's physical well-being.

The general recovery potential related to substance use disorders should be considered in reviewing admissions to specialty court programs. Factors such as the level of family and peer support, stable housing, medication adherence, and availability of crisis services and other ancillary mental health services should be considered in this process.

Participants who have co-occurring disorders may not be fully aware of the interdependent nature of their mental health and substance abuse problems, and even with this knowledge, may not be motivated to make lifestyle changes related to their substance abuse. Treatment options other than specialty courts may be needed for those individuals who are unable or unwilling to reduce their substance abuse in light of adverse health consequences.

critical domain

Severity of Criminal Charges and Criminal History Criminal history and current charges are key factors in determining eligibility for specialty courts, and may also affect the conditions of community release and supervision. Most programs do not accept participants who have a history of violent offenses or multiple prior felonies. The elaboration of this domain is beyond the scope of this monograph and is best handled by court personnel. Additional information regarding this domain and related screening and assessment approaches is available in a monograph published by the U.S. Department of Justice (Peters & Peyton, 1998).

critical domain

Motivation for Recovery and Stages of Change Initially, motivation for involvement in specialty court services is typically low for persons with co-occurring disorders; it may vary considerably over time. Substance abuse issues may not be perceived as significant problems, given the range of other problems (e.g., homelessness, HIV/AIDS, unemployment) that may be present. The nature and severity of the mental illness may be disputed. Individuals with co-occurring disorders may need different sets of incentives to engage them in specialty court services. These may include low-cost housing, food assistance, and vocational training opportunities. Often the most important and powerful incentives are not obvious and need to be explored with the specialty court participant.

The motivation level of participants with co-occurring disorders can be expected to fluctuate considerably over time. This fluctuation is normal for clients in both mental health and substance abuse programs, and is particularly evident among individuals who have substance use disorders and who are faced with giving up their drug(s) "of choice" and making major lifestyle changes (e.g., related to peers, jobs, and old habits).

Individuals progress through various "stages of change" as they enter and move through recovery from co-occurring disorders. Most new specialty court participants will be in very early stages of motivation for treatment, in which they are unconvinced that they have a problem and may be thinking about changes without taking any major action. As they progress through treatment (often over the course of several years), specialty court participants are likely to develop greater internal motivation for treatment, as indicated by their recognition of the need to make lifestyle change and to take steps towards recovery goals.

In early stages of recovery, key tasks of specialty court staff will include engagement of participants in a working relationship and persuasion to help the participant view co-occurring disorders as problems that should be worked on, and that they have a reasonable chance of overcoming. Staff often misattribute participants' behavior in early stages of recovery as "resistance" and "denial," when in fact their ambivalence is a normal consequence of facing uncertainties related to making major behavioral and lifestyle change.

A variety of brief screening approaches are available to identify levels of participant motivation and commitment related to treatment. Specialized treatment interventions such as Motivational Interviewing (MI) and the related Motivational Enhancement Therapy (MET) are also available to help engage participants in

specialty court programs, and described in more detail later in this document.

critical domain

Ancillary Program Resources and Other Relevant Domains The availability of additional resources will affect whether individuals with co-occurring disorders can participate effectively in specialty courts:

- Access to psychiatric consultation and medications
- Access to other mental health services
- Detoxification services
- Outreach and crisis services
- Case management

Other factors may affect an individual's ability to participate effectively in specialty court:

- the willingness of family to participate in community follow-up
- need for child care
- physical health
- access to transportation and
- stable living situations.

Guidelines for Specialty Court Programs

The following general guidelines should be considered regarding *specialty court programs* for individuals with co-occurring disorders:

- Specialty courts should strive to be inclusive in admitting individuals with co-occurring disorders and other potentially disabling conditions (e.g., physical handicaps). Many individuals with mental health and substance abuse problems have successfully participated in specialty courts in the past, including a significant number in drug courts who were not diagnosed with mental disorders until after admission to these programs.
- A mission statement should be developed that describes how the specialty court intends to deal with mental health and substance abuse issues and related confidentiality concerns.
- Each specialty court program should evaluate its capacity to work with individuals who have co-occurring mental disorders. This should include identification of the number of program participants who have mental disorders, the type of disorders, and the level of functional capacity of these participants. Courts should examine existing program resources and procedures for participants who have mental disorders and whether mental health screening/assessment is being conducted. Courts should ascertain which other community mental health and specialized co-occurring disorder services are available for referral, review which requirements of the specialty court program may create special hardships for those with mental disorders, and clarify the levels of functioning needed to participate effectively in the specialty court program.
- To the extent possible, each previously described "critical domain" should be assessed to determine the functional status and risk level of candidates considered for placement in specialty courts.
- Programs should prioritize how to use existing resources to address participants who have co-occurring mental disorders.
- Partnerships should be established with family members and other care providers to assist in developing treatment plans and in coordinating services related to housing, transportation, child care, financial support, and involvement in treatment.

Section 3

Evidence-Based Practices and Principles of Care

Evidence-Based Practices: Services with demonstrated positive outcomes in multiple research studies are called "evidence-based practices." Mental health and substance abuse research has demonstrated that "treatment works." However, this is not true of all treatments as delivered by all providers. Given the high prevalence rates and negative outcomes associated with co-occurring disorders, the identification of effective interventions has gained both immediacy and a growing database. For the past 15 years, extensive efforts have been made to develop integrated models of care that bring together mental health and substance abuse treatment. Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help persons with co-occurring disorders reduce substance use and attain remission (Drake et al., 1998). Positive outcomes associated with integrated approaches include a reduction in hospital utilization, psychiatric symptomatology, substance use, and other problematic negative outcomes.

Other evidence-based practices have been identified for persons with serious mental illnesses. These include

- pharmacologic treatment
- illness self-management and recovery skills
- supported employment
- family psychoeducation and
- Assertive Community Treatment.

Most states face revenue shortages and are having to make critical decision about the allocation of scarce resources. So too, courts are finding community systems with diminished capacity to take on new clients. It is incumbent on decision-makers to ensure that available resources are spent in a way likely to achieve the desired outcomes. As key decision-makers, judges and other court personnel should be engaged in the process of building and sustaining resources for specialty courts.

Toward the goal of effective resource management, it is useful to understand what research has proved to work and to ensure, at a minimum, that these services are available to specialty court participants. This research base has allowed the development of treatment principles associated with positive outcomes for the general population with co-occurring disorders. On a cautionary

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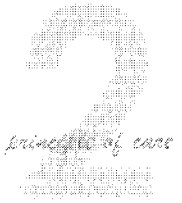
note, the generalization of these principles to court-involved populations has not been fully established.

Ten Principles of Care: While historically mental health and substance abuse treatment approaches have been somewhat different, principles of care within the two fields converge on respect for the individual, reaching out to engage those who cannot yet trust, and the importance of community, family, and peers to recovery. These principles emerge from research and practice experience in providing services to persons with co-occurring disorders. They serve to bridge the gap between the service orientations and characterize an effective system of care for persons with co-occurring disorders. They can be used for both planning court orders and evaluating the quality of community providers.

Integration An integrated conceptual framework is needed to design an effective service system for persons with co-occurring disorders. For example, the court should recognize, and treatment should address, the interwoven nature of the disorders. This can be achieved by implementing the following procedures:

- Develop a common language for describing the target population;
- Develop a common methodology for describing categories of integrated services in the system based on the severity of disability;
- Assure that each disorder receives specific and appropriately intensive primary treatment that takes into account the complications resulting from the co-occurring disorders; and
- Identify a primary clinician, or team of practitioners, for each individual who has the responsibility of coordinating ongoing treatment interventions for both disorders.

While no specific model should assume to be generalizable across systems, the common goal should be for individuals with co-occurring disorders to get their needs comprehensively addressed within one setting, by one set of providers. Successful integrated efforts reduce conflicts between providers, eliminate administrative barriers to care, and assist the consumer by providing a consistent message about recovery principles (Minkoff, 1989).



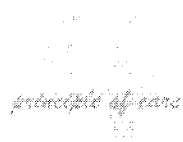
Individualized Planning Any psychiatric disorder with any substance use disorder may occur in any person, regardless of age, gender, or socio-economic status. Effective responses must be tailored to the needs of the specialty court participant, instead of participants needing to fit the specifications of the program. Integrated continuous treatment relationships should be developed to support the participant with a balance of appropriate case management and care. The system should be created utilizing existing services and programs as much as possible, with matching of program to individual needs. Specialty courts should develop an implementation plan that identifies priorities for and barriers to change, and that recommends strategies to overcome barriers. This plan should be derived from:

- Identification of existing services for persons with co-occurring disorders and specification of the role of those services in the court orders;
- Identification of significant gaps in existing services that require new services, programs, and/or funding to address those gaps;
- Development of a process to modify conditions, procedures, regulations, or laws in order to create flexible programs; and
- Creation of an infrastructure empowered to oversee and direct the implementation process.

Assertiveness Successful programs recognize that co-occurring disorders are an expectation and not an exception. As such, efforts by specialty courts to assess and incorporate clinical conditions into treatment and release planning are

expected. It is often necessary to provide outreach services to engage individuals in treatment and assure compliance with release plans. Successful community programs use active interventions, such as mobile treatment so that "going wherever the client is" shapes the nature of the counseling relationship.

Intensive case management gives caseworkers smaller caseloads needed to devote considerable time to working with each client. One evidence-based program useful in work with the most disabled individuals is Assertive Community Treatment. This is ideally suited to addressing needs of homeless persons with co-occurring disorders. If available, this is likely to be a limited resource in most communities.



Close Monitoring This principle of care is well suited to court-based interventions where monitoring can be built in to conditions of supervision. Close monitoring refers to intensive supervision, usually with the participants' consent, but sometimes involuntarily, that follows compliance with treatment and court orders. Monitoring may already be a part of the participants' daily routine. For example, when accessing public entitlements, participants with substance-related disability payments might be required to have a representative payee. This person receives the monthly disability payment and helps the individual manage his or her funds to ensure that important bills (e.g., rent) are prioritized. Drug tests can be mandated and supervised by staff. Protocols for drug testing are in widespread use by drug courts throughout the country. While participants often express ambivalence or disdain about monitoring in the beginning, as they recover from substance abuse, they typically need less supervision.

Longitudinal Perspective Co-occurring disorders can be chronic conditions characterized by slips and relapse. The language of substance abuse treatment refers to "recovering," not "recovered" to convey the long-term process. Effective treatment occurs continuously over years and progress can be measured over that time. The court must determine what part it plays in this longitudinal course. Some would argue that conditions of release or probation sentences should not be in excess of what typical sanctions for defendants withouth mental illness would be. If the court can play a role in effectively linking participants to quality programs, it may well

Effective treatment occurs continuously over years and . . . the court must determine [its role] in this longitudinal course.

be necessary for this treatment relationship to continue after the court monitoring has ended.

Staged Interventions Persons with co-occurring disorders are typically in various stages of recovery with different levels of, and capacity for, motivation. Effective programs assess individuals with co-occurring disorders and design interventions for their stages in recovery. Osher & Kofoed (1987) provide a model with four stages of treatment:

- engagement
- persuasion
- active treatment
- relapse prevention.

Engagement is the process of forming a trusting relationship with the client. *Persuasion* is the process of helping the client develop motivation to participate in recovery-oriented programs. *Active treatment* provides skills training and other services that are necessary to achieve abstinence and medication compliance. *Relapse prevention* provides a set of strategies for maintaining recovery. Other models of treatment evaluate the individual's motivation for change and gear interventions to the assessed stage of change. Specialty courts can play an important role in motivating participants to engage in treatment, although long-term changes in motivation will need to be internalized.

Harm Reduction Harm reduction is a philosophy derived from clinical experience. It is based on the assumption that behaviors exist on a continuum—for example, that substance use runs from abstinence through problematic use to abuse and dependence. Central to this approach to care is a belief that if the quantity, frequency, or type of use is reduced, the likelihood of negative consequences will go down.

Harm reduction provides an alternative to the traditional "abstinence only" philosophies and is more likely to engage persons who at the onset cannot embrace abstinence, or the use of medication, as a goal. Harm reduction is the theoretical underpinning to needle exchange programs that use the delivery of clean intravenous equipment as an opportunity to engage the substance abuser in alternative behavior.

Specialty courts can play an important role in motivating participants to engage in treatment, although long-term changes in motivation will need to be internalized.

principle of care

Stable Living Situation To address the needs of persons with co-occurring disorders, it is necessary to confront the affordable housing crisis in the United States. It is estimated that 15–20 percent of the homeless population has co-occurring disorders. Homeless persons are very visible in our communities, and are arrested frequently for vagrancy, panhandling, loitering, and public intoxication. "Mercy bookings" by law enforcement bring homeless persons to the shelter of jail when winter temperatures might otherwise kill them. Participants' homelessness will make any specialty court intervention very difficult to implement.

The absence of reliable transportation is also an important issue for many specialty court participants with co-occurring disorders and may prevent regular participation in treatment and court activities. Successful efforts to provide housing and to divert individuals who have co-occurring disorders from jails and prisons will require the participation and coordination of representatives from mental health and substance abuse administrators, criminal justice officials, and family and consumer advocates. Coordinated and integrated programs have been found to enhance continuity of care, improve clinical outcomes, and to reduce criminal recidivism (CMHS, 1995).

principle of care

Cultural Competency Inadequate consideration of culture and ethnicity, as well as frequent misdiagnosis of behavioral disorders, are common phenomena experienced by persons of color in the justice system. In a consumer/family-oriented system for persons with co-occurring disorders, the service goal is to ensure that each clinical contact is welcoming, empathic, hopeful, culturally sensitive, and consumer-centered. Special efforts should be made to engage persons who may be unwilling to accept or participate in recommended services, or who do not fit into the available program models. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2000) within the Department of Health and Human Services has defined cultural competency as:

> *An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.*

Specialty courts and their health care partners should implement strategies to recruit, retain, and promote . . . a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Specialty courts and their health care partners should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. They should also ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Optimism for Change Growing evidence indicates that persons with co-occurring disorders who receive services based on the aforementioned principles have positive outcomes. This is in contrast to the attitudes among many court personnel, providers, families, and consumers, which can undermine the goals of specialty courts and treatment systems. In its application of therapeutic jurisprudence, the specialty court can advance optimism by sharing the belief that because the participants' problems are severe, they deserve help and by creating a vision of what a hopeful outcome might be. Every specialty court participant, regardless of the severity and disability associated with his or her co-occurring disorders, is entitled to experience the promise and hope of recovery.

Key areas for specialty court modification:

- *Screening and assessment*
- *Education*
- *Monitoring*
- *Graduated sanctions*
- *Community treatment providers*
- *Crisis response*

Section 4

Modification and Enhancement of Specialty Courts for Co-Occurring Disorders

The ability of specialty courts to address mental health and substance abuse issues will vary according to the functioning level of participants with co-occurring disorders and the level of program resources. However, all specialty courts should provide several "core" modifications to services for participants with co-occurring disorders that address their unique needs. A number of evidence-based practices have been established that can help guide specialty courts in designing program modifications to provide these basic services. Key areas for specialty court modification include the following:

- Screening and assessment approaches that examine both mental health and substance abuse content.
- Education regarding mental and substance use disorders.

- Medication monitoring and drug testing.
- Flexible application of graduated sanctions to accommodate the effects of mental disorders and other individual needs of program participants.
- Liaison with other community mental health and substance abuse treatment providers.
- Court hearings and judicial monitoring approaches that provide a rapid response to potential crises and
- Specific court-ordered requirements for mental health and substance abuse services.

Depending on the level of program services available, some specialty courts will be able to provide further enhancements to services to include integrated treatment components (e.g., co-occurring disorder groups or "tracks") designed to address the unique needs of participants who have co-occurring disorders. Specialty courts that provide more intensive program enhancements may choose to implement a number of structural and clinical approaches that have been used effectively in justice settings. Many of these enhancements do not require new program resources, and can be accomplished through reorganizing existing services.

Enhanced supervision and treatment approaches are generally longer, more intensive, slower paced, more flexible, and accommodate various cognitive impairments in implementing sanctions, treatment groups, and other services.

Modified Drug Courts Several drug courts have successfully implemented separate program "tracks" for participants who have co-occurring disorders, or have developed separate programs for this population. These enhanced programs provide a blended set of mental health and substance abuse services, and use a "phased" approach that includes sequenced interventions focusing on orientation, intensive treatment, and relapse prevention and transition. Other major program enhancements for specialty courts include enriched motivational interventions, greater use of individual counseling, on-site psychiatric consultation, intensive case management and outreach services, and community supervision teams that include smaller case loads and staff who are trained in co-occurring disorders. The following section describes several modified services that should be provided by all specialty courts working with individuals who have co-occurring disorders. Subsequent sections describe enhancements to specialty courts beyond this "core" set of modified services, and implementation strategies for developing program enhancements.

Several drug courts have . . . separate "tracks" for participants with co-occurring disorders ... [with] programs [that] provide a blended set of mental health and substance abuse services . . .

Modified Services for Co-Occurring Disorders in Specialty Courts

Screening and Assessment Mental health and substance abuse screening should be conducted prior to all specialty court program admissions. Routine screening for both disorders is warranted due to the high rates of co-occurring disorders among specialty court participants, and to the negative consequences for non-detection of these disorders. Screening for mental health and substance abuse problems should be completed at the earliest possible point, so that impairment in functioning and suitability for the program can be determined, and timely referrals made for mental health services. Early detection of behavioral health problems also increases the likelihood of stabilization of symptoms, and for placement in community treatment settings.

Acute effects of drugs and alcohol often are indistinguishable from mental health symptoms, and may cloud the true extent of mental health problems until a period of abstinence has been achieved. Ideally, to obtain the most valid results, screening for co-occurring disorders should be delayed until an individual reaches sobriety. However, this approach is impractical in many cases, and some information is needed quickly to make a determination regarding specialty court eligibility. In most cases, important

How Drug Courts Can Modify Screening for Co-Occurring Disorders

In addition to substance abuse information routinely collected by drug courts, mental health information that should be gathered during *screening* includes the following (Peters & Bartoi, 1997):

- Acute mental health symptoms (e.g., depression, hallucinations, delusions).
- Suicidal thoughts and behavior.
- Age at which mental health symptoms began.
- History of mental health treatment and use of psychotropic medication.
- History of trauma such as sexual/physical abuse.
- Family history of mental illness.
- Chronology of mental and substance use disorders.
- Motivation for treatment of mental and substance use disorders.

How Drug Courts Can Modify Assessment for Co-Occurring Disorders

In addition to substance abuse information routinely collected by drug courts, mental health information gathered during *assessment* includes the following (Peters & Bartoi, 1997):

- Chronology of mental and substance use disorders.
- Interactive effects of substance abuse and mental disorders (e.g., exacerbation of symptoms, masking symptoms).
- Cognitive impairment (e.g., ability to process information and to communicate an understanding of concepts related to treatment).
- Impairment in abilities to handle stress, and to interact with staff and other participants in treatment activities.
- Perceived level of mental health problems.
- Results from previous court-ordered evaluations related to mental health issues.

screening and assessment information can be obtained even if an individual has recently used drugs or alcohol.

In some jurisdictions, specialty courts may be able to obtain information regarding prior involvement in community mental health treatment services through cooperative arrangements developed by the jail, court services, or between treatment providers. Efforts should also be made to acquire as much information as possible from previous court cases and court-ordered evaluations (e.g., related to the medication history, history of violence, significant others who can serve as resources). Release forms should be routinely signed by specialty court participants in order to obtain this type of information.

Behavioral health screening and assessment should focus on areas of functional impairment that would prevent effective participation in the specialty court program and should not focus on ascertaining precise diagnoses or specific symptoms in the absence of attempts to understand their relation to specialty court functioning. Key functional areas to be examined include

- ability to process information from homework
- ability to process information from counseling
- ability to process information from other treatment activities
- ability to communicate difficulties in comprehending information to staff
- ability to communicate effectively with treatment staff and other program participants
- ability to handle stress (e.g., criticism, confrontation)
- reading skills
- ability to interact effectively in group settings (e.g., process groups, community meetings)

Similar or standardized screening and assessment instruments for co-occurring disorders should be used across different justice settings, including specialty courts. This approach will promote greater awareness of co-occurring disorders and needed treatment interventions, and can reduce unnecessary repetition of screening for individuals identified as having co-occurring disorders. Several recommended instruments for screening and assessment of co-occurring disorders are described in a monograph developed by the National GAINS Center (Peters & Bartoi, 1997).

Judges, supervision staff, treatment staff, and other specialty court staff must be aware of changes in the participant's living arrangements, treatment plan, medications, and in other treatment services.

Unless there are significant public safety risks, incarceration should be used sparingly as a specialty court sanction for participants with co-occurring disorders.

Although specialty court programs will certainly benefit from careful screening and assessment of participants who have co-occurring disorders, and matching these individuals to appropriate levels of services, identification of co-occurring disorders can potentially lead to stigmatization and reluctance to participate in program activities. Caution should be used in labeling specialty court participants as "mentally ill," or with other diagnostic labels (e.g., "schizophrenic"). Although mental health diagnoses are inevitably used in the assessment and treatment planning process, they often inaccurately imply a level of functional impairment that may not be present. In addition, these diagnoses are often interpreted incorrectly as evidence of a permanent condition, when in fact mental health symptoms are frequently controlled quite effectively by medication. Use of mental health labels can augment the stigma and shame experienced by participants who have already been identified as substance abusers and offenders.

Education Regarding Co-Occurring Disorders Education should be provided to all specialty court participants regarding mental and substance use disorders. This can be provided in psychoeducational groups, individual counseling sessions, and/or through assigned homework that may include reading and exercises. Educational content may address the interactive nature of co-occurring disorders; symptoms and diagnoses related to mental and substance use disorders; the prevalence, course, and treatment of these disorders; medications used to treat mental and substance use disorders; side effects of medications; interaction of medications and alcohol/illicit drugs; and available community treatment resources, including peer support groups. Several psychoeducational modules are available that have been used effectively in community treatment settings (Mueser, et al., 2003; Mueser & Fox, 1998; Peters et al., 2002).

Medication Monitoring and Drug Testing For specialty court participants with co-occurring disorders who are not currently receiving mental health services, an initial psychiatric consultation and assessment should be provided to review the need for medication. Ongoing psychiatric services are needed to evaluate and monitor the use of prescribed medications, to provide education regarding the interactive effects of medication with alcohol and illicit drugs, and to discuss side effects and medication adherence issues.

Psychiatrists also can provide support for the continued use of medication while participants are involved in peer support groups. Routine and random drug testing

Judicial Orders Related to Specialty Court Participation

The following types of *court-ordered conditions* have been found to be useful for individuals with co-occurring disorders who are supervised in judicial settings:

- Complete a psychological evaluation to determine the extent of mental health problems.
- Comply with recommendations for treatment described in the psychological evaluation.
- See a psychiatrist, if recommended in the psychological evaluation.
- Take medications, if prescribed by the psychiatrist.
- Complete a substance abuse evaluation.
- Attend substance abuse treatment as recommended in the evaluation.
- Abstain from use of alcoholic beverages and illegal drugs.
- Refrain from visiting businesses whose major source of income is the sale of alcoholic beverages.
- Report to the community supervision staff as ordered.
- Abide by standard orders of curfew.
- Comply with other community supervision orders (e.g., fees, victim restitution).
- Sign a release/waiver of information form to allow access to records describing prior treatment and medication use.
- Attend the next scheduled case review/hearing.