

Key Issues in Screening and Assessment of Co-occurring Disorders in the Justice System

Prevalence and Significance of Co-occurring Disorders in the Justice System

The number of people entering the criminal justice system has significantly increased in the past several decades. The population under correctional supervision in the United States rose from 5.1 million adults in 1994 to a peak of 7.3 million in 2007 but has fallen each successive year (Brown, Gilliard, Snell, Stephan, & Wilson, 1996; Glaze & Kaeble, 2014). In 2013, the total correctional population fell to 6.9 million adults (Glaze & Kaeble, 2014). Approximately 2.9 percent of the U.S. adult population is currently under some form of criminal justice supervision (Glaze & Herberman, 2013). The significant growth in the justice system has resulted from changes in drug laws and law enforcement practices and from the absence of public services for people who have mental or substance use disorders, who are homeless, and who are impoverished. Mental disorders are quite elevated in criminal justice settings such as jails and prisons (Lurigio, 2011; Steadman et al., 2013). For example, individuals in prison are diagnosed with schizophrenia at much higher rates than the general population (Grella, Greenwell, Prendergast, Sacks, & Melnick, 2008; Steadman et al., 2013). Recent estimates indicate that 17–34 percent of jail inmates have a recent history of mental disorders (Steadman et al., 2009; Steadman et al., 2013), including depressive disorders, bipolar disorders, and posttraumatic stress disorder (PTSD), while approximately 3 percent of offenders have psychotic disorders (Grella et al., 2008; Steadman et al., 2013). Approximately

a quarter of offenders report other disorders, such as anxiety disorders (Grella et al., 2008; Zlotnick et al., 2008), and about half report any type of mental disorder (James & Glaze, 2006). Use of conservative and more comprehensive diagnostic measures yields estimates of mental disorders that range from 10 to 15 percent of people incarcerated in jails and prisons (Steadman et al., 2013).

Rates of substance use disorders among justice-involved individuals are also significantly higher than in the general population (Lurigio, 2011; Steadman et al., 2013). Well over half of all incarcerated individuals have significant substance use problems (Baillargeon et al., 2010; Baillargeon et al., 2009; James & Glaze, 2006; Lurigio, 2011; Steadman et al., 2013). The lifetime prevalence of DSM-IV substance use disorders among prisoners is over 70 percent (Baillargeon et al., 2010; Baillargeon et al., 2009; Lurigio, 2011). These rates far surpass those found in the general population (Robins & Regier, 1991; Lurigio, 2011; Steadman et al., 2013). Importantly, many of these individuals report that their crimes leading to the most recent arrest were committed while using drugs or alcohol, and 86 percent of offenders report using illicit substances in their lifetime (Lurigio, 2011; Mumola & Karberg, 2006).

An increasing number of individuals in jails, prisons, and community settings have both mental and substance use disorders, or CODs, which presents numerous challenges in providing effective services (Baillargeon et al., 2010; James & Glaze 2006; Lurigio, 2011; Peters et al., 2012). Studies indicate that 60–87 percent of justice-involved individuals who have severe mental

disorders also have co-occurring substance use disorders (Abram & Teplin, 1991; Abram, Teplin, & McClelland, 2003; Chiles, Cleve, Jemelka, & Trupin, 1990; James & Glaze, 2006; Lurigio, 2011; Peters et al., 2012; Steadman et al., 2013). There are also high rates of co-occurring mental disorders among offenders who have substance use disorders, including those who are sentenced to substance use treatment (Baillargeon et al., 2010; Hiller, Knight, Broome, & Simpson, 1996; Lurigio et al., 2003; Lurigio, 2011; National Institute on Drug Abuse [NIDA], 2008; Peters et al., 2012; Swartz & Lurigio, 1999). Overall, an estimated 24–34 percent of females and 12–15 percent of males in the justice system have CODs (Steadman et al., 2009; Steadman et al., 2013).

Despite the high rates of CODs, relatively few justice-involved individuals are receiving adequate treatment services for these disorders in jails, prisons, or other justice settings (SAMHSA's GAINS Center, 2004; Peters et al., 2004; Peters et al., 2012). Moreover, few existing specialized CODs treatment programs have been developed in justice settings (Peters et al., 2004; Peters et al., 2012). This is due in part to the lack of available integrated treatment programs (Lurigio, 2011). Traditionally, treatment programs in the community and in correctional settings have adhered to either sequential or parallel treatment models to address mental illness and substance use. Sequential treatment involves treating one type of disorder at a time, with the underlying assumption that either the mental health or substance use disorder is “primary” and must be treated first. However, since this model does not address the interactive nature of CODs, treating each type of disorder sequentially does not lead to positive long-term outcomes (Horsfall, Cleary, Hunt, & Walter, 2009). Another approach involves parallel or concurrent treatment of both types of disorders, allowing offenders to participate in treatment for these disorders simultaneously but with treatment services typically provided by different agencies. This approach has also led to poor outcomes, does not deal with the intertwined nature of CODs, and can provide confusing

or even conflicting messages about recovery and interventions that are needed (e.g., use of medications). Integrated treatment approaches that focus on the interactive nature of the two types of disorders and that provide services by the same staff and within the same settings have been the most successful among non-offender and offender samples (Lurigio, 2011; Mueser et al., 2003; Peters et al., 2012).

Individuals with CODs present significant challenges to those working in all areas of the criminal justice system and other social service systems (National Alliance on Mental Illness, Ohio, 2005; Peters et al., 2012). People with CODs are significantly more likely to be arrested (Balyakina et al., 2013). People with CODs often engage in drug use to alleviate symptoms associated with serious mental disorders, including difficulty sleeping, depression, anxiety, and paranoia (Lurigio, 2011; Mueser, 2005), in addition to use that is driven by an inherent shift in brain chemistry. A major challenge involves the rapid cycling of people with CODs through different parts of the criminal justice and social service systems, including law enforcement, jail, community emergency services, and shelters. These individuals are frequently unemployed, homeless, and lacking in vocational skills, and have few financial or social supports (Peters et al., 2012; Peters, Sherman, & Osher, 2008). This is due in part to functional impairment related to social, occupational, and cognitive functioning. For some individuals who have CODs, using and selling drugs is a way to experience social connectedness and to create structure and a sense of meaning, in the absence of social contact related to employment, education, or activities with family and friends (Lurigio, 2011).

CODs are also associated with compromised psychosocial functioning, which places offenders at risk of a range of negative outcomes (Lurigio, 2011; Peters et al., 2012), including the following:

- Pronounced difficulties in employment, education, family, and social relationships (e.g., social isolation)

- Serious medical problems
- Reduced ability to refrain from substance use
- Premature termination from treatment
- Rapid progression from initial substance use to substance use disorder
- Frequent hospitalization for mental disorders
- Housing instability or homelessness
- Poor prognosis for completion of treatment
- Temporal instability in severity of symptoms related to mental and substance use disorders
- Noncompliance with medication and treatment interventions
- High rates of depression and suicide
- Poor level of engagement and participation in treatment
- Criminal recidivism

When released from prison, jail, or residential treatment facilities, people with CODs may not have access to the medications that stabilized them prior to release and often experience difficulties engaging in community mental health and drug treatment services (Osher, Steadman, & Barr, 2002, 2003; Weisman, Lamberti, & Price, 2004). Other barriers to community integration include lack of affordable housing and transportation, barriers to accessing employment once one has a criminal record, and the termination of income supports and entitlements. Coordinating the diverse medical, mental health, substance use, and supervision needs of these individuals can be a daunting task and often requires the ability to navigate among service systems, institutions, and agencies that have very different missions, values, organizational structures, and resources (Chandler et al., 2004; Lurigio, 2011; Peters et al., 2012).

Despite these challenges, an increasing number of CODs treatment programs have been successfully implemented in justice settings (Peters et al., 2004, 2012). Most comprehensive programs in justice settings provide an integrated treatment approach,

consistent with evidence-based practices developed in non-justice settings (National Institute on Drug Abuse, 2006). These programs are typically intensive and highly structured, and provide case management and adaptations to clinical services that address the complicated needs of offenders, including integrated dual disorder treatment (IDDT) and interventions to address criminogenic risk factors (Peters et al., 2012; Kleinpeter, Deschenes, Blanks, Lepage, & Knox, 2006; Pinalis, Packer, Fischer, & Roy-Bujnowski, 2004; Smelson et al., 2012).

Participants in correction-based treatment programs for CODs often show positive treatment outcomes, including lower dropout rates in comparison to community treatment programs (Lurigio,

2011; Peters et al., 2012). Research indicates that comprehensive prison treatment programs for CODs can significantly reduce recidivism, and that the addition of community reentry services can augment these positive outcomes (Lurigio, 2011; Peters et al., 2012; Sacks, Sacks, McKendrick, Banks, & Stommel, 2004).

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Defining Co-occurring Disorders

Several different terms have been used to describe mental and substance use disorders that are present simultaneously, including co-occurring disorders (CODs), comorbidity, dual disorders, and dual diagnosis. These terms vary in their meaning and use across criminal justice settings. The term “co-occurring disorders” has achieved acceptance within the practitioner and scientific communities and within federal agencies over the past 25 years and is most commonly used to indicate the presence of at least one mental disorder and at least one substance use disorder, as defined by

DSM-5 (Diagnostic and Statistical Manual of Mental Disorders; APA, 2013).

People in the justice system with CODs typically experience more than one mental disorder, in addition to more than one substance use disorder. Mental disorders can cause significant psychosocial impairment, and disorders like bipolar disorder, major depressive disorder, and psychotic disorders (e.g., schizophrenia) and related disorders (e.g., schizoaffective disorder) can be some of the more disabling, although severity can differ across individuals. Other conditions such as anxiety disorders, adjustment disorders, and other forms of depression are very common among people in the justice system but do not typically require specialized interventions for CODs. People with these disorders can frequently receive adequate care in traditional mental health or substance use treatment settings. Several other issues deserve consideration in identification and treatment of CODs within the justice system, including developmental disabilities, learning disabilities, sexual disorders, and personality disorders. While all of these issues present valid focal areas to be addressed in case/treatment planning, treatment, and supervision, they generally do not involve the same level of impairment as bipolar disorder, major depressive disorder, and psychotic disorders that co-occur with substance use disorders. People in the justice system who have CODs are also significantly more likely than those in the general population to have other major health disorders, such as HIV/AIDS, diabetes, Hepatitis C, and tuberculosis (TB), creating unique challenges and opportunities for involvement in specialized services and in treatment programs for CODs.

Although there is a growing recognition of the need for specialized services among people who have CODs in the justice system, there are often pressures to refer individuals to CODs treatment services who have severe behavioral problems or more pronounced characterological and interpersonal problems (referred to as personality disorders, such as antisocial [ASPD]

and borderline personality disorders [BPD]). In fact, many offenders who are involved in substance use and mental health treatment in the justice system have personality disorders, including ASPD and BPD, in addition to their other disorders (Grant et al., 2008; Ruiz, Pincus, & Schinka, 2008; Walter et al., 2009). People with characterological problems can typically be accommodated within treatment programs that focus on addressing “criminogenic needs,” such as antisocial attitudes, beliefs, behaviors, and peers. However, mixing people who have more predatory characterological disorders in specialized CODs programs with others who have significant impairment related to bipolar disorder, depression, or psychosis may be problematic. First, people with pronounced characterological disorders may be at higher risk for criminal recidivism, and it is contraindicated to combine offenders who are at significantly different risk levels in treatment and supervision services (Andrews & Bonta, 2010a, 2010b; National Association of Drug Court Professionals [NADCP], 2013). Second, people with more severe impairment related to CODs are frequently victimized while in the justice system and may be more vulnerable to emotional and physical abuse when placed with offenders who are at higher criminal risk levels. Third, people with more severe impairment related to their mental or learning disorders require distinctive interventions, including medication management, basic life skills training, crisis stabilization, and intensive case management. As a result of these concerns, it is important to carefully define the target population for CODs services and to provide rigorous screening and assessment to ensure that scarce treatment resources within justice settings are reserved for those who are in the greatest need and who stand to benefit the most.

Changes to the DSM-5 Diagnostic Classification System

There have been several major changes in diagnostic and classification approaches from DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders–Text Revision; APA, 2000)

to the more recent DSM-5 (APA, 2013) that affect definitions of substance use, mental disorders, and CODs. Previous versions of DSM classified mental disorders by different “axes,” with Axis I denoting a major mental disorder (including substance use disorders), Axis II denoting a personality disorder and intellectual disability (formerly known as mental retardation), and Axis III denoting other health disorders. Distinctions have traditionally been made between axes to assist in identifying the differential impact of these disorders. With the advent of DSM-5, disorders are no longer defined in terms of axes, and instead all disorders can be identified but are not labeled with any multi-axial distinction.

Substance Use Disorders

The most important change to DSM-5 in defining substance use disorders is that there is no longer a differentiation between “dependence” and “abuse.” These terms were eliminated due to the lack of concordance between their respective categorical diagnoses and the severity of substance use problems. For example, withdrawal symptoms were often present (e.g., among those abusing prescription opiates) even if the person was not diagnosed as having a “dependence” disorder. Substance use disorders are diagnosed by the type of substance used (e.g., “Stimulant Use Disorder”). Alcohol use disorders are subsumed under the category of substance use disorders. Criteria for achieving a “substance use disorder” now exist along a continuum of “mild,” “moderate,” and “severe,” combining the previously distinctive DSM-IV abuse and dependence symptoms to make up this continuum. One symptom, “legal difficulties from drug use,” which was formerly listed as a criterion for “substance abuse” is no longer present. One reason for this change is the growing inconsistency between state criminal laws that made for diagnostic differences. As laws related to marijuana emerge, including the legalization of “medical marijuana” in some states and the decriminalization of marijuana possession in others, this is an important change in diagnostic classification. An important new criterion for

substance use disorders is “cravings,” reflecting factors surrounding the intensity of desire for ongoing substance use. Criteria for diagnosing substance use disorders along the continuum of current severity are as follows: “mild” severity requires 2–3 symptoms, “moderate” severity requires 4–5 symptoms, and “severe” requires 6 or more from a total of 11 symptoms (APA, 2013).

Mental Disorders

Major changes have also been made to DSM-5 diagnoses of mental disorders, including changes to criteria related to schizophrenia, bipolar disorder, and depressive and anxiety disorders (APA, 2013). Schizophrenia is no longer categorized by subtypes (e.g., paranoid), as diagnoses involving these subtypes do not appear to be distinctive and have low reliability and validity. Similar to the revised classification of substance use disorders, a dimensional system is now available to assess the severity of core symptoms related to specific mental disorders. Changes to Criterion A of bipolar disorders include the addition of “noticeable changes in energy level” in addition to changes in mood (e.g., irritability, hyperactivity). In order to meet diagnostic criteria for bipolar I: mixed episode, an individual no longer has to simultaneously meet both manic and major depressive criteria, and instead, the term “mixed features” is used when an individual has both manic and depressive symptoms. Depressive disorders now include additional disorders, such as “disruptive mood dysregulation disorder” for children up to age 18, and “premenstrual dysphoric disorder.” Dysthymia is now categorized as a persistent depressive disorder, although there have been no significant changes to the diagnosis of major depressive disorder. Obsessive-compulsive disorder is now included in a new category entitled “obsessive compulsive and related disorders.” PTSD and acute stress disorder are now included in a diagnostic category entitled “trauma and stressor-related disorders.” Trauma can include experiences of vicarious trauma (e.g., experiences at home, work, or other settings), and PTSD criteria in the

DSM-5 have changed regarding symptomatic expression, cognitive processing, and the like. Detailed information regarding specific changes to PTSD criteria is provided later in this monograph. Finally, panic and agoraphobia are now two separate disorders rather than being classified as panic disorder with or without agoraphobia (APA, 2013).

Distinguishing between Co-occurring Disorders: Differential Diagnoses

A hallmark of CODs is the highly interactive nature of mental and substance use disorders and how each disorder affects the symptoms, course, and treatment of the other disorder. The American Psychiatric Association (2013) describes a number of different ways in which the two sets of disorders are interdependent and interactive:

- One disorder may predispose a person to another type of disorder
- A third type of disorder (e.g., chronic health condition, such as HIV/AIDS) may affect or elicit the onset of mental or substance use disorders
- Symptoms of each disorder may be augmented, as these often overlap between mental and substance use disorders (e.g., anxiety, depression [APA, 2013])
- Other disorders, such as borderline personality disorder (BPD, as classified by DSM-IV), may predispose individuals to more severe mental disorders such as major depressive disorder and substance use disorders
- Alcohol or other drugs may induce, or more frequently mimic or resemble, a mental disorder

As a result of the intertwined nature of mental and substance use disorders among people in the justice system, it is critically important to assess the recent and historical use of substances to determine whether there were direct effects (e.g., symptom exacerbation) that resulted from substance use. For example, it is important to determine if mental health symptoms appeared

after engaging in substance use. Similarly, assessment should consider whether engaging in substance use was motivated by attempts to alleviate symptoms of mental disorders (e.g., agitation, anxiety, depression, sleep disturbance). Other strategies to ascertain an accurate diagnostic picture include establishing a temporal framework to better understand the relationship between substance use and mental health symptoms; for example, investigating the presence of mental health symptoms following periods of abstinence (either voluntary or coerced) can help determine if there is a causal relationship between the mental and substance use disorders. Similar steps during assessment should be taken to rule out mental disorders occurring due to a general medical condition.

Evidence-based screening and assessment strategies for justice-involved individuals who have CODs recognize the interactive nature of the disorders and the need for ongoing examination of the relationship between the two disorders. Attention to the interactive nature of the disorders should be reflected in ongoing assessment activities and use of repeated measures to assess changes in the diagnostic picture and in symptoms and levels of impairment related to the two sets of disorders. Treatment planning, provision of clinical services, and community supervision strategies should consider the interdependent nature of the disorders. This approach does not necessarily entail providing concurrent services for the disorders in equal intensity, but instead prioritizes the sequence of services according to the presence of acute crises (e.g., suicidal behavior, intoxication) and areas of functional impairment (e.g., cognitive impairment) that affect treatment participation. The focus of treatment at any given time should be on remediating areas of functional impairment caused by one or both disorders, and the sequence of interventions should be dictated accordingly.

Importance of Screening and Assessment for Co-occurring Disorders in Justice Settings

People in the justice system with CODs differ widely in type, scope, and severity of symptoms and in complications related to their disorders. Screening and assessment provide the foundation for identification, triage, and placement in appropriate treatment interventions. Early identification is vitally important for people who have CODs to determine specialized needs during the period of initial incarceration, pretrial release, sentencing/disposition, and reentry to the community. Use of comprehensive screening and assessment approaches has been found to improve outcomes among criminal justice populations that have mental or substance use disorders (Shaffer, 2011).

Many areas of psychosocial problems are augmented among justice-involved individuals who have CODs, including risk for suicide, acute symptoms of mental disorders, history of trauma/PTSD, homelessness, and lack of financial support and transportation. The absence of a front-end integrated screening may exacerbate behavioral problems that require placement in specialized custody or intensive supervision settings and undermine the effectiveness of treatment provided and is likely to delay placement in specialized diversion or in-custody programs designed for people with CODs. Lack of initial screening for multiple psychosocial problems may also delay completion of a more comprehensive clinical assessment to determine the scope, intensity, and duration of specialized services that are needed. Given that many people in the justice system with CODs are at high risk for recidivism, screening and assessment of risk level are needed in advance of classification to custody units, placement in diversion programs, or sentencing and disposition. The combination of screening and assessment of psychosocial needs and criminal risk is essential to the treatment planning process and in determining

the level of treatment services and supervision that are needed.

Unfortunately, screening and assessment of issues related to CODs are not routinely conducted in many justice settings, and as a result, mental and substance use disorders are underidentified and underdiagnosed (Abram & Teplin, 1991; Balyakina et al., 2013; Hiller et al., 2011; Lurigio, 2011; Peters et al., 2012; Peters et al., 2008; Taxman, Cropsey et al., 2007; Taxman, Young et al., 2007). In some justice settings, identification of CODs is hampered by parallel screening and assessment activities for mental and substance use disorders. This approach often leads to non-detection of CODs and other related issues, inadequate information sharing, poor communication regarding overlapping areas of interest, and failure to develop integrated service goals that address both mental health and substance use issues (Fletcher et al., 2009; Lehman, Fletcher, Wexler, & Melnick, 2009; Taxman, Henderson, & Belenko, 2009). Another common problem is that information gathered in community-based or other justice settings may not follow the individual as he or she moves through different points in the system, making it more difficult to make sound decisions about treatment, sentencing, and community release.

Common reasons for non-detection of CODs in the justice system (Balyakina et al., 2013; Chandler et al., 2004; Taxman et al., 2009; Fletcher et al., 2009) include the following:

- Lack of staff training
- Short duration of time and limited resources provided for screening and assessment in many correctional settings
- Lack of established protocols related to screening, assessment, diagnosis, and treatment
- Absence of electronic records that can be shared across justice settings
- Perceived or real negative consequences associated with self-disclosure of symptoms

- Mimicking or masking of symptoms of one disorder by symptoms of the other co-occurring disorder
- Cognitive and perceptual difficulties associated with severe mental illness or toxic effects of recent alcohol or drug use

Low detection rates of CODs may also be attributable to the absence of screening procedures in justice settings to comprehensively examine both mental health and substance use issues (Cropsey, Wexler, Melnick, Taxman, & Young, 2007; Hiller et al., 2011; Osher, 2008; Peters et al., 2012; Peters et al., 2004).

Inaccurate detection of CODs in justice settings may result in a wide range of negative consequences (Chandler et al., 2004; Hiller et al., 2011; Harris & Lurigio, 2007; Lurigio, 2011; Osher et al., 2003; Peters et al., 2008), including the following:

- Recurrence of symptoms while in secure settings
- Increased risk for recidivism
- Missed opportunities to develop intensive treatment conditions as part of release or supervision arrangements
- Failure to provide treatment or neglect of appropriate treatment interventions
- Overuse of psychotropic medications
- Inappropriate treatment planning and referral
- Poor treatment outcomes

Once CODs are identified in justice settings, the challenge is to provide specialized treatment and transition services. Justice-involved individuals with CODs exhibit more severe psychosocial problems, poorer institutional adjustment, and greater cognitive and functional deficits than other individuals (Lurigio, 2011; Ruiz, Douglas, Edens, Nikolova, & Lilienfeld, 2012; Sung, Mellow, & Mahoney, 2010). Comprehensive treatment practices involve integrating mental health and substance use services (Houser, Blasko, & Belenko, 2014; Lurigio, 2011; NIDA, 2008) and

require coordination between behavioral health and criminal justice system staff. Unfortunately, treatment and service practitioners in these two areas often have different approaches to working with CODs. Finally, most jurisdictions have few resources to support community transition and follow-up treatment activities for justice-involved individuals who have CODs (Lurigio, 2011; Sacks, 2004; Potter, 2014; Sung et al., 2010; Travis, Solomon, & Waul, 2001).

As previously noted, offenders who have CODs are characterized by great diversity in the types of disorders

experienced, the nature of symptoms, the level of impairment, personal strengths, and risk for criminal recidivism.

In addition to compiling information related to treatment and case planning, one of the major benefits of gathering comprehensive screening and assessment information

is the ability to match

offenders to appropriate services. For example, some jurisdictions operate multiple court-based programs (e.g., drug courts, mental health courts, specialized dockets for CODs) that are differentially appropriate for offenders according to their individual treatment and supervision needs. In custody settings, program options may differ by duration, intensity, and degree of isolation from the general inmate population. In some justice settings, offenders who have CODs may be routed to different program “tracks” (e.g., in a drug court, jail, or prison), depending on the severity of CODs and supervision needs/criminal risk level. In each of these cases, screening and assessment should be used to strategically examine relevant program eligibility and exclusion criteria, and to gauge the “fit” between key needs of the

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offender and available services. Research also indicates the importance of matching offenders to program services based on an individualized profile of “criminogenic needs,” criminal risk level, and “responsivity” factors (Andrews, 2012; Andrews & Bonta, 2010a) that affect the ability of offenders to engage in evidence-based treatment and supervision—areas that are discussed in “Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System.”

Several approaches for treatment matching of offenders to treatment and supervision services are described in this monograph. One model used to identify the severity of substance use and co-occurring mental disorders and to match people to treatment services is the Patient Placement Criteria (PPC), developed by the American Society of Addiction Medicine (ASAM). The ASAM PPC are used to match individuals to appropriate levels and types of treatment and have been effective as an assessment approach in the criminal justice system for people who have CODs. This model provides an assessment of six dimensions related to treatment, such as severity, frequency, and duration of substance use, in addition to other factors, including risk of relapse, co-occurring mental health symptoms, motivation and readiness for treatment, and social and occupational functioning (Mee-Lee, 2013; Stallvik & Nordahl, 2014). These factors are used to match patients to different levels of services, ranging from early intervention to medically managed intensive inpatient services and including specialized treatment programs for CODs. Research indicates that the ASAM PPC are able to triage people who have mental disorders to more intensive treatment programs geared towards CODs (Stallvik & Nordahl, 2014) and that people referred to more intensive treatment services have more severe mental health and substance use problems.

Opportunities for Screening and Assessment

Opportunities for screening and assessment are present at all points of contact within the criminal justice system. The Sequential Intercept Model (see Figure 1) provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness. Within the criminal justice system there are numerous intercept points—opportunities for linkage to services and for prevention of further penetration into the criminal justice system. This linear illustration of the model shows the paths an individual may take through the criminal justice system, where the five intercept points fall, and areas that communities can target for diversion, engagement, and reentry.

Intercept 1: Law Enforcement

In general, opportunities for screening at Intercept 1 are presented to law enforcement; other first responders, such as emergency medical technicians; and to emergency room personnel (see Figure 2). Law enforcement officers have a brief opportunity to flag signs of mental and substance use disorder and hand off individuals experiencing a mental health crisis to appropriate services. Mental health co-response services have expanded in recent years as a specialized response to mental health crises. With the expansion of Crisis Intervention Teams has come the development of law enforcement-friendly crisis stabilization units as one-stop drop-off sites for people experiencing a mental health crisis.

Law enforcement agencies with limited training in mental health and substance use disorders are at a disadvantage in identifying and appropriately handling people with mental illness or co-occurring disorders. Eight-hour Mental Health First Aid training can provide law enforcement officers with basic skills in identifying and responding to mental illness and substance use disorders. The most comprehensive responses are by Crisis Intervention Teams, which consist of a

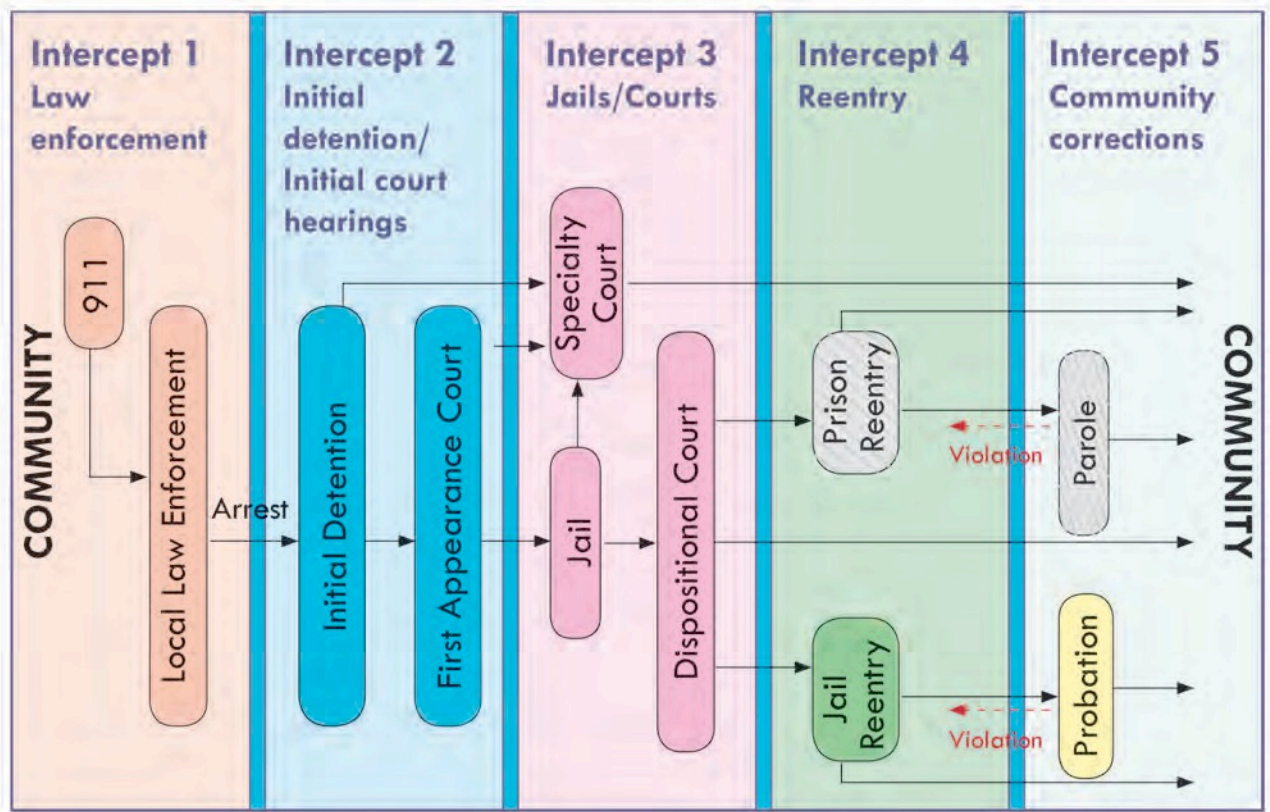


Figure 1. The Sequential Intercept Model

cadre of officers who have completed 40 hours of training and are responsible for resolving calls involving people experiencing a mental health crisis. These officers often have a dedicated drop-off site, and many use checklists to aid the identification of mental illness and substance use. Tracking forms and databases are used for record-keeping and identification of repeated contacts.

First responders, especially law enforcement officers, are expected to resolve calls in as swift a manner as possible. Opportunities to train responders in the identification of the signs and symptoms of mental and substance use disorders and to more quickly resolve crisis situations, whether through training in de-escalation techniques or in the administration of naloxone to counter a heroin overdose, have more operational value than adding extensive screening procedures. Nevertheless, law enforcement officers should document their observations and ensure that information is provided to emergency room, crisis

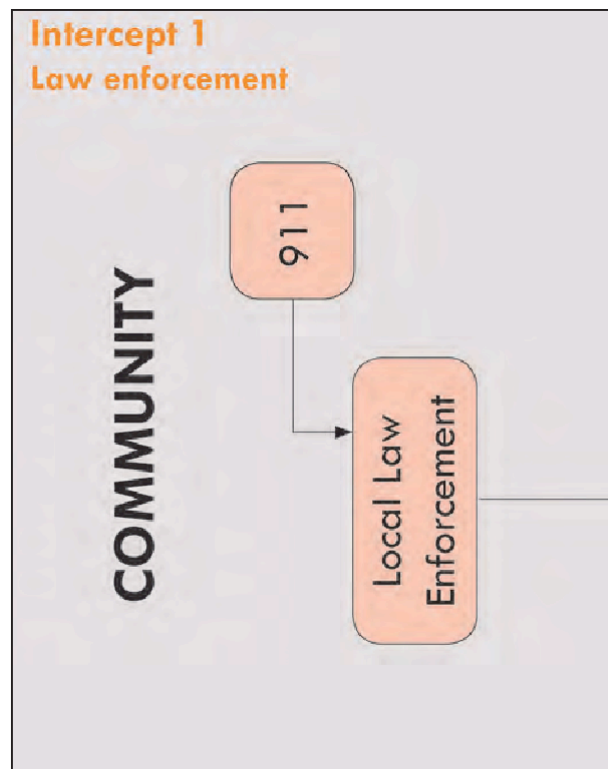


Figure 2. Intercept 1: Law Enforcement

stabilization unit, or mobile crisis staff. Where a hand off to a health care practitioner is not possible, information should be communicated to jail booking or lockup officers.

The ability to effectively screen and assess for co-occurring disorders during a crisis also poses a challenge for crisis response staff, whether they are mental health mobile crisis clinicians or emergency room personnel. When responding to a person in crisis, identification of co-occurring disorders is challenging due to limited health history, functional capacity, and the difficulty in differentiating mental health and substance use symptoms.

Emergency room settings are the most challenging setting for screening and assessment of co-occurring disorders. Across the country, emergency rooms are overextended and lack staff to appropriately triage and treat people with co-occurring disorders. Emergency rooms may use blood tests to reliably detect substances but generally must dedicate their resources to medical emergencies.

An alternative to emergency rooms are crisis stabilization units that provide up to 23-hour care and allow for screening and assessment of co-occurring disorders. Crisis stabilization units offer a specialized response for people with co-occurring disorders, prompt triage, and referral to appropriate services. Often these services are co-located with detoxification facilities. In this setting, the tools listed in a subsequent section of this monograph, “Screening Instruments for Co-occurring Mental and Substance Use Disorders,” will provide for efficient and standardized assessment.

Mobile crisis teams, which co-respond with law enforcement officers or provide support to crisis stabilization units and emergency rooms, can improve the usefulness of screening by developing uniform screening guidelines with local hospitals and crisis centers. In addition, mobile crisis teams are increasingly able to access current health records of people with co-occurring disorders

who are services recipients, thus enhancing the opportunity to expedite screening and assessment and assisting in timely disposition.

Intercept 2: Initial Detention/Initial Court Hearings

Once a person has been arrested, there are two primary opportunities to screen and assess for co-occurring disorders (see Figure 3). The first opportunity is for jail booking personnel and health screeners to conduct brief, structured screens to flag people who may have co-occurring disorders for further clinical assessment.

Where available, the second opportunity for screening is by pretrial service staff. Pretrial services may be a function of an independent agency or probation; either way they have an opportunity to briefly screen for co-occurring disorders while developing the pretrial release/detention recommendation. In some communities, arrestees are initially detained in a police or

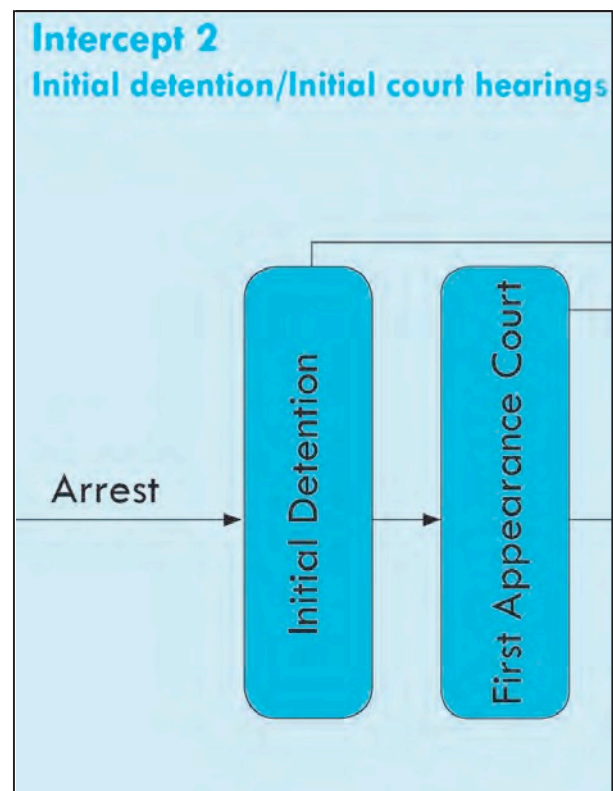


Figure 3. Intercept 2: Initial Detention/Initial Court Hearings

court lockup rather than jail prior to their initial appearance. Pretrial services may be the first opportunity to screen these individuals since their being placed under arrest.

For courts with a court clinic or embedded clinicians, clinicians may be available to screen people for co-occurring disorders and to identify service recipients. Diversion program case workers may also conduct screenings prior to the first court appearance to determine program eligibility.

The challenge at this intercept is the short time frame between initial detention and first appearance. Individuals may be held for only a matter of hours before being released, which can hamper efforts to screen and prohibits further clinical assessment.

Intercept 3: Jails/Courts

The purpose of brief screening at jail booking is typically to identify people who may have a mental or substance use disorder for further clinical assessment. The initial screen may be conducted by booking officers or jail health staff. Some jails have their newly booked inmates matched with the client databases of state or local behavioral health authorities to assist continuity of care. Screening and assessment within the jail also aids the housing classification and management of inmates and the connection with available behavioral health services within the jail. Apart from the jail, specialty court and other diversion programs may conduct clinical and program eligibility assessments of individuals identified by the jail or during Intercept 2 (see Figure 4).

Jail size and resources may impact the practicality of implementing comprehensive assessment procedures. The holding capacity of jails ranges from a handful of cells to space for 15,000 inmates. Small and even mid-size jails may lack the resources to provide basic screening, assessment, and treatment. These jails often rely on reach-in services by community-based providers. However, jails are required to conduct

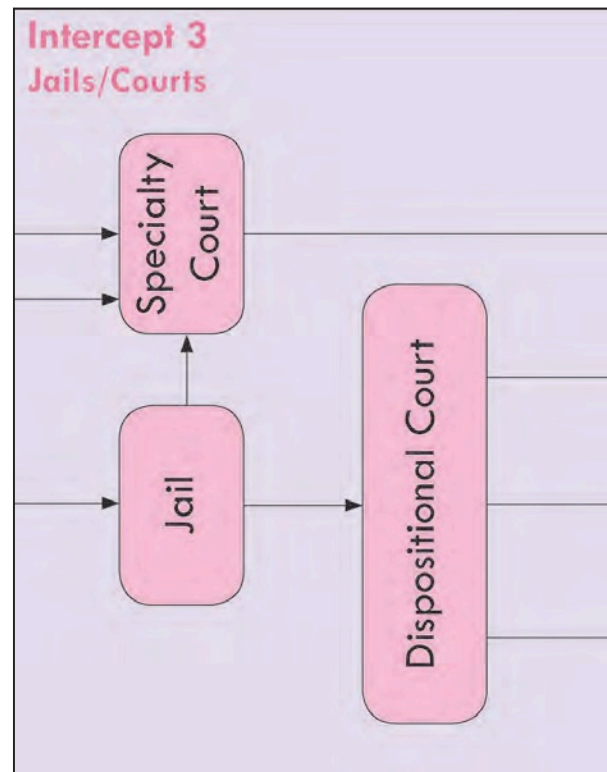


Figure 4. Intercept 3: Jails/Courts

at least basic screening for suicide, mental health, and substance use. Larger jails will have in-house behavioral health professionals to conduct more intensive screening and assessment. The average jail stay is fewer than 7 days; screening and assessment information collected during the jail booking process should be used to refer and link inmates to court-based diversion programs and to community-based services upon release.

At the dispositional court, screening and assessment are important for the purpose of informing the disposition and sentencing decisions. Defense attorneys often gather information on a client's behavioral health history, even if it is not presented in court. Public defenders in larger jurisdictions may have a staff social worker to help identify clients' treatment needs. Defender-based advocacy programs, operated by a nonprofit or a county agency, may review a client's history (i.e., criminal, familial, educational, occupational, and health) to develop a dispositional recommendation.

Court-based diversion programs, including specialty courts, often have extensive screening and assessment procedures to identify eligible individuals and to formulate treatment plans. Efforts to develop unified screening and assessment procedures across programs greatly benefit the programs by increasing the likelihood that individuals are placed into the most appropriate program.

Probation officers responsible for the presentence investigation may conduct screens and incorporate treatment history into their sentencing recommendations to the judge. The presentence investigation is notable because it may include treatment recommendations. Many probation agencies are implementing criminal risk and need assessments to better match individuals to supervision and treatment resources. These assessments should be shared with community-based practitioners to ensure that criminal risk, need, and responsivity are addressed through services.

Intercept 4: Reentry

For jails, the opportunity for screening presents itself at Intercept 2 or Intercept 3. Among the population of sentenced inmates, officers that are trained in the identification of mental health symptoms can generate referrals to health services for inmates with a mental illness who did not present at booking. Jails with sufficient resources may offer basic behavioral health programming.

Planning for reentry should begin at jail booking (see Figure 5). Periodic screening and assessment should take place over time to determine changes in inmate needs for institutional programming and to inform reentry services. Jail transition planners can work with inmates and practitioners to identify appropriate services and supports, including access to health coverage, as inmates approach the end of their jail sentence. Transition planners can also work with probation officers on the hand off for inmates being released into the custody of probation.

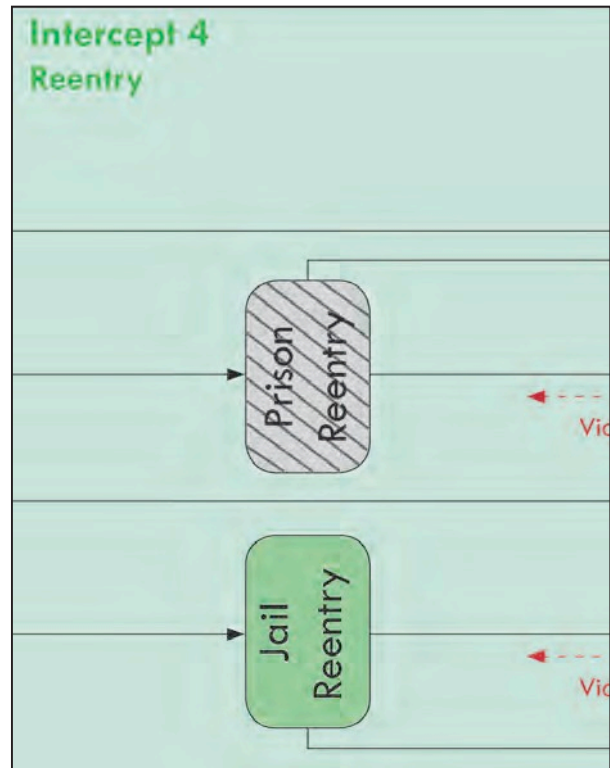


Figure 5. Intercept 4: Reentry

Prisons have the opportunity during the reception process to screen and assess for co-occurring disorders. Prisons are more likely to offer comprehensive mental health and substance use programming. Screening and assessment at reception and periodically over the course of an inmate's sentence can guide prison treatment services and transition planning. As with jails, officers can identify inmates who did not present with sufficient acuity at the time of reception to merit a referral to health services. Ninety days from release, prison transition planners can work with inmates to identify service needs, connect to health coverage, and prepare for reintegration into the community. Transition planners who are working with inmates being released to parole supervision can work with inmates to prepare for the immediate requirements of parole. Most prisons are remote from the community of return, and the responsibility for identifying appropriate treatment resources often falls on the parole department. Many states and communities have established transitional case management

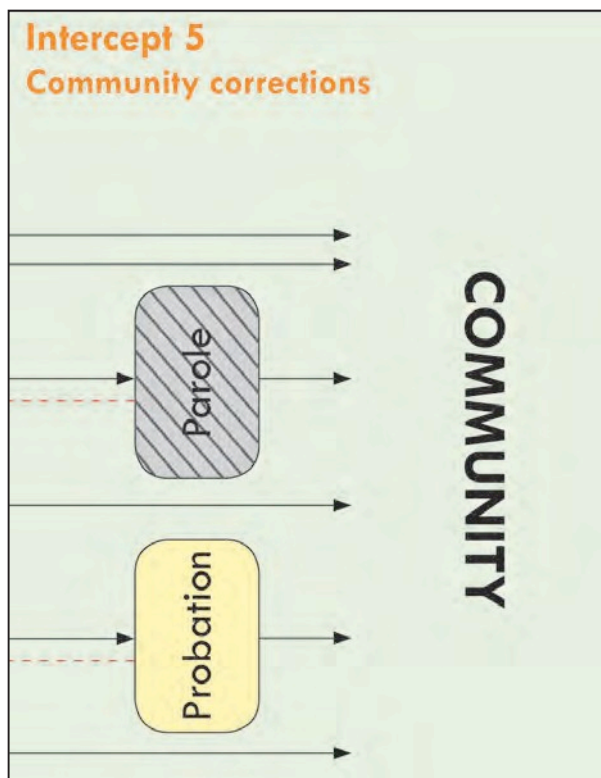


Figure 6. Intercept 5: Community

capacity to work with inmates while they are still incarcerated and for a period of time after release. As with probation agencies, prisons and parole departments are implementing risk and need assessment instruments to guide supervision and treatment programming. Information gathered from these instruments should be shared with community practitioners to better inform the treatment process.

Intercept 5: Community Corrections

Probation

The majority of people under correctional supervision are on probation. Collaboration between probation agencies and behavioral health programs are essential to reducing recidivism and promoting recovery (see Figure 6). For probation agencies, new probationers can be screened at booking for co-occurring disorders. Officers can also take advantage of information on a probationer’s treatment needs that has been gathered during earlier intercepts, such as at pretrial or for the presentence investigation.

For probationers who have been diverted to a specialized program at Intercept 2 or Intercept 3, the information may be available from the agency responsible for case management. Probation officers can use the information to place probationers into appropriate services, such as groups, or into specialized, lower ratio caseloads where officers have received additional training in the supervision of people with mental or substance use disorders. Specialized probation caseloads and co-located probation and mental health services are some of the strategies being used to achieve better probation outcomes for individuals with co-occurring disorders. Comprehensive screening and assessment can match probationers to appropriate services, while criminal risk and need assessments can match them to appropriate supervision levels. Probationers who are struggling to comply with the terms of supervision may need to be screened for co-occurring disorders in order to determine if the noncompliance is a result of symptoms or functional impairment.

Parole

As with at-risk probationers, screening and assessment of parolees is crucial as they are transitioning from a long-term stay in an institutional environment. Parolees with substance use disorders may have difficulty managing their abstinence from alcohol and drugs upon release. Mental health problems may arise due to the difficulties of transitioning back into the community, especially if a parolee is experiencing a gap in access to services and medication.

In many states, prison and parole services are two parts of one agency. Information on prison inmates with mental or substance use disorders may be available to parole officers in advance of an inmate’s release into the custody of the parole agency.

Defining Screening and Assessment

Individuals in the justice system who have CODs are characterized by diversity in the scope and

intensity of mental health, substance use, social, medical, and other problems. As a result, no single clinical approach fits the needs of this population, and effective and comprehensive screening and assessment procedures are of paramount importance in defining the sequence, format, and nature of needed interventions. Screening and assessment of CODs are part of a larger process of gathering information that begins at the point of contact of the individual with the justice system. The Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) Series #42 and other government monographs (Center for Substance Abuse Treatment [CSAT], 2005a; Steadman et al., 2013; NIDA, 2006) outline a set of sequential steps that are often followed in gathering information related to CODs. These steps provide a blueprint for developing a comprehensive system of screening and assessment activities and include the following:

- Engage the offender
- Collect collateral information (e.g., from family, friends, other practitioners)
- Screen and detect CODs
- Determine severity of mental health and substance use problems
- Determine the level of treatment services needed
- Diagnosis
- Determine the level of disability and functional impairment
- Describe key areas of psychosocial problems
- Identify strengths and supports
- Identify cultural and linguistic needs and supports
- Determine an offender's level of motivation and readiness for treatment (i.e., "stage of change")
- Develop an individualized treatment plan

Screening for CODs in the justice system is used to identify problems related to mental health, substance use, trauma/PTSD, criminal risk, other

areas that are relevant in determining the need for specialized services (including treatment, case management, and community supervision), and the need for further assessment. Screening also helps to identify acute issues that require immediate attention, such as suicidal thoughts or behaviors, risk for violence, withdrawal symptoms and detoxification needs, and symptoms of serious mental disorders. Often, multiple screenings are used simultaneously to identify problem areas that require referral or additional assessment. This may be particularly useful at the point of first appearance hearings/pretrial release or at the time of case disposition. Due to the volume of people processed at different points in the justice system, such as booking in larger jails, intake in prison reception centers, and first appearance hearings, it is impractical (and unnecessary) to routinely provide a full psychosocial assessment, and one or more screens will typically provide sufficient information to inform decisions about referral for services and further assessment.

Assessment is implemented when there is a need for more detailed information to help place people in a specific level of care (e.g., outpatient versus residential treatment) or type of service (e.g., COD treatment, intensive community supervision). Assessment differs from screening in that it addresses not only immediate needs for services, but also informs treatment planning or case planning. Thus, assessment examines a range of long-term needs and factors that may affect engagement and retention in services, such as housing, vocational and educational needs, transportation, family and social supports, motivation for treatment, and history of involvement in behavioral health services. Several types of assessments are available that vary according to the scope and depth of coverage needed. For example, several sets of instruments that are described in this monograph (e.g., Global Appraisal of Individual Needs [GAIN], Mini International Neuropsychiatric Interview [MINI], Texas Christian University Drug Screen [TCUDS]) provide different options for assessment that may be tailored to a particular justice setting.

Screening

Screening for CODs is a brief, routine process designed to identify indicators, or “red flags,” for the presence of mental health, substance use, or other issues that reflect an individual’s need for treatment and for alternative types of supervision or placement in housing or institutional settings. Screening may include a brief interview, use of self-report instruments, and a review of archival records. Brief self-report instruments are often used to document mental health symptoms and patterns of substance use and related psychosocial problems. Generally, screening instruments do not require that staff members are licensed, certified, or otherwise credentialed, and minimal training is usually required to administer, score, and interpret findings. However, staff training may be needed to provide effective referral to services if a screening indicates the presence of problems in a particular area (e.g., related to trauma history and current symptoms of PTSD).

In justice settings, screening for CODs should be conducted for all individuals shortly after the point of arrest and at the time of transfer to subsequent points in the system. While separate screening instruments have been developed to detect mental health and substance use issues in the justice system, until recently, few instruments were available for examining CODs. Optimally, screening tools should be well validated and reliable, with demonstrated properties in both justice and non-justice settings (Steadman et al., 2013). Screening should be conducted early in the process of compiling information, so that results can inform the need for assessment and diagnosis (Hiller et al., 2011; NIDA, 2006).

Among the goals of screening for CODs are the following:

- Detection of current mental health and substance use symptoms and behaviors
- Determination as to whether current symptoms or behaviors are influenced by CODs (e.g., trauma history)
- Examination of cognitive deficits

- Identification of criminal risk level to inform the need for placement in more or less intensive levels of treatment, supervision, and custody
- Identification of acute needs (e.g., violent behavior, suicidal ideation, severe medical problems) that may need immediate attention
- Determination of eligibility and suitability for specialized CODs treatment services
- Level of functional impairment (e.g., stress tolerance, interpersonal skills)

It is important to consider the multiple types and purposes of screening. For example, a series of screenings may be provided in jails and prisons to address several different issues. Classification and risk screening is typically conducted early on to identify security issues (e.g., history of escape, past aggressive behavior within the institution) and to determine level of custody; program needs; and other issues, including history of trauma. Medical screening identifies health issues, and may address mental health status and substance use history. Mental health and substance use screenings often are also included within interviews conducted by pretrial services or other court-related agencies. In community and jail settings, presentence or postsentence investigations (PSIs) are frequently completed to assist in determining the judicial disposition or case planning. These often involve an interview and set of brief screenings to identify whether individuals are at high risk for violence or recidivism and to identify problems that may be addressed through treatment or supervision, including specific mental health problems such as PTSD related to trauma. Brief screening may address literacy and educational deficits. In related areas of cognitive and behavioral impairment (e.g., interpersonal skills deficits, stress tolerance), there are few well-validated screening tools that gather information relevant for placement and disposition. As a result, these areas are typically examined through behavioral observation (Steadman et al., 2013).

Assessment

Assessment of CODs is typically conducted through a clinical interview and may include psychological, laboratory, or other testing and compilation of collateral information from family, friends, and others who are in close proximity to the individual. Assessment is usually conducted by a trained professional who is either licensed or certified to provide mental health and substance use treatment services. Those conducting assessments for substance use and mental health problems would optimally have received advanced graduate-level training and supervised field experience in providing clinical services and have significant experience assessing and diagnosing mental and substance use disorders. Assessment in the criminal justice setting should be conducted by individuals who are knowledgeable about the dynamics of criminal behavior and who understand the pathways and interactions between criminal behavior and clinical pathology related to substance use and mental disorders.

Assessment of CODs provides a comprehensive examination of psychosocial needs and problems, including the severity of mental and substance use disorders, conditions associated with the occurrence and maintenance of these disorders, problems affecting treatment, individual motivation for treatment, and areas for treatment interventions. A risk assessment is often provided that examines a range of “static” (unchanging) and “dynamic” (changeable) factors that independently contribute to the likelihood of criminal recidivism, violence, institutional misconduct, or other salient behaviors. The risk assessment process is described in more detail in “Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System.” As indicated previously, assessment is an ongoing process that helps to engage justice-involved individuals in the treatment planning process, identify strengths and weaknesses, review motivation and readiness for change, examine cultural and other environmental needs, provide diagnoses related to CODs, and determine the appropriate setting and intensity

and scope of services necessary to address CODs and related needs. Several multistaged models for assessing CODs are described in monographs that address both offender and non-offender populations (Mee-Lee, 2013; CSAT, 2005a; 2006a; Steadman et al., 2013).

Goals of the CODs assessment process include the following:

- Examine the scope and severity of mental and substance use disorders, conditions associated with the occurrence and maintenance of these disorders, and interactions between these disorders (e.g., history of symptoms, psychotropic medication use, collateral information)
- History of previous mental health or substance use treatment(s) and response to treatment(s)
- Family history of mental health or substance use disorders
- Development of diagnoses according to formal classification systems (e.g., DSM-5)
- Identification of the full spectrum of psychosocial problems that may need to be addressed in treatment
- Determination of the level of service needs related to mental and substance use problems
- Identification of the level of motivation and readiness for treatment
- Review of other factors that may inhibit engagement in evidence-based services for CODs, such as literacy, transportation, and history of trauma/PTSD
- Examination of individual strengths, areas of functional impairment, cultural and linguistic needs, and other environmental and social supports that are needed
- Evaluation of the risk for behavioral problems, violence, and criminal recidivism that may affect placement in various institutional or community settings
- Review of criminogenic risk factors (or “criminogenic needs”), such as antisocial attitudes and peers, educational deficits,

unemployment, lack of social supports, and absence of prosocial leisure skills

- Provide a foundation for treatment planning

Key Areas to Examine in Assessing Co-occurring Disorders within the Justice System

The following types of information should be examined in assessing CODs within the justice system (Mee-Lee, 2013; CSAT, 2005a; Steadman et al., 2013; NADCP, 2014):

- Juvenile and adult justice system history and current status
- Mental health history, current symptoms, and level of functioning
- Substance use history, current symptoms, and level of functioning
- Suicide risk
- Reasons for living
- Feelings of belonging to a particular social group
- Ability to follow through with intentions of self-harm
- Detail of plans surrounding suicidal ideation
- Length, recency, and frequency of suicidal thoughts
- Chronological history of the interaction between mental and substance use disorders
- Family history of mental and substance use disorders (including birth complications and *in utero* substance exposure)
- Medical status and history of medical disorders
- Current medications and treatment and service providers
- Trauma exposure (including combat, non-combat, and general trauma)
- Social and family relationships
- Family history of criminal involvement, substance use, and mental health conditions
- Interpersonal coping strategies, social skills deficits, problem-solving abilities, and communication skills
- Ingrained patterns of criminal thinking
- Risk for criminal recidivism (i.e., rearrest)
- Each criminal risk factor (also referred to as “criminogenic needs”) that independently contributes to the likelihood of future arrest/recidivism—optimally, assessment will include separate risk scores across each of these domains, so that treatment and supervision strategies can be targeted to address areas of most urgent need
 - » substance use disorders
 - » antisocial beliefs or attitudes
 - » personality style
 - » peers
 - » lack of educational achievement
 - » employment deficits
 - » lack of social support
 - » lack of prosocial leisure skills
- History of violent or aggressive behavior
- Employment/vocational status and related skills
- Socioeconomic status
- Educational history and status
- Literacy, IQ, and developmental disabilities
- Treatment history related to mental disorders, substance use disorders, and CODs, and response to and compliance with treatment (including psychopharmacological interventions)
- Prior experience with peer support groups, including specialized groups for CODs (e.g., Double Trouble) and traditional self-help groups for substance use disorders (e.g., Alcoholics Anonymous [AA] and Narcotics Anonymous [NA])
- Cognitive appraisal of treatment and recovery, including motivation and readiness for change; motivation to receive treatment; self-efficacy; and expectancies related to substance use, use of medication,

and presence of mental and substance use disorders

- The offender's understanding of treatment needs
- Personal goals (short- and long-term) related to treatment and recovery, and other life goals
- Resources and limitations affecting the offender's ability to participate in treatment (e.g., transportation problems, homelessness, child care needs)

Areas to Obtain More Detailed Assessment Information

- *Symptoms of CODs*
 - » Specific mental health and substance use symptoms and severity of the related disorders
 - » Whether symptoms are acute or chronic and how long the individual has had the symptoms and related disorders
 - » Exaggeration or suppression of symptoms to achieve a purposeful goal, such as to avoid placement in an intensive treatment program or to gain access to a more favorable housing unit
- *Substance use history and recent patterns of use*
 - » Assessment of substance use should include the primary substances used over time; other drugs used over time; misuse of prescription drugs; reasons for substance use; context of substance use; involvement with substance-involved peers; periods of abstinence; how abstinence was obtained; frequency of attempts to cut down or quit; substance use treatment history (including medication-assisted treatment); age at first use of substances; and frequency, amount, and duration of use, including patterns of high and low intensity use and level of cravings

- *Mental health history and current psychological functioning*
 - » Mental health information should include current and past symptoms (e.g., suicidality, depression, anxiety, psychosis, paranoia, stress, self-image, inattentiveness, impulsivity, hyperactivity, history of trauma/PTSD), history of mental health treatment (including hospitalizations) and use of medication, and patterns of denial and manipulation
 - » If severe cognitive impairment (e.g., traumatic brain injury [TBI]) is suspected, a Mini Mental Status Examination (MMSE; Folstein, Folstein, McHugh, 1975) or other type of cognitive screen should be administered to assess the level of impairment
 - » If a history of attention deficit/hyperactivity disorder (ADHD) is suspected, assessment should examine attention and concentration difficulties, hyperactivity and impulsivity, and the developmental history of childhood ADHD symptoms
- *History of interaction between the CODs*
 - » It is particularly important to examine the chronological history of the two disorders, including periods before the onset of drug and alcohol use and during periods of abstinence (including enforced abstinence while in jail or prison). Current mental disorders should be assessed relative to the use of alcohol and other drugs to determine if the symptoms subside during periods of abstinence
 - » In some settings, substance use and mental health history information is collected separately. This tends to hinder an understanding of the effects of drugs and alcohol on mental health symptoms, and the extent to which mental disorders exist independently from substance use disorders. These

- issues are particularly important in providing differential diagnosis and in identifying the specific nature of CODs. Unfortunately, few assessment instruments examine the chronological relationship between CODs and the intertwined nature of these disorders
- *Medical/health care history and status*
 - » Key areas to examine include history of injury and trauma, chronic disease, physical disabilities, substance toxicity and withdrawal, impaired cognition (e.g., mental status examination for severe cognitive impairment), neurological symptoms, and prior use of psychiatric medication. Assessment should also examine the presence of chronic health disorders (e.g., diabetes, heart conditions) and infectious disease (e.g., HIV/AIDS, TB, Hepatitis C)
 - *Criminal justice history and status*
 - » The complete criminal history should be reviewed, including prior arrests and reasons for arrests/incarceration, in addition to current criminal justice status
 - *Cultural and linguistic needs*
 - » Cultural beliefs about mental and substance use disorders, treatment services, and the role of treatment professionals, including potential feelings of discrimination from treatment and service practitioners and willingness to report mental health symptoms
 - » Abilities to adapt to the treatment culture and to deal with conflict in these settings
 - » Reading and writing skills
 - » Barriers to providing cultural and linguistic services
 - *Individual strengths and environmental supports*
 - » Ability to manage mental and substance use disorders
- » Risk and protective factors in the home environment (e.g., substance-involved family members or peers) and the potential for relapse to both mental and substance use disorders
 - » Interests and skills
 - » Expectancies related to treatment and recovery
 - » Motivation for change and incentives and goals that are salient for the individual
 - » Vocational skills and educational achievements
- *Social relationships*
 - » Social interactions and lifestyle, effects of peer pressure to use drugs and alcohol, family history, and evidence of current support systems.
 - » Stability of the home and social environment, including violence in the home (e.g., intimate partner violence) and effects of the home and other relevant social environments (e.g., work, school) on abstinence from substance use
 - » Social supports (e.g., peers, family)
 - *Other psychosocial areas of interest*
 - » Housing/living arrangements
 - » Vocational/employment history and training needs
 - » Financial support
 - » Eligibility for entitlements and health insurance status

Developing a Comprehensive Screening and Assessment Approach

Integrated (or blended) screening and assessment approaches should be used to examine CODs in the justice system. In the absence of specialized instruments to address both disorders, an integrated screening approach typically involves use of a combination of mental health and

substance use instruments. Integrated screening and assessment approaches are associated with more favorable outcomes among people in the justice system and in the community (Henderson, Young, Farrell, & Taxman, 2009; Hiller et al., 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011) and help to maximize the use of scarce treatment resources.

Screening and assessment can help to determine the relationship between CODs and prior criminal behavior and to identify the need for criminal justice supervision. Because of the high rates of CODs in justice settings, detection of one type of disorder (i.e., either mental or substance use) should immediately “trigger” screening for the other type of disorder. In general, the presence of mental health symptoms is more likely to signal a substance use disorder than substance use symptoms to signal a mental disorder. However, due to high base rates of both disorders in the justice system, screening and assessment should routinely address both areas. If both mental and substance use disorders are present, the interaction of these disorders and motivation for treatment should also be assessed.

One approach that integrates screening and assessment is the Screening, Brief Intervention, and Referral to Treatment model (SBIRT; SAMHSA, 2011). The SBIRT approach uses evidence-based screening instruments to provide early identification of drug and alcohol problems. Screening information is then used to determine the risk for substance use relapse and to identify the necessity for a brief intervention, counseling, or treatment referral. Although SBIRT demonstrates good potential in identifying people who are at risk for substance use disorders (Madras et al., 2009), there have been equivocal findings related to outcomes with different types of substance-involved populations (Bernstein et al., 2010; Saitz et al., 2007). Additional research is needed to examine SBIRT outcomes implemented in the justice system, and in particular among people who have CODs. The SBIRT approach is

described in more detail in “Screening Instruments for Substance Use Disorders.”

Recommendations for developing an integrated and comprehensive screening and

assessment approach for

CODs in the justice system include the following:

- All individuals entering the justice system should be screened for mental and substance use disorders. Universal screenings are warranted due to the high rates of CODs among individuals in the justice system and to the negative consequences for non-detection of these disorders.
- Universal screening should also be conducted for history of trauma and for PTSD. Although female offenders are disproportionately affected, male offenders also have very high rates of these disorders relative to the general population. Veterans in the justice system may have unique combat-related experience with trauma that a screen may help to identify. Trauma screening is also complicated due to the sensitive nature of the information obtained. Universal trauma awareness and staff training may help to facilitate more detailed assessment of trauma by clinicians working with justice populations.
- Mental health and substance use screening should be completed at the earliest possible point after entry to the justice system. For example, identification of these problems among pretrial defendants will assist the judge in establishing conditions of release (e.g., drug testing, involvement in treatment) that will increase the likelihood of stabilization in the community and the individual’s return for additional court hearings.

The SBIRT approach uses evidence-based screening instruments to provide early identification of drug and alcohol problems.

- Ongoing screening for CODs should be provided at the different stages of criminal justice processing, such as diversion, entry to jail, pretrial and presentence hearings, sentencing, probation, entry to prison, parole or aftercare, and revocation hearings. Ongoing screening will help to identify individuals who are initially reluctant to discuss mental health or substance use problems but who may become more receptive to involvement in treatment services over time. For example, some individuals may seek treatment after learning more about the availability and quality of correctional program services, while others may experience mental health symptoms while incarcerated and elect to participate in treatment.
- Ongoing assessment of CODs and level of criminal risk should occur within the justice system, as the level of functional impairment, symptoms of CODs, motivation to engage in services, and risk level may change over time in both community and institutional settings. Reassessment can lead to important adjustments related to the treatment/case plan, movement to different levels of intensity of treatment and supervision, duration of placement in services, and to sanctions and incentives.
- Whenever feasible, similar and standardized screening and assessment instruments for CODs should be used across different justice settings, with information regarding the results shared among all settings involved. This approach promotes greater awareness of CODs and needed treatment interventions and reduces unnecessary repetition of screening and assessment for individuals identified as having CODs.
- Information from previously conducted screening and assessment should be communicated across different points in the criminal justice system. A systemic approach to information sharing is needed, including development of memoranda

of understanding or agreement among agencies having contact with the offender at different linkage points.

Key Information To Address in Screening and Assessment for Co-occurring Disorders

Individuals with CODs are characterized by diversity in the scope, severity, and duration of symptoms; functional abilities; and responses to treatment interventions (Baillargeon et al., 2009; Clark, Samnaliev, & McGovern, 2007; Lehman, 1996; Mueser et al., 2003; Seal et al., 2011; Van Dorn, Volavka, & Johnson, 2012). The intertwined nature of mental and substance use disorders is reflected in the latest edition of the American Psychiatric Association's DSM-5 (2013), which differentiates between mental disorders and a range of other "substance-induced" mental disorders. Each set of CODs is characterized by differences in prevalence, etiology, and history. The following section specifies key information that should be examined during screening and assessment of CODs in justice settings.

Risk Factors for Co-occurring Disorders

A number of risk indicators for developing CODs should be considered in screening and assessment in the justice system (Brady & Sinha, 2007; Drake et al., 1996; Drake, Mueser, & Brunette, 2007; Gregg et al., 2007; Horsfall, Clearly, Hunt, & Walter, 2009; Seal et al., 2011; Seal et al., 2009; Sung et al., 2010). People who have several of these characteristics should be carefully screened for CODs. As more of these characteristics are observed, there is a greater likelihood of CODs and a corresponding need for more detailed screening for mental health and substance use problems. The following characteristics carry elevated risk for CODs:

- Male gender
- Youthful offender status
- Low educational achievement

- History of unstable housing or homelessness
- History of legal difficulties or incarceration
- Suicidality
- History of emergency room or acute care visits
- High frequency of relapse to substance use
- Antisocial or substance-using peers
- Poor relationships with family members
- Family history of substance use or mental disorders
- History of mental health and substance use treatment, often coupled with patterns of poor adherence to treatment
- History of disruptive behavior

Observable Signs and Symptoms of Co-occurring Disorders

In addition to the previously listed risk factors for CODs, several observable signs and symptoms of mental and substance use disorders should be reviewed during screening and assessment. These include the following:

- Unusual affect, appearance, thoughts, or speech (e.g., confusion, disorientation, rapid or slurred speech)
- Suicidal thoughts or behavior
- Paranoid ideation
- Impaired judgment and risk-taking behavior
- Drug-seeking behaviors
- Agitation or tremors
- Impaired motor skills (e.g., unsteady gait)
- Dilated or constricted pupils
- Elevated or diminished vital signs
- Hyperarousal or drowsiness
- Muscle rigidity
- Evidence of current intoxication (e.g., alcohol on breath)
- Needle track marks or injection sites

Indicators of Mental Disorders

Key indicators relevant to mental disorders that should be examined when screening or assessing for CODs, include the following:

- Acute and observable mental health symptoms
- Suicidal thoughts and behavior
- Age of onset of mental health symptoms
- Mental health treatment history (including hospitalizations), response to treatment, and use of psychotropic medication(s)
- History of trauma, abuse, and neglect
- Disruptive or aggressive behavior
- Family history of mental illness
- Reports of unusual thoughts or behaviors from those who have routine contact with the individual, including family members and community supervision and correctional officers

Indicators of Substance Use Disorders

Similarly, substance use indicators suggest the presence of CODs:

- Evidence of acute drug or alcohol intoxication
- Signs of withdrawal from drugs or alcohol
- Signs of escalating drug or alcohol use (e.g., from drug test results)
- Cravings for drugs or alcohol
- Negative psychosocial consequences associated with substance use
- Self-reported substance use, including
 - » Age at first use
 - » History of use
 - » Current pattern of use
 - » Drug(s) of choice
 - » Motivation for using
- Prior substance use treatment history, including detoxification, outpatient, and residential treatment services
- Peers and associates who are drug users or who have antisocial features

- Family history of substance use disorders
- History of overdose
- History of trauma, abuse, and neglect

Recommended screening instruments for mental, substance use, and co-occurring mental and substance use disorders are provided in the section “Instruments for Screening and Assessing Co-occurring Disorders.”

Cognitive and Behavioral Impairment

Screening and assessment can be useful in detecting key cognitive and behavioral features related to CODs, which can influence the course of treatment and may inform the type and format of treatment provided. One area that typically does not receive sufficient attention during screening and assessment of CODs is cognitive and behavioral impairment related to psychosocial and interpersonal functioning. This functional impairment often affects the individual’s ability to engage and effectively participate in treatment (Bellack et al., 2007; Clark, Power, Le Fauve, & Lopez, 2008; DiClemente et al., 2008; Drake et al., 2008; Gregg et al., 2007; Horsfall et al., 2009). Impairment in interpersonal or social skills is important to assess, as this influences the ability to interact with treatment staff, supervision officers, judges, and other treatment team members. Related areas of functional ability include reading and writing skills and how the individual responds to confrontation or stress and manages unusual thoughts and impulses.

These areas of cognitive and behavioral impairment are not frequently examined through traditional mental health or substance use assessment instruments and yet are often more important than diagnoses in predicting treatment outcome and identifying needed treatment interventions. Assessment of functional impairment typically requires extended observation of the individual’s behavior in settings relevant to the treatment and reentry process. An understanding of functional impairment, strengths, supports, skills deficits, and cultural barriers is

essential to developing an informed treatment plan and to selecting appropriate levels of treatment services (Andrews & Bonta, 2010b; Mee-Lee, 2013; CSAT, 2005a).

People in the justice system who have CODs often have significant cognitive impairment, including deficits related to concentration and attention, verbal memory, and planning abilities or “executive functions” (Bellack et al., 2007; Blume & Marlatt, 2009; Brady & Sinha, 2007; Levy & Weiss, 2009; Peters et al., 2012). In comparison to other offenders, those with CODs are characterized by the following cognitive and behavioral impairments:

- Difficulties in comprehending, remembering, and integrating important information (particularly verbal information), including guidelines and expectations for treatment and supervision
- Lack of recognition of the consequences related to criminal behavior or violations of community supervision arrangements
- Poor judgment (e.g., related to substance use, discontinuation of medication)
- Disorganization in major life activities (e.g., lack of structure in daily activities, lack of follow through with directives)
- Poor problem-solving skills and planning abilities
- Short attention span and difficulty concentrating for extended periods
- Poor response to confrontation and stressful situations
- Impairment in social functioning
- Low motivation to engage in treatment

These cognitive and behavioral deficits are important to consider in the context of screening and assessment for several reasons. First, they may influence the accuracy of information obtained during screening and assessment. For example, due to diminished attention span, agitation, and difficulty in remembering historical information, assessments may need to be administered in several different sessions. Second,

these considerations may shape the process of conducting screening, assessment, treatment, and supervision. For example, the format of treatment groups may need to be modified to include more experiential work; repetition of material; and extensive modeling, practice, and feedback related to psychosocial skills. Third, these deficits may affect the outcomes of treatment and supervision and should be considered in determining the intensity, duration, and scope of treatment and supervision services. Finally, these areas may become the focus of some treatment and supervision activities through interventions such as cognitive and behavioral skills training and motivational enhancement groups. Unfortunately, many of these complex areas of cognitive and behavioral functioning are not easily measured or assessed using traditional instruments. Assessment of these areas is most effectively accomplished over a period of time and through an approach that incorporates observation, interview of collateral sources, review of records, and use of specialized assessment instruments.

Other Psychosocial Areas of Interest

Assessing individual strengths and environmental supports can help to provide optimism for successful recovery, establish strategies for managing mental and substance use disorders, identify key interests and skills, and determine expectancies related to treatment (CSAT, 2005a; Drake et al., 2007; Drake et al., 2008; Horsfall et al., 2009). Treatment goals and interventions developed for justice-involved people who have CODs should capitalize on existing skills and strengths. Cultural and linguistic issues are also important in designing treatment interventions for CODs (CSAT, 2005a; Alegria, Carson, Goncalves, & Keefe, 2011; Hatzenbuehler, Keyes, Narrow, Grant, & Hasin, 2008). Cultural beliefs, for example, may influence perceptions about mental and substance use disorders, engagement in treatment services, and the role of treatment professionals. They may also influence the ability or willingness to adapt to the treatment culture and to handle conflict.

Several demographic and psychosocial indicators should also be reviewed when examining CODs. Assessment should examine educational history, reading and writing capabilities, housing and living arrangements, social interactions and lifestyle, peer influences on use of drugs and alcohol, family history, and current support systems. Deficiencies in reading and writing skills may also influence the ability to successfully engage in treatment planning and other key activities. The stability of the home and social environment should be assessed, to include the occurrence of violence and effects of the home and other relevant social environments (e.g., work, school) on substance use and psychological functioning. Assessment should also consider the vocational and employment history, psychosocial skills, training needs, financial support, and eligibility for entitlements. Many of these psychosocial factors accounted for in mental disorder and substance use assessments are also important for criminal risk and needs assessments. Finally, assessment should explore advantages (and disadvantages) of reducing substance use and becoming abstinent, and should identify various types of “competing responses” to use of substances (e.g., prosocial leisure activities and peers).

Criminal Justice Information

Assessment of CODs in the justice system should carefully examine the criminal history and current criminal justice status. The pattern of prior offenses may reveal important information regarding how mental health and substance use problems have affected criminal behavior. The criminal justice history may also help to identify the need for supervised reentry, case management services, placement in structured residential programs following release from custody, and relapse prevention strategies. Information regarding current criminal justice status will assist in coordinating treatment and management issues with courts and community supervision staff.

In recent years, a number of key “criminal justice characteristics” have been identified among individuals in the justice system who have CODs. These individuals tend to be younger at the time of their first offense and often have a history of aggressive or violent behavior. They also tend to have histories of multiple incarcerations and are often unable to function independently in criminal justice settings (Baillargeon et al., 2010; Castillo & Alarid, 2011; Kubiak, Essenmacher, Hanna, & Zeoli, 2011; McCabe et al., 2012; Mueser, 2005; Sindicich et al., 2014).

Criminal risk should also be carefully examined, as described in more detail in “Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System.” The most salient area of risk is for criminal recidivism, although assessment is sometimes conducted to identify risk for institutional violence, technical violations while on community supervision, and for committing sexual offenses. People in the justice system who have CODs are generally at higher risk for recidivism than other offenders (Skeem, Nicholson, & Kregg, 2008). As described later in this monograph, key areas to include in risk screening and assessment include “static” risk factors (e.g., history of prior felony arrests/convictions, and age at first arrest); “dynamic” risk factors related to antisocial beliefs, attitudes, behaviors, and peers; substance use problems; educational deficits; unemployment/vocational deficits; social and family problems; and lack of prosocial leisure skills. Parental history of involvement in the justice system may give information about the development of antisocial personality characteristics and issues related to child development and early attachment and loss. Assessment of criminal risk can identify the severity of problems in each of these areas and the most important targets for intervention during treatment and supervision. A range of risk assessment instruments are available that can be administered at several different points in the justice system (e.g., pretrial, incarceration, reentry, community supervision).

The following criminal justice information can assist in shaping treatment, supervision, and case/treatment planning services for justice-involved individuals who have CODs:

- Risk for criminal recidivism
- History of felony arrests (including age at first arrest, type of arrest)
- Juvenile arrest history
- Alcohol and drug-related offenses (e.g., driving under the influence (DUI) or driving while intoxicated (DWI), drug possession or sales, reckless driving)
- Number of prior jail and prison admissions and duration of incarceration
- Disciplinary incidents in jail and prison
- History of probation and parole violations
- Current court orders requiring assessment and involvement in treatment, including the length of involvement in treatment (if specified)
- Duration and conditions of current justice system supervision
- Current supervision arrangements (e.g., whether the person is supervised as part of a specialized caseload, the supervising probation or parole officer, frequency of court or supervision appointments, and fees and reporting requirements)
- Currently mandated consequences for noncompliance with conditions of supervision, including any conditions related to treatment follow up

Drug Testing

There is a long-recognized relationship between chronic drug use and crime (Bennett, Holloway, & Farrington, 2008; Hser, Longshore, & Anglin, 2007; Paparozzi & Guy, 2011; Schroeder, Giordano, & Cernkovich, 2007; Stevens, 2010; Warren, 2008). National studies conducted by the Arrestee Drug Abuse Monitoring (ADAM) program indicate that over 60 percent of individuals charged with a criminal offense test positive for drug use at the time of arrest (National Institute of Justice [NIJ], 2003; Valdez, Kaplan,

& Curtis, 2007). Heavier drug users demonstrate more frequent and more severe criminal behavior that fluctuates with their drug use (Anglin et al., 1996; Bennett et al., 2008; Carpenter, 2007). Decreasing substance use among justice-involved individuals through treatment and monitoring can ultimately reduce the frequency of crimes (particularly violent crimes) committed by this population. Drug testing is often used to identify and monitor substance use, abstinence, relapse, and overall treatment progress in the justice system due to limitations of self-report data (Dupont & Selavka, 2008; Kleinpeter, Brocato & Koob, 2010; Large, Smith, Sara, Paton, Kedzior, & Nielsens, 2012; Martin, 2010; Peters, Kremling, & Hunt, 2015; Rosay et al., 2007). Drug testing is preferred over other means of detecting use, such as self-report or observation of symptoms, because it increases the likelihood of detection and reduces the lag time between relapse and detection (Dupont & Selavka, 2008; Large et al., 2012; Martin, 2010).

Drug testing can be conducted at all stages of the justice system, including after arrest; before trial; and during incarceration, probation, and parole (Friedmann, Taxman, & Henderson, 2007; Kleinpeter et al., 2010; Paparozzi & Guy, 2011). Drug testing can inform judges whether conditions regarding substance use should be included in bail setting and sentencing. It can be used to ensure that an individual is meeting such requirements; for example, testing can provide information about abstinence during probation and parole supervision. Use of drug testing is particularly important in drug courts, mental health courts, and in other diversion programs that provide supervised treatment and case management services in lieu of prosecution or incarceration (Marlowe, 2003; NADCP, 2014; Paparozzi & Guy, 2011). For example, within drug courts, routine monitoring of substance use is often linked to sanctions that are established in advance and that escalate. Examples of sanctions include verbal reprimands by the judge, writing assignments, community service, and increasing intervals of detention.

When used in combination with treatment, routine drug testing can encourage treatment retention, compliance, and program completion. Positive drug tests, failure to submit to drug testing, or adulterated samples should lead to routine notification of judges, supervision officers, and others who provide oversight of the individual within the justice system. In order to reduce the prevalence of adulterated samples, individuals should be supervised by a gender-matched individual while providing the sample, and a confirmatory sample should be provided as soon as possible if adulteration is suspected (Mee-Lee, 2013; Cary, 2011; NADCP, 2014). Saliva testing can be used as a confirmatory sample because saliva collection is less easily tampered with and is relatively easy to obtain (Heltsley et al., 2012; Sample et al., 2010). Refusal to submit to drug testing and tainted samples should be regarded as positive test results. However, positive test results must be confirmed by use of additional “gold standard” testing procedures (e.g., gas chromatography/mass spectrometry–GC/MS) using the original specimen provided (Mee-Lee, 2013; Cary, 2011; Meyer, 2011; NADCP, 2014; Paparozzi & Guy, 2011).

Research examining the effectiveness of drug testing and supervision in reducing relapse, rearrest, failure to appear in court, and unsuccessful termination from probation and parole has demonstrated mixed results (Cissner et al., 2013; Gottfredson Kearley, Najaka, & Rocha, 2007; Hawken & Kleiman, 2009; Kinlock, Gordon, Schwartz, & O’Grady, 2013; Kleinpeter et al., 2010; Zweig, Lindquist, Downey, Roman, & Rossman, 2012). For example, when assessing whether pretrial drug testing reduced individual misconduct during pretrial release, drug testing was related to lower rearrest rates but not lower failure-to-appear rates at one site, and lower failure-to-appear rates but not lower rearrest rates at another site (Rhodes, Hyatt, & Scheiman, 1996). Variability in drug testing procedures (e.g., frequency, responses to positive drug tests) has been cited as a possible cause of these differences

(Carey, Finigan, & Pukstas, 2008; Kleiman, 2011; NADCP, 2014; Zweig et al., 2012).

Drug testing has different legal implications based on the stage of justice processing at which it is used (NADCP, 2014; Cary, 2011; Carey, Mackin, & Finigan, 2012; Harrell & Kleiman, 2001; Marlowe, 2011; Marlowe, 2012b). When drug testing is performed at the pretrial stage, it typically cannot be used as evidence or considered in case outcomes, unless the arrestee enters a preplea diversion program. Under these conditions, prosecution is deferred pending successful completion of a substance use treatment or other intervention program. Drug testing is often used in conjunction with treatment and sanctions after a guilty plea has been submitted and prior to sentencing. Individuals unable to remain abstinent or to otherwise abide by program requirements and guidelines in diversionary or postsentence treatment settings are often sentenced and processed through traditional criminal justice channels (NADCP, 2014; Carey et al., 2012).

All justice-involved individuals who have CODs, including those in jail and prison, should be drug tested (Carey et al., 2008; Carey et al., 2012; Gotfredson et al., 2007; Hawken & Kleiman, 2009; Kinlock et al., 2013; NADCP, 2014). More frequent drug testing should be provided for individuals who are at high risk for relapse, including people who have CODs, difficulties in achieving sustained abstinence, a history of frequent hospitalization, unstable housing arrangements, and who have been recently released from custody or are returning from community furloughs/visits. In general, drug testing should begin immediately after an arrest or other triggering event that brings the individual into contact with the justice system, and should be administered randomly but at consistent intervals during the course of treatment, supervision, and incarceration.

For offenders with CODs, drug testing should be provided at least weekly, and optimally twice weekly during the first few months of community

treatment and supervision (Carey et al., 2008; Carey et al., 2012; NADCP, 2014). The frequency of drug testing may be tapered off as the individual demonstrates the ability to remain abstinent. However, risk of relapse is an ongoing issue, particularly when the frequency and intensity of services are reduced as participants move successfully through program stages. Thus, it is important to continue drug testing over time to confirm gains made during treatment, and as people progress through treatment in the justice system (Cary, 2011; Marlowe, 2011, 2012; NADCP, 2014). It is equally important to develop models of intervention that recognize that relapse is part of the recovery process.

Drug testing can present some interesting challenges when working with justice-involved individuals who have CODs. For example, among people with mental disorders, drug testing can lead to distrust of treatment and service practitioners and reluctance to actively engage in treatment. It is important to carefully discuss drug-testing expectations, parameters, and consequences and to adhere consistently to drug-testing guidelines and to reconfirm these on a regular basis. Individuals who are aware of these expectations and parameters at the onset of substance use treatment are more likely to comply with these guidelines (Burke & Leben, 2007; NADCP, 2014; Tyler, 2007).

Another challenge is coordination of drug testing among several different treatment and service practitioners. Often times, drug testing and treatment planning are not properly coordinated between community treatment and service practitioners (e.g., primary care physicians) and staff working in criminal justice settings. For example, physicians in the community may prescribe anti-anxiety medications (e.g., benzodiazepines) that may interfere with or undermine substance use treatment, and this information may not be communicated with community supervision staff or other justice-related personnel. In some cases, medications prescribed for alcohol or opioid addiction (e.g.,

methadone, naltrexone, buprenorphine) may be misused by offenders and may actually undermine substance use treatment if drug testing and careful monitoring are not provided. In other cases, drug testing may be ordered by several different treatment and service practitioners, and this information needs to be shared with staff who are providing criminal justice supervision and treatment services. Thus, it is important for staff in criminal justice settings to involve community health care practitioners in treatment planning and in ongoing discussions about medication use, including sharing of information regarding drug testing and prescription medication. This approach will assist in preventing relapse, crafting appropriate sanctions, and reinforcing the importance of drug testing as an integral part of the overall treatment plan.

Frequency of Drug Testing

Two types of testing schedules are typically used once it is determined that drug testing is appropriate for a particular individual (Robinson & Jones, 2000). “Spot testing” is usually performed if it is suspected that an individual is currently intoxicated and if a certain event occurs, such as a suspected resumption of criminal activity. Spot testing can also be useful for detecting drug or alcohol use during high-risk periods, such as weekends or holidays (NADCP, 2014). These are unscheduled and use drug-testing methods that can be administered easily and inexpensively on site. Research indicates that during the initial phases of treatment, conducting drug tests at least twice weekly are most effective because drug detection windows are 2–4 days for most types of drugs (Carey et al., 2008; Carey et al., 2012). Blood and saliva testing are the most accurate methods of testing, as these are difficult to adulterate (Paparozzi & Guy, 2011). The utilization of breathalyzers is also useful during early stages of treatment, as well as examination for physical and behavioral signs of drug effects, such as cognitive symptoms or hand-eye coordination.

Random drug testing allows programs to discourage use while minimizing the cost of

frequent testing. Individuals do not know when they will be called in for testing and as a result are less likely to use substances or to tamper with the drug testing process. Offenders in the community are often required to phone in to a central location each morning to learn if they have to submit to a drug test that day. If they are given such a notice, they are required to report for drug testing within 10–12 hours. Although it is common practice to schedule testing in weekly blocks, individuals should be tested multiple times a week, so that offenders can’t anticipate what day of the week they will be tested. Testing in weekly blocks increases the chances that offenders will engage in short-term drug use, in which the drugs may be out of their system by the next drug test (Marlowe & Wong, 2008). Random drug testing is the most effective in deterring substance use because the likelihood of detection is very high (Mee-Lee, 2013; American Society of Addiction Medicine, 2010; Auerbach, 2007; Cary, 2011, McIntire et al., 2007).

Regardless of the drug testing schedule, any on-site testing should be sent to a lab for confirmation of a positive result to ensure the results are legally admissible. This is particularly important for alternative drug testing methods, such as hair, sweat, or saliva testing. Confirmatory lab testing is rarely performed, however, due to the expense of such testing. However, it is important to be able to confirm drug test results, as it may become necessary to produce this as evidence in court.

Types of Drug Testing

Several different types of drug tests are available that vary according to the level of accuracy and intrusiveness but are generally quite reliable. Six types of drug testing are commonly used in justice settings, including those that examine urine, blood, hair, saliva, sweat, and breath. Improvements in urine testing across classes of drugs include the use of portable urine technology (PUTT), which provides several advantages over larger but outdated approaches (e.g., Enzyme Multiple Immunoassay Technique –EMIT). PUTT can be provided at a relatively low cost, provides fast and efficient results, and

offers ease of testing and interpretation. Examples of PUTT are test strips, test cups, and hand-held cassettes, which allow for frequent and random drug testing (Paparozzi & Guy, 2011). Another detection device that has gained recent attention for improving compliance among alcohol users is the Secure Continuous Remote Alcohol Monitor (SCRAM). The SCRAM device is worn on the ankle, and is able to detect alcohol vapor in sweat and to wirelessly transmit this data.

Hair testing provides an option for long-term detection of drug use, and has advantages in that it is difficult to adulterate hair samples. However, as noted in Table 1, caution should be used when conducting hair testing because of the risk for external environmental contaminants and for racial bias (Cooper, Kronstrand, & Kintz, 2012; Vignali, Stramesi, Vecchio, & Groppi, 2012).

In order to decrease the probability of external contamination, it is recommended that hair samples be taken from the scalp, as this hair has the least variability in growth, and increases the probability of detecting the ingested drug(s). Hair samples should be approximately 0.5–1 inch in length. Moreover, it is recommended that hair samples be washed prior to testing because this removes not only environmental contaminants, but also contaminants from skin cells, bodily fluids, and hair products. Although there are no standard procedures for washing hair samples, solvents like acetone should be used because this removes external contaminants but does not remove traces of the ingested drug(s). Other solvents with methanol should not be used because these can remove traces of the ingested drug(s).

Table 1. Comparison of Alternate Drug Testing Methodologies

Sample	Invasiveness of Sample Collection	Detection Time	Cutoff Levels	Advantages	Disadvantages	Cost
Urine	Intrusion of privacy	Hours to days	Yes	High drug concentrations; established methodologies; quality control and certification	Cannot indicate blood levels; easy to adulterate	Low to moderate
Blood	Highly invasive	Hours to days	Variable limits of detection	Correlates with impairment	Limited sample availability; infectious agent	Medium to high
Hair	Noninvasive	Weeks to months	Variable limits of detection	Permits long-term detection of drug exposure; difficult to adulterate	Potential racial bias and external contamination	Moderate to high
Sweat	Noninvasive	Days to weeks	Screening cutoffs	Longer time frame for detection than urine; difficult to adulterate	High inter-individual differences in sweating	Moderate to high
Saliva	Noninvasive	Hours to days	Variable limits of detection	Results correlate with impairment: provides estimates of blood levels	Contamination from smoke; pH changes may alter sample	Moderate to high
Breath	Noninvasive	Hours	No, except for ethanol	Ethanol concentrations correlate with impairment	Very short time frame for detection; only detects volatile compounds	Low to moderate

Hair samples should be collected within 4–6 weeks after drug ingestion to increase chances of detection. A positive hair sample should be confirmed with a separate second hair sample test. Hair samples should be dried upon collection, as wet samples can alter analysis results (Cooper et al., 2012). Finally, it is important to consider racial bias, as it is unclear whether hair testing is equally effective in identifying cocaine use among ethnic or racial minorities. For example, studies indicate that there may be low agreement in frequency of consumption and concentration levels found in hair samples, particularly among African Americans, for whom concentrations may be higher than indicated by self-reported substance use (Vignali et al., 2012).

Other forms of urine testing are available that increase the window of detection for up to several days for specific metabolites of alcohol, ethyl glucuronide (EtG) and ethyl sulfate (EtS) (Cary, 2011). Procedures are also available to detect adulteration of drug test samples, including measurement of the temperature of samples (temperatures should range between 90 and 100° F), where lower temperatures may indicate tampering. Creatinine levels can also be measured, for which lower concentrations (below 20 mL) may indicate adulteration of test samples (Mee-Lee, 2013; Katz, Katz, Mandel, & Lessenger, 2007). Detailed information about each type of drug testing is included in Table 1, which also provides a comparison of key features, as well as advantages and disadvantages of the different types of drug testing. Standard procedures used by most drug-testing companies include the SAMHSA 5 (previously known as the NIDA 5), and the NIDA 7, NIDA 8, and NIDA 10, which provide testing for commonly used illegal drugs whose detection has been standardized by the National Institute on Drug Abuse (NIDA) due to the frequency of their use (Clark & Henry, 2003). The NIDA 7, 8, and 10 test for additional drugs not covered by the SAMHSA 5 panel. For example, the NIDA 8 test panel examines the following drugs:

- cannabinoids (marijuana, hash)
- cocaine (cocaine, crack)
- amphetamines (amphetamines, methamphetamines, speed)
- opiates (heroin, opium, codeine, morphine)
- phencyclidine (PCP)
- MDMA (ecstasy)
- barbiturates
- benzodiazepines

The NIDA 10-panel screen tests for hydrocodone and oxycodone in addition to the drugs in the NIDA 8 panel, while the NIDA 7 screens for MDMA in addition to the standard SAMHSA 5 drugs and distinguishes between amphetamines and methamphetamines.

Standardization of drug testing procedures occurred while NIDA was responsible for overseeing the National Laboratory Certification Program (NLCP), which certifies all nationally recognized drug-testing laboratories. The NLCP is now operated by SAMHSA. The NIDA 8-10 panels are not typically conducted on site, and are sent to SAMHSA-certified labs for analysis.

In general, it is important to note the rapid development of alternative drugs that are not identified through these standard drug-testing procedures, such as “Spice” and “K2.” Offenders may elect to use these during periods of drug testing (e.g., while involved in treatment) to avoid detection of cannabinoids. Thus, random testing of a wide variety of standard and alternative drugs is advised (Mee-Lee, 2013; Cary, 2011; Perrone, Helgesen, & Fischer, 2013).

Chain of Custody Process

To ensure that a drug test sample is admissible in court, documented procedures must be in place for collection, testing, and storage. Clear procedures should be established that delineate the chain of custody from the time of sample collection to the time of official reporting of drug test results within the justice system. All professionals involved in this process are ultimately held accountable

for their role in maintaining standards for drug testing (Mee-Lee, 2013; Cary, 2011; Meyer, 2011; NADCP, 2014). All laboratory tests should examine the likelihood of tampering or adulteration. Specimens should be stored in a locked, temperature-controlled space and remain there until the possibility of a challenge or court hearing has passed. Records should be kept that document the chain of custody regarding responsibility for oversight of the specimen at each point in the drug testing process, as well as the time and date that any particular activity occurred. Key drug testing activities include the following (NADCP, 2014):

- The individual reporting for testing or check-in
 - Sample collection
 - Storage procedures
 - Examination of the sample for adulteration
 - Transportation to the laboratory
 - Sample testing
 - Follow-up tests
 - Review of the results
 - Recording of the results
- Previous results of screening and assessment, which have been conducted under suboptimal conditions or by untrained staff who may not be aware of unique issues related to CODs
 - Incomplete, mislabeled, or misleading clinical or criminal justice records
 - The transparent nature of screening and assessment instruments may lead to individuals providing false information
 - Offenders may anticipate negative consequences related to disclosure of mental health or substance use symptoms
 - Symptoms may be feigned or exaggerated if an offender believes this will lead to more favorable placement or disposition
 - Results of previous screening or assessment may be invalid due to changes in the level of functioning, symptoms, and level of criminal risk

Enhancing the Accuracy of Information in Screening and Assessment

There are numerous challenges in gathering accurate screening and assessment information regarding people who have CODs in the justice system (Fletcher et al., 2009; Lehman et al., 2009; Taxman et al., 2009). Accuracy of information obtained during screening and assessment can be compromised by many factors (Cropsey et al., 2007; Hiller et al., 2011; Osher, 2008; Peters et al., 2012; Zweig et al., 2012), including the following:

- Inadequate staff training and poor familiarity with mental and substance use disorders
- Time constraints in conducting screening and assessment

Another complicating factor is that individuals vary greatly in their expression of CODs. Mental and substance use disorders have a waxing and waning course and may manifest differently at different points in time. Individuals who have mental disorders may be particularly vulnerable to the effects of substance use, even in relatively small amounts. For example, small amounts of alcohol or drug use can heighten symptoms of mental disorders. Symptoms of severe substance use disorders may vary depending on the substances used and accompanying mental disorders. The chronic nature of substance use also makes it difficult to date the onset and duration of CODs and periods of abstinence. Cognitive impairment and other mental health symptoms may lead to inaccurate recall of information. Undiagnosed TBI (e.g., as a result of frequent fights, injuries from falling, or of combat among veterans) may also influence the level of cognitive impairment. Finally, the consequences of substance use among justice-involved people who have CODs may be quite different than among other populations, including revocation of

probation or parole, and incarceration in jail or prison.

Symptom Interaction between Co-occurring Disorders

Screening and assessment of CODs are often rendered more difficult by symptom interactions, including symptom mimicking, masking, precipitation, and exacerbation (Brady & Sinha, 2007; Horsfall et al., 2009; Schladweiler, Alexandre, & Steinwachs, 2009; Tsuang, Fong, & Lesser, 2006). Understanding these interactions is important in identifying issues that may contribute to substance use relapse, recurrence of mental health symptoms, or both (Donovan, 2005; Gil-Rivas, Prause, & Grella, 2009; Mazza et al., 2009; Schladweiler et al., 2009). Ongoing observation of symptom interaction is often needed to provide differential diagnosis of various mental and substance use disorders.

Several important types of symptom interaction should be noted:

- Use of alcohol and drugs can create mental health symptoms
- Alcohol and drug use may precipitate or elicit symptoms of some mental disorders
- Mental disorders can precipitate substance use disorders. Most individuals who have CODs indicate that mental health symptoms preceded their substance use
- Mental health symptoms may be worsened by alcohol and other drugs
- Mental health symptoms or disorders are sometimes mimicked by the effects of substance use (e.g., cocaine intoxication can cause auditory or visual hallucinations)
- Alcohol and other drug use may mask or hide mental health symptoms or disorders (e.g., alcohol intoxication may mask underlying symptoms of depression)

The considerable symptom interaction between CODs often leads to difficulty in interpreting whether symptoms are related to a mental disorder or to a substance use disorder (Steadman et

al., 2013). Justice-involved individuals who have CODs may have difficulty providing an accurate history of symptom interaction due to cognitive impairment, active mental health symptoms, confusion regarding the effects of their substance use, and to the chronic nature of their alcohol and drug use (Bradburn, 2000; Langenbucher & Merrill, 2001; Sacks, 2008). Justice-involved individuals may also anticipate negative consequences related to self-disclosure of mental health or substance use symptoms, such as placement under more restrictive conditions of supervision or placement in more intensive treatment. Alternatively, symptoms may be feigned or exaggerated if an individual believes this will lead to more favorable placement or disposition. For example, individuals who are incarcerated may falsely report mental health symptoms to receive medication, housing in medical units, or contact with medical staff.

Accuracy of Self-report Information

Screening and assessment of mental and substance use disorders in the justice system is most often based on self-report information. In general, self-report information has been found to have fair to good reliability and specificity but does not always identify the full range of symptoms of CODs (Drake, Rosenberg, & Mueser, 1996; Peters et al., 2015; Hjorthoj, Hjorthoj, & Nordentoft, 2012; Schuler, Lechner, Carter, & Malcolm, 2009; Wood, 2008). Furthermore, self-report information obtained from justice-involved individuals has been found to be valid and useful for treatment planning (Landry, Brochu, & Bergeron, 2003; Schuler et al., 2009; Peters, et al., 2015; Wood, 2008). In post-adjudicatory settings, self-reported criminal history information tends to be more comprehensive than information obtained solely from archival records, and self-reported demographic information is quite consistent with archival records.

Accuracy of self-reported substance use can be influenced by several factors. Self-reported substance use information provided by justice-

involved individuals has been found to be generally less accurate than that provided by clients enrolled in substance use treatment and patients interviewed in emergency rooms (Magura & Kang, 1996; McCutcheon et al., 2009; Sloan, Bodapati, & Tucker, 2004). The validity of self-report information in the justice system is also influenced by the type of substances used (Mieczkowski, 1990; Peters et al., 2015; Hjorthoj et al., 2012; Rosay et al., 2007). For example, individuals are more likely to admit to marijuana use rather than opiate or cocaine use, and are least likely to admit to cocaine use, followed by amphetamines, opiates, and marijuana (Knight, Hiller, Simpson & Broome, 1998; Lu, Taylor, & Riley, 2001; Peters et al., 2015; Hjorthoj et al., 2012; Rosay et al., 2007). Accuracy of self-reported substance use is less accurate for patterns of recent use (De Jong & Wish, 2000; Large et al., 2012; Lu, Taylor, & Riley, 2001; Magura & Kang, 1996; Yacoubian, VanderWall, Johnson, Urbach, & Peters, 2003). In one study (Harrison, 1997), only half of arrestees who tested positive for drug use reported recent use.

Other important factors influencing accuracy of self-reported substance use are discrimination and perceived consequences related to detection of use, including enhanced severity of criminal sentences, more stringent conditions of supervision, more intensive treatment, and incarceration. Some offenders may try to influence others' perception of their drug use to avoid social exclusion (i.e., positive impression management) by minimizing reported substance use. Demographic and background variables may affect the accuracy of reporting. Youthful and African American offenders tend to underreport crack/cocaine use in comparison to other offenders. Female offenders are more likely than males to provide accurate self-reporting of substance use (Peters et al., 2015; Rosay et al., 2007; Schuler et al., 2009). The presence of mental disorders and physical and cognitive impairment may also affect the accuracy of self-disclosed substance use, in addition to cultural issues and credibility of the interviewer (Blume, Morera, & García de la Cruz, 2005; Del

Boca, Darkes, & McRee, 2013; Kuendig et al., 2008; Peters et al., 2015). Given the potentially significant consequences for detection of alcohol and other drug use in justice settings, it is widely accepted that self-report information should be supplemented by collateral information and drug testing when available.

Strategies for maximizing the accuracy of self-report information include providing clear instructions regarding the screening and assessment process, engaging justice-involved individuals in a dialogue about the purpose of screening and assessment, establishing rapport through use of motivational interviewing and other related techniques, and carefully explaining the scope of and limits to confidentiality and the potential consequence for reporting mental health and substance use problems (Del Boca et al., 2013; Sacks, 2008). Specifying a time frame related to past substance use rather than asking about "typical" or "usual" substance use patterns also enhances the reliability of self-report information (Del Boca & Darkes, 2003; Del Boca et al., 2013).

Use of Collateral Information

Whenever possible, results from interviews and instruments used to examine CODs should be supplemented by collateral information obtained from family members, friends, house mates, and other informants who have close contact with the individual (DeMarce, Burden, Lash, Stephens, & Grambow, 2007; Stasiewicz et al., 2008). In addition, observations of symptoms and behaviors by arresting officers, booking officers, correctional staff, probation and parole officers, treatment staff, case managers, and other staff can provide relevant collateral information. Nonclinical staff who interact with the justice-involved individual may be particularly helpful in describing withdrawal symptoms; relapse indicators; mental health symptoms; and other significant psychosocial problems, such as self-destructive behaviors or interpersonal difficulties.

Observation by family members, friends, or direct care staff can provide information that is

as accurate as data compiled from interviews or standardized instruments (Comtois, Ries, & Armstrong, 1994; DeMarce et al., 2007; Stasiewicz et al., 2008). For example, in community settings, the combination of ongoing observation, collateral reports, and interviews has produced the most accurate information regarding current alcohol use among individuals with schizophrenia (Drake et al., 1990). Substance-using associates often provide more accurate information than non-using family members regarding patterns of substance use (Hagman, Cohn, Noel, & Clifford, 2010; Kosten & Kleber, 1988). Unfortunately, individuals who have CODs often have constricted social networks and live in isolated settings, thus limiting the use of collateral informants (Drake, Alterman, & Rosenberg et al., 1993; Hawkins & Abrams, 2007; Min, Whitecraft, Rothbard, & Salzer, 2007; Stasiewicz et al., 2008).

Use of an Extended Assessment Period

Many individuals who are screened or assessed for CODs in justice settings may be under the influence of alcohol or other drugs. In order to accurately examine CODs and related issues, these individuals need to be provided a period of detoxification. Even for those in jail or prison, residual effects of substance use may cloud the symptom picture for several months after incarceration.

If there is uncertainty regarding recent substance use, an extended assessment period or “baseline” is recommended to help determine whether mental health symptoms are likely to resolve, persist, or worsen. While the DSM-IV-TR and DSM-5 (APA, 2000; APA, 2013) indicate that individuals should be abstinent for approximately 4 weeks before an accurate mental health diagnosis can be provided, the precise length of the extended baseline for screening and assessment should be determined by the severity of the symptoms and the general health status. The utility of screening and assessment in detecting mental health or substance use needs may be limited among justice-involved individuals whose symptoms are

in temporary remission, especially if the instruments utilized focus primarily on current symptoms. It may be more relevant to examine and incorporate the history and level of psychosocial functioning during the past year in making determinations related to service and treatment needs.

...it is...important to reassess risk for criminal recidivism, as the specific factors that contribute to recidivism risk (e.g., criminal peers, employment, family supports) can change over time, leading to lower or higher risk levels

When using an extended assessment period, addressing acute symptoms and safety issues (e.g., suicidal behavior) should take precedence over the development of diagnoses. With careful medical assessment, psychotropic medication can be provided to treat acute mental health symptoms among individuals with CODs who are suspected of recent drug or alcohol use. Given the variability of symptoms over time among justice-involved individuals with CODs, diagnostic indicators should be continually reexamined by staff who are knowledgeable about patterns of symptom interaction. As discussed previously, it is also important to reassess risk for criminal recidivism, as the specific factors that contribute to recidivism risk (e.g., criminal peers, employment, family supports) can change over time, leading to lower or higher risk levels. In many justice settings, criminal risk is reassessed via standardized risk assessment instruments approximately every 6 months, as this provides a sufficient window to allow relevant changes to occur.

Several steps are often taken during an extended assessment period to determine the presence, scope, and severity of CODs:

- Assess the significance of the substance use disorder

- » Obtain a longitudinal history of mental health and substance use symptom onset
- » Analyze whether mental health symptoms occur only in the context of substance use and identify specific types of mental health symptoms and related behavioral problems that have been elicited by prior substance use. For justice-involved individuals, it is particularly important to identify in advance the types of sanctionable behaviors that have occurred in the past during periods of relapse. It is also useful to ascertain whether criminal justice sanctions and rewards have influenced the degree and intensity of substance use
- » Determine whether sustained abstinence leads to rapid and full remission of mental health symptoms
- Determine the length of current abstinence
 - » If 4 weeks of abstinence has not been achieved, diagnosis and full interpretation of the interactive effects of CODs may be delayed until abstinence has been achieved
- Reassess mental health symptoms after a period of sustained abstinence
- As mental health symptoms resolve, traditional substance use treatment services may be appropriate (e.g., drug courts, intensive outpatient programs); if not, the individual may require specialized mental health or CODs treatment services
- Periodically reevaluate criminal risk and the symptoms of mental and substance use disorders to determine the level of treatment, ancillary services, housing assignments (if in correctional settings), and supervision that are needed

Other Strategies To Enhance the Accuracy of Screening and Assessment Information

- Use archival records to examine the onset, course, diagnoses, and response to treatment of mental and substance use disorders, and other relevant history
- Wait to use self-report instruments until it is determined that an individual is not intoxicated or in withdrawal
- Re-evaluate using self-report instruments if initial assessments were conducted during a period when mental health symptoms were more prominent
- Provide repeated screening and assessment over time
- Utilize interview settings, to the extent possible in justice settings, to promote disclosure of sensitive clinical information
- Compile self-report information in a nonjudgmental manner and in a relaxing setting when possible (some screenings take place in lock-ups and other more restrictive settings, and the lack of privacy, external noise, and other factors may need to be taken into account when examining responses)
- The interview should be prefaced by a clear articulation of the limits of confidentiality, and the justice entities involved in receiving information
- Examine nonintrusive information first (e.g., background information), during the assessment interview. After rapport has been established, proceed to address substance use issues and other domains (e.g., living situation, educational and vocational history). Sometimes gathering mental health information near the end of the assessment interview offers a chance to develop rapport before asking about information that may be more prejudicial and difficult to disclose; at the same time, engaging with the person requires that the interviewer meet the person where they

are, and if they choose to begin with their mental health history, the interviewer needs to flexibly adapt to this new interview sequence

- Use motivational interviewing techniques to enhance accurate self-reporting. Key techniques include expressing empathy, fostering an understanding of the discrepancy between a person's stated life goals and current behaviors (e.g., substance use), avoiding arguing, addressing resistance by offering new options, encouraging behavior change, and supporting self-efficacy and self-confidence
- Depending on the context, use of a structured interview approach may be preferable. This may include (1) screening for consequences of substance use, (2) a lifetime history related to CODs, (3) a calendar method to document patterns of substance use in recent months (e.g., use of timeline follow-back procedure), and (4) assessment of current and past substance use
- Review the psychometric properties of available screening and assessment instruments. Research indicates that these instruments have different levels of specificity, sensitivity, and overall accuracy in justice settings and may also vary in their effectiveness with different ethnic and racial groups

Special Clinical Issues in Screening and Assessment for Co-occurring Disorders in the Justice System

Risk Assessment

Identifying "High Risk" and "High Need" Offenders

There is abundant evidence indicating that programs for offenders with CODs, where there are limited resources and where the goal is to reduce recidivism, should target those who are at "high risk" for recidivism (Andrews, 2012; Andrews & Bonta, 2010a; Kushner, Peters,

& Cooper, 2014). Criminal risk is typically determined by examining a combination of "static" or unchanging factors (e.g., age at first arrest, number of prior arrests/convictions) and "dynamic" or changeable factors, otherwise known as "criminogenic needs" (see description to follow), which independently contribute to the risk for recidivism. Programs that target high-risk offenders reduce recidivism by an average of 10 percent (Bonta & Andrews, 2007), and yield approximately double the economic benefits (Bhati, Roman, & Chalfin, 2008; Lowenkamp, Holsinger, & Latessa, 2005; Lowenkamp, Latessa, & Holsinger, 2006). Targeting "high risk" and "high need" offenders is consistent with principles of the widely accepted Risk-Need-Responsivity (RNR) model, which is described later in this monograph (Andrews, Bonta, & Wormith, 2006; Bonta & Andrews, 2007; McMurrin, 2009). The "Risk Principle" from this model indicates that the intensity of services provided by CODs programs should be proportional to the risk of recidivism, and that the most intensive services should be reserved for higher risk offenders (Andrews & Bonta, 2010; Bonta & Andrews, 2007).

Research has identified a common set of "criminogenic needs" that should be addressed in offender treatment programs, including specialized CODs programs (Andrews et al., 2006). Attention to these needs can have a cumulative effect in reducing recidivism (Andrews & Bonta, 2010a; Carey & Waller, 2011). Thus, offender programs should focus on multiple needs that are linked to recidivism (Bonta & Andrews, 2010). These criminogenic needs are dynamic, and can be changed through interventions such as those provided in specialized and highly structured CODs treatment programs. Offender programs that focus on criminogenic needs result in average reductions in recidivism of 19 percent (Bonta & Andrews, 2007). The major criminogenic needs include the following:

- Antisocial attitudes
- Antisocial personality features
- Antisocial friends and peers

- Substance misuse
- Family and social/relationship problems
- Education deficits
- Poor employment skills
- Lack of prosocial leisure activities

Programs for offenders with CODs should also avoid targeting areas that have been found to be unrelated to the risk for recidivism, such as self-esteem and emotional discomfort, and structured disciplinary programs, such as “boot camps” (Andrews & Bonta, 2010b).

Although mental disorders are not independently linked with recidivism (Fisher et al., 2014; Junginger, Claypoole, Laygo, & Crisanti, 2006), offenders who have mental disorders are at high risk for recidivism due to elevated levels of criminogenic needs, including substance use disorders, lack of education, unemployment, and lack of social support (Skeem, Nicholson, & Kregg, 2008). Thus, while treating mental disorders alone does not reduce risk for recidivism among offenders with CODs, it is vitally important to involve these people in comprehensive treatment that addresses a range of criminogenic needs. Enhanced mental health functioning can contribute to the responsivity of other interventions that reduce recidivism (e.g., substance use treatment); thus, mental health treatment is considered an important area to target among offenders. For example, if an individual is too depressed to get out of bed, he or she may miss a probation appointment or a mandated drug screen, potentially resulting in a violation of conditions of probation and arrest. This does not mean the mental disorder increases criminal conduct, but it can contribute to further penetration within the justice system, especially related to technical violations. Also, the ability for probation to supervise effectively can be impacted by mental disorders. While there are legal mandates for providing mental health services in correctional settings, these services also help to ameliorate behavioral problems and human suffering. In addition, treatment of mental health problems is

of critical importance in engaging offenders who have CODs in other evidence-based services, such as substance use treatment, vocational training, educational services, and family counseling, again fostering their responsivity to these interventions.

Criminal justice programs should not focus intensive oversight and services on offenders who have low levels of risk and criminogenic needs, as this approach is likely to ineffectively allocate intensive resources for individuals who do not require them (DeMatteo, 2010; Lowenkamp & Latessa, 2005). Placement of low risk/low need offenders in intensive treatment services can increase the probability of substance use and crime (Lowenkamp & Latessa, 2005), as these offenders do not require intensive treatment or supervision, and reductions in recidivism are likely to be quite small. Also, mixing low risk/low need offenders with people who have more pronounced and ingrained antisocial characteristics can be counterproductive and lead to poor outcomes (Andrews & Dowden, 2006; Bonta & Andrews, 2007). This can also reduce “protective factors” for criminal behavior among lower risk offenders, such as involvement in school, employment, and family, and can provide exposure to more severe antisocial behaviors and peer groups that are more likely to reinforce and support criminal activity (Lowenkamp & Latessa, 2004). However, CODs treatment, in general, can serve low risk offenders who may be at risk of increased substance use without treatment.

Matching offenders who have CODs to different levels of supervision is also important (Kushner et al., 2014). For example, offenders have better outcomes when the frequency of court status hearings is matched to their risk level (Listwan, Sundt, Holsinger, & Latessa, 2003). High-risk offenders experience better outcomes when attending frequent status hearings, while low-risk offenders have worse outcomes (Marlowe, Festinger, Lee, Dugosh, & Benasutti, 2006). The purpose of matching offenders to different levels of supervision is based on an understanding of the offenders’ needs and how meeting these needs

will enhance outcomes. For instance, high-risk offenders have multiple criminogenic needs (e.g., substance use, antisocial beliefs and values, education, employment) that require frequent and ongoing supervision specifically tailored to these needs, to the risk for relapse, and to the level of social and occupational functioning. In addition to involvement in mental health treatment and specialized dual disorders treatment, high-risk offenders who have CODs should be encouraged to engage in prosocial activities, cognitive restructuring related to criminal thinking, educational and vocational training programs, and family and social support services. Other key areas include relapse prevention and case management to assist with housing, transportation, and enrollment in benefits. On the other hand, low risk offenders tend to have higher functioning related to the criminogenic need areas and therefore may not require the same level of intensive treatment services and community supervision (Steadman et al., 2013). In fact, evidence shows that placing people who are at low risk in highly intensive services can lead to increases in recidivism and other adverse outcomes (Andrews, 2012; Lowenkamp & Latessa, 2004).

Implications for Screening and Assessment of CODs in the Justice System

Screening and assessment of offenders who have CODs should include identification of risk for recidivism, including specific “criminogenic need” factors. This information is most effectively compiled through administration of a formal risk assessment instrument, which addresses both static and dynamic factors that influence the likelihood for recidivism. Both CODs treatment and supervision may be structured quite differently for people who have different levels of risk and criminogenic needs (Marlowe, 2012a). Several key issues in conducting risk assessment are highlighted below:

- Eligibility screening processes for offender CODs programs should prioritize admission for people who have high risk

and high levels of criminogenic needs, such as people who have a significant criminal history and a severe substance use disorder

- Risk level should be identified at the earliest possible point prior to disposition (e.g., sentencing) of offenders who have CODs. In many criminal justice settings, a two-tiered process is used for risk identification. This includes an initial brief risk screening to identify and sort out low-risk offenders, who can benefit from low-intensity programs (e.g., diversion), and a comprehensive risk assessment to more precisely identify the risk level and to identify specific criminogenic needs that should be targeted in CODs programs
- A variety of standardized and validated risk assessment instruments are available for offenders with CODs. These instruments generally address similar sets of static and dynamic risk factors, and are quite effective in the initial sorting of offenders to low, medium, and high risk categories. Review of criminal justice records (e.g., arrest history) and other archival information is routinely included in the risk assessment process. Staff training is required for administration and scoring of risk assessment instruments. Most risk assessment instruments include brief screening versions that vary in the time required for administration
- Risk assessment instruments vary in their predictive validity with different gender and race/ethnicity groups (Desmarais & Singh, 2013). Third and fourth generation risk assessment instruments that include structured professional judgment tend to have better predictive ability than second generation instruments, which rely on actuarial approaches (Singh, Fazel, Gueorguieva, & Buchanan, 2014)
- Several monographs provide detailed descriptions of available risk assessment instruments, including those developed by the Council of State Governments Justice Center (Desmarais & Singh, 2013) and the National Center for State Courts

(Casey, Warren, & Elek, 2011). Although a comprehensive description of risk assessment instruments is beyond the scope of this monograph, several commonly used instruments include the following:

- » Level of Service Inventory–Revised (LSI-R; Andrews, & Bonta, 1995)
- » Ohio Risk Assessment System (ORAS; Latessa, Smith, Lemke, Markarios, & Lowencamp, 2009)
- » Correctional Offender Management Profiling for Alternative Sanctions (COMPAS; Brennan & Oliver, 2000)
- » Wisconsin Risk/Needs (WRN; Henderson, 2007) scales and the Client Management Classification (CMC; Arling & Lerner, 1980)
- » Risk and Needs Triage (RANT; Marlowe et al., 2011)
- » Historical-Clinical-Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997)
- » Short-Term Assessment of Risk and Treatability (START; Webster, Martin, Brink, Nicholls, & Middleton, 2004)
- » Risk-Needs-Responsivity Simulation Tool (Crites & Taxman, 2013)
- Risk assessments should be periodically readministered to offenders with CODs, as risk level and criminogenic needs change over time. Changes detected in the overall risk level and in the pattern of criminogenic needs will help inform placement in treatment and supervision services and may signal the need for further psychosocial assessment. The frequency of reassessing risk assessments should be determined by the justice setting and the likelihood for change among the dynamic risk factors assessed. For example, people who are placed on community supervision will ordinarily have greater potential for change in dynamic risk factors related to employment, family and social supports, and substance use in comparison to people who are in custody settings
- As mentioned previously, major deficits related to criminogenic needs that are identified during risk assessment should be addressed in CODs treatment programs and in community supervision, with specific goals, objectives, and interventions articulated for each area of criminogenic need
- Information regarding criminal risk and types of criminogenic needs should be considered in placing offenders with CODs in treatment and supervision. For example, within court-based programs, criminal risk level may be particularly useful in determining the frequency of status hearings. Other formal placement criteria (e.g., American Society of Addiction Medicine Patient Placement Criteria; ASAM PPC; Mee-Lee, 2013) may also be very helpful in triaging offenders with CODs to different levels and types of treatment
- CODs programs for offenders may benefit from including special “tracks” that are tailored for participants with varying levels of criminal risk and criminogenic needs (Marlowe, 2012a). For participants with higher levels of risk and need, these tracks may be longer in duration; include more intensive treatment and supervision services; and provide services to address specific criminogenic needs, such as cognitive interventions to modify criminal attitudes and beliefs
- Clinical judgment and input from treatment and service practitioners should be included when determining level of risk and matching offenders to varying levels of treatment and supervision
- The validity of risk assessment instruments may vary according to characteristics of different justice-involved populations; conditions present within the jurisdiction/setting (e.g., law enforcement and prosecutorial practices, community supervision resources); and the population base rates of arrest, crime, and violence. As a result, risk assessment instruments

should be validated within the specific jurisdiction and justice setting for which they are intended to be used. Validation should examine the ability of a particular instrument to accurately classify justice-involved populations into categories of risk (e.g., low, medium, and high) according to outcomes of interest, such as arrest or return to custody. This analysis determines the “positive predictive value” of the risk assessment instrument.

Evaluating Suicide Risk

More than 90 percent of people who commit suicide in the United States have a history of mental disorder(s), particularly depression and substance use (U.S. Department of Health & Human Services, 2003; Nock et al., 2008; Nock et al., 2009; Rush, Dennis, Scott, Castel & Funk, 2008). Within justice settings, suicide attempts are five times more likely among people who have mental disorders (Goss, Peterson, Smith, Kalb, & Brodey, 2002; Hayes, 2010), perhaps due to increased stress related to incarceration and community supervision and to the disproportionate numbers of those who have CODs. Ongoing suicide screening is particularly important for offenders who have CODs, as the combination of serious mental illness, such as severe depression, bipolar disorder, and schizophrenia, and substance use or withdrawal has been found to significantly elevate the risk for suicide (Hawkins, 2009; Hayes, 2010; Nock et al., 2009; Ruiz, Douglas, Edens, Nikolova, & Lilienfeld, 2012). Given the high proportion of people with CODs in the justice system, it is essential that suicide screening be conducted in a comprehensive and systematic manner. Screening should be conducted at the time of entry into justice settings and at transfer to different settings, including correctional institutions. A number of well-validated suicide screening and assessment instruments are described later in this monograph.

Screening for suicide risk in the justice system is important for both legal and ethical/professional reasons. Much of the litigation involving

correctional mental health services has focused on inadequate suicide screening and prevention procedures. Screening for suicide risk should be conducted at every major transition point within the criminal justice system, including at arrest, booking in jail, enrollment in diversion programs, involvement in community supervision, transfer to prison, and release from custody. Many standardized suicide risk screening tools are available that can be administered by either mental health professionals or other staff working in justice settings. Many of these screens do not require intensive training to administer, score, and interpret, although all staff who administer suicide risk screening should be fully versed in methods to refer offenders with elevated suicide risk to appropriate resources. For example, if there are questions regarding the level of suicide risk or if the level of suicide risk is determined to be high, a full assessment should be conducted by a trained and licensed or certified mental health clinician.

Most suicidal behavior is preventable through implementation of comprehensive screening, triage, supervision procedures, and changes to the immediate residential environment (e.g., removal of items from the jail or prison cell, increasing the frequency of staff monitoring). The goals of screening for suicide risk are to identify risk and protective factors and to implement a plan of preventive action, as needed. It is useful to gather suicide screening information from multiple sources, including interviews with the offender, objective/self-report instruments, collateral reports from those who have ongoing contact with the person, and medical/treatment records and other archival information. Direct questioning of the offender is needed to examine suicidal intentions, lethality of potential behavior, probability of the behavior (e.g., specific plans), and means available to accomplish suicide.

The Suicide Risk Decision Tree framework provides a comprehensive approach in assessing suicide risk (Cukrowicz, Wingate, Driscoll, & Joiner, 2004; Joiner, Walker, Rudd, & Jobes, 1999; Joiner, Van Orden, Witte, & Rudd, 2009).

This interview assessment tool addresses two important factors in determining suicide risk: (1) desire, and (2) capability to commit suicide. Desire is composed of two main components: lack of belonging to important social groups and perceived burdensomeness; for example, the individual feels like a burden to his or her family and friends. The second factor, capability, is the acquired ability to engage in self-harm, which is influenced by fearlessness of death, suicidal plans and preparations, and duration and intensity of suicidal ideation.

The Suicide Risk Decision Tree interview also examines other risk and protective factors to determine the overall severity of suicide risk. The Interpersonal Needs Questionnaire (INQ)/Acquired Capability for Suicide Scale (ACSS) is a shorter, two-part self-report suicide screen based on the Suicide Risk Decision Tree (Van Orden, Cukrowicz, Witte, & Joiner, 2012). The INQ/ACSS, Suicide Risk Decision Tree, and other screening and assessment instruments for suicide risk are described later in this monograph. As mentioned previously, assessments using the Suicide Risk Decision Tree or other approaches should be conducted by trained and licensed or certified mental health professionals who are familiar with suicide risk and protective factors and who can provide clinical services or referral to these services.

Suicide Risk Factors

The following suicide risk factors are important to examine in the process of screening and assessment for suicide risk (Centers for Disease Control and Prevention, 2008; Hayes, 2010). Review of these risk and protective factors can help identify people who need more comprehensive assessment, close supervision, and other precautions to prevent suicide:

- Age (escalation of risk with age, particularly over 45; however, suicide rates among young people have been increasing)

- Gender (higher risk of completed suicides for males, higher risk of suicide attempts for females)
- Race and ethnicity (highest risk for suicide among Whites)
- Previous or current psychiatric diagnosis
- Current evidence of depression
- Substance use
- Poor problem solving or impaired coping skills
- Social isolation and limited social support
- Previous suicide attempt(s)
- Family history of suicidal behavior
- History of physical, sexual, or emotional abuse; family violence; and exposure to punitive parenting
- History of prostitution
- Current and identifiable stressors, with a particular focus on recent losses and diminished supports (e.g., related to homelessness, unemployment, loss of a loved one)
- Fearlessness of death (e.g., repeated exposure to traumatic events)
- Impending court dates
- Recent incarceration

Areas for Brief Screening of Suicide Risk

Brief screening for suicide risk can be conducted by nonclinical staff, although screening staff should be trained in how to provide immediate responses to promote safety and to prevent suicide, including referral sources for further assessment. Suicide risk screening should address the following areas:

- Current mental health symptoms
- Current suicidal thoughts
- Previous suicide attempts and their seriousness
- Whether suicide attempts were intended or accidental
- The relationship between suicidal behavior and mental health symptoms

- Lack of social support or feelings of connectedness to important social groups
- Feelings of burdensomeness to family and friends
- Acquired ability to engage in self-harm (e.g., capability, fearlessness of death)

As mentioned previously, for people with identified suicide risk, a thorough assessment should be conducted by a trained and licensed or certified mental health professional. Assessment of suicide risk/potential should include an interview to review thoughts, behaviors, and plans related to suicide. In addition to the screening items described previously, the following areas should be reviewed during the assessment interview:

- Thoughts related to suicide (i.e., frequency, intensity, duration, specificity), distinguishing between passive and active suicidal thoughts
- Current plans (specificity, method, time and date)
- Lethality of suicidal plans and availability of potential instruments (e.g., drugs, weapons)
- Preparatory behavior
- Self-control
- Reasons for living
- Social support

In summary, suicide screening should be provided for all justice-involved individuals at the point of arrest, at the time of entry into or transfer from correctional institutions, and at sequential stages during justice system processing (e.g., arrest, booking, pretrial diversion, probation, parole). Suicide screening is particularly important during the first month of incarceration or when there is an impending court date (Hayes 2010). While suicide screening is important for all individuals in the justice system, it is particularly important for those who have mental disorders and CODs (Baillargeon et al., 2010; Ruiz et al., 2012). At highest risk for suicide are people who have severe depression, schizophrenia, or who are suffering from certain

types of drug withdrawal (Hayes, 2010). All suicidal behavior (including threats and attempts) should be taken seriously and assessed promptly to determine the type of immediate intervention that is needed. In some cases, suicide screening is incorporated within health/clinical assessments, such as those routinely conducted for all offenders in institutions.

Trauma History and Posttraumatic Stress Disorder (PTSD)

Trauma histories are common among justice-involved people and members of the general population. In 2014, SAMHSA published the following concept of trauma: “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAMHSA, 2014). For offenders who have substance use disorders alone, rates of trauma and PTSD range from 20 to 40 percent (Steadman et al., 2013). In the past two decades, there has been a significant influx of women to the justice system (Greenfeld & Snell, 1999; Mumola & Karberg, 2006; Shaffer, Hartman, & Listwan, 2009). Rates of mental disorders among justice-involved women are significantly higher than among the general population, and are higher in comparison to justice-involved men (Mallik-Kane & Visher, 2008; Teplin, Abram, & McClelland, 1996; Veysey, Steadman, Morrissey, & Johnsen, 1997; Zlotnick et al., 2008; Steadman et al., 2009). Moreover, women are more likely to have a substance-related disorder or offense (Shaffer et al., 2009; Gunter et al., 2008; Federal Bureau of Investigation, 2007; Couture, Harrison, & Sabol, 2007).

As many as 78 percent of justice-involved women report a history of childhood or adult physical, sexual, or emotional abuse (Goldenson, Geffner, Foster, & Clipson, 2007; Messina, Grella, Burdon, & Prendergast, 2007; Lynch, DeHart, & Green,

2013; Moloney, van den Bergh, & Moller, 2009; Prendergast, 2009). High rates of PTSD are found among both men and women in the justice system. PTSD and other co-occurring drug use and mental disorders are highly prevalent in other special populations such as returning veterans. In addition to having high rates of substance use and mental disorders, returning veterans have rates of PTSD that range from 50 to 73 percent (Seal et al., 2009; 2011). There is also emerging evidence that trauma and PTSD among veterans may be related to combat or pre-military experiences. Veterans often enter the justice system due to behaviors related to mental or substance use disorders and are sometimes placed in diversion programs such as Veterans Treatment Courts (Russell, 2009; Christopher, 2010).

Given the prevalence of trauma among justice-involved individuals, trauma screening and assessment is essential in jails, prisons, and community settings. In the past, trauma-related issues have not been fully addressed in some

Veterans often enter the justice system due to behaviors related to mental or substance use disorders, and are sometimes placed in diversion programs such as Veterans Treatment Courts (Russell, 2009; Christopher, 2010).

justice settings due to concerns that staff are not adequately trained to provide treatment services or to fears that addressing these issues will disrupt treatment activities or lead to exacerbation of mental health symptoms. In fact, failure to address trauma issues often undermines engagement in treatment and may result in commonly experienced trauma-related symptoms, such as depression, agitation, and detachment, being mistakenly attributed to other causes (Steadman et al., 2013). Other consequences of not screening for trauma include inappropriate treatment referral, dropout from treatment, and premature termination of treatment (Belknap, 2006; Hills, Siegfried, & Ickowitz, 2004; Mallik-Kane & Visser, 2008; Shaffer et al.,

2009; Steadman et al., 2013). Without screening for trauma/PTSD in justice settings, it is unlikely that specialized treatment interventions will be provided.

Substance use and withdrawal symptoms (e.g., increased anxiety, difficulty sleeping, and increased intrusion of traumatic thoughts) can minimize, mask, or mimic symptoms of trauma and PTSD, and therefore screening and assessment of these issues should be conducted or supplemented during periods of abstinence. PTSD is optimally diagnosed after offenders have moved beyond acute stages of withdrawal from alcohol or other drugs. As with screening for suicide, trauma screening can be conducted by nonclinical staff through use of standardized self-report instruments, which require minimal training. However, all staff who administer trauma screens should be knowledgeable about appropriate referral sources and the nature of trauma-related services. Offenders who are identified with significant symptoms of trauma/PTSD should receive a thorough assessment by a trained and licensed or certified mental health professional. In some cases, trauma screening is incorporated into routine health/clinical assessments that are conducted for all offenders in a particular justice setting (e.g., jail or prison).

Several specific factors should be considered in screening and assessment for trauma/PTSD and related CODs among justice-involved women. Most justice-involved women are primary caretakers of dependent children and may experience significant anxiety, guilt, low self-esteem, and lack of self-efficacy related to their inability to care for children during periods of incarceration (Chesney-Lind & Pasko, 2012; Douglas, Plugge, & Fitzpatrick, 2009; Grella & Greenwell, 2006; Mallik-Kane & Visser, 2008; Shaffer et al., 2009; Sacks, 2004). Justice-involved women who have a history of trauma and PTSD also frequently have significant medical problems, such as HIV/AIDS, other sexually transmitted diseases, or hepatitis, and these conditions should be identified during screening

and assessment (Douglas et al., 2009; Mallik-Kane & Visser, 2008). Given that two-thirds of incarcerated women are from cultural or ethnic minorities (Greenfeld & Snell, 1999; Rettinger & Andrews, 2010), screening and assessment approaches should be selected that are culturally valid and sensitive.

A significant amount of research on trauma and PTSD has been conducted in recent years, and a number of specialized screening and assessment instruments are available for use in justice settings. DSM-5 has introduced a new schema for diagnosing PTSD. Important changes to the diagnosis of PTSD involve more inclusive definitions of Criterion A (the indexed traumatic event) and dividing the old Criterion C into two criteria (negative cognitions and mood, arousal; APA, 2013). A summary of each of these instruments is provided in “Screening and Diagnostic Instruments for Trauma and PTSD.”

Motivation and Readiness for Treatment

As is the case with most behavioral health interventions, outcomes related to CODs treatment are highly dependent upon personal relationships established with service practitioners during screening and assessment and during early stages of treatment (CSAT, 2005a, 2006a; Lurigio, 2011). Justice-involved individuals who have CODs generally do not have a history of successful participation in treatment services, nor of vocational and educational achievement, and may have little optimism and few expectations for successful outcomes within justice treatment settings (Chandler et al., 2004; Lurigio, 2011). Moreover, these individuals are often demoralized by financial, service-related, or other barriers, or by their own limitations that affect employment, interpersonal relationships, and emotional well-being.

For these reasons, assessment and treatment planning for CODs in the justice system should address motivation and readiness for treatment. Motivation has been found to be an important

predictor of treatment compliance, dropout, and outcomes (Lurigio, 2011; Olver, Stockdale, & Wormith, 2011; Peters & Young, 2011). In particular, justice-involved people with low motivation have higher rates of treatment dropout (Lurigio, 2011).

However, it is a common misperception that motivation to engage in treatment is necessary to provide effective services for justice-involved individuals. Rather, targeting self-efficacy through goal setting and use of motivational interviewing strategies can encourage successful treatment outcomes (CSAT, 2005b; Lurigio, 2011; Olver et al., 2011).

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Motivation and Engagement Strategies

Motivational interventions for offenders who have CODs should be provided throughout the justice system, including in coerced treatment settings, such as court-mandated jail treatment or treatment programs provided as a condition of probation or parole. Although treatment in prison and participation in court-based diversion programs is often voluntary in nature, coercion is applied from use of behavioral reinforcement that includes loss or attainment of privileges and sanctions and incentives that are systematically and consistently applied. For example, drug courts offer an opportunity for offenders to participate in court-supervised substance use treatment in exchange for deferred prosecution and dismissal of charges. Motivation for treatment in justice settings is affected by perceived sanctions and incentives, such as probation revocation and “good time” for involvement in correctional treatment.

Perceived coercion (i.e., external pressures, including legal sanctions) is an important factor that affects offenders' motivation to enter and engage in treatment. Offenders who are court-referred are assumed to have been coerced to enter treatment due to legal contingencies related to reduced jail or prison time, dismissal of charges, or other factors. However, actual level of engagement in treatment is often determined by an offender's perception of choice in entering these treatment programs. Although justice involvement is related to perceived coercion, offenders typically have a choice to voluntarily enter treatment or be processed through normal judicial channels. Many offenders report that if offered, they would have entered treatment even without legal pressures (Prendergast, Greenwall, Farabee, & Hser, 2009; Farabee, Prendergast, & Anglin, 1998). Offenders' perception of coercion is often influenced by the consequences of not engaging in treatment, with higher levels of perceived coercion related to more severe legal consequences. Interestingly, offenders who have stronger perceptions of coercion also report lower motivation to engage in treatment and readiness to change (Day et al., 2009; Prendergast et al., 2009). In summary, it is unclear to what extent perceived coercion influences treatment completion and recidivism, as treatment outcomes are equivalent among coerced and voluntary participants (Prendergast et al., 2009). The best predictor of treatment outcomes may be the interaction between perceived coercion and motivation over the course of treatment (Knight, Hiller, Broome, & Simpson, 2000; Prendergast et al., 2009).

Motivation increases when continued substance use threatens current housing, involvement in mental health treatment, vocational rehabilitation, family and relationships, and when continued substance use will lead to incarceration (Peters & Young, 2011; Ziedones & Fisher, 1994). Drug courts and other coerced drug treatment programs allow offenders to gain insight into their addiction and co-occurring disorders and to receive a comprehensive range of services to address psychosocial problems. Although participants in

drug courts and other coerced treatment programs do not typically have high internal motivation to change their behaviors during early stages of treatment, they often develop internal motivation after engaging in intensive services, observing progress among other participants, and addressing their own ambivalence to make major lifestyle changes.

People in the justice system who have CODs may not be as motivated to enter treatment as those who have substance use disorders alone (Horsfall et al., 2009; Drake et al., 2008). Those who have CODs often experience a range of problems that contribute to low motivation, which can lead to difficulty engaging in treatment, treatment drop-out, relapse, and other adverse outcomes (Barrowclough, Haddock, Fitzsimmons, & Johnson, 2006; Gregg et al., 2007; Horsfall et al., 2009). For example, the presence of severe mental health symptoms can inhibit treatment engagement and motivation. Justice-involved people who have CODs frequently have low tolerance to stress, low cognitive functioning, poor coping skills, and poor psychosocial functioning, which often prevent meaningful participation in treatment and recognition of the need for treatment and behavior change (DiClemente et al., 2008; Carey, Maisto, Carey, & Purnine, 2001; Gregg et al., 2007; Horsfall et al., 2009).

Offenders who have CODs may also lack the interpersonal skills necessary to establish a healthy social support system and to work effectively with others in a structured treatment setting. Without the presence of a strong social support system, these individuals may have increased difficulty coping with related stress and changes during treatment, which can result in resorting to substance use as a coping mechanism (Horsfall et al., 2009). Even people who are medically managed for their mental health symptoms may have difficulty finding energy to participate in treatment, due to the side effects of their medications (Gregg et al., 2007; Horsfall et al., 2009). Moreover, changing motivation among people who have CODs may be problematic

during treatment because of the cognitively taxing nature of activities such as goal setting, decision-making, and cognitive-behavioral skill development (DiClemente et al., 2008). Another issue is that people who have CODs may be motivated to change their thoughts and behaviors related to substance use but not their mental disorders (DiClemente et al., 2008; Heesch, Velasquez, & von Sternberg, 2005; Freyer et al., 2005).

Treatment of CODs in the justice system typically involves constructing several targeted goals relevant to substance use, mental disorders, and other related issues. Targeting multiple problems and goals may be confusing and difficult for people who have CODs. Thus, multimodal engagement strategies are used that include motivational interviewing and behavioral reinforcement techniques to facilitate understanding of the interactive nature of CODs and to establish small but achievable goals (Bellack, Bennett, Gearon, Brown, & Yang, 2006; DiClemente et al., 2008).

Due to the low levels of internal motivation for treatment and recovery among many offenders who have CODs, motivational interviewing techniques provide a very helpful mechanism to address ambivalence towards making major lifestyle changes that include modifying thoughts, beliefs, and behaviors related to engagement in mental health and substance use treatment and to criminal activities. The purpose of motivational interviewing is not to normalize ambivalence towards change, but to develop discrepancy between the offenders' current attitudes and behaviors and their values and goals. Through motivational interviewing, offenders are guided to examine these discrepancies, identify their current problems and areas for change, and determine how treatment and recovery can assist in meeting their personal goals. The key is to facilitate self-insight and encourage internal motivation for addressing changes in attitudes and behaviors. Treatment staff serve as guides, remaining objective towards the offender's problems, but still questioning

the offender's opinions regarding their current lifestyle in order to elicit concern about current lifestyle choices. Once the offender identifies discrepancies between his or her current attitudes and behaviors and personal goals, work can begin to develop cognitive and behavioral skills to accomplish lifestyle changes that are congruent with recovery from mental and substance use disorders.

Engagement in treatment for justice-involved individuals who have CODs can also be enhanced by utilizing other key motivational interviewing strategies, including providing a welcoming attitude during the screening and assessment process, normalizing ambivalence to making lifestyle changes, showing empathy and respect for the challenges inherent to the difficult process of treatment and recovery, understanding initial resistance to change, avoiding arguments with offenders related to lifestyle change, and maintaining optimism for individuals' ability to achieve behavior change and recovery (CSAT, 2006b; Miller, Rollnick, & Moyers, 1998; Lurigio, 2011; Peters & Young, 2011). Several evidence-based treatment curricula (McMurrin, 2009) have been developed to operationalize motivational interviewing approaches, including Project MATCH (Matching Alcohol Treatments to Client Heterogeneity; Miller, Zweben, DiClemente, & Rychtarik, 1999) and Project START (Screening to Augment Referral and Treatment; Martino, Ondersma, Howell, & Yonkers, 2010). These curricula are based on Motivational Enhancement Therapy (MET) and cognitive behavioral therapy (CBT) approaches. Specific programmatic interventions that are frequently provided during early stages of treatment for people with CODs include "engagement" and "persuasion" groups. These groups target ambivalence in making major lifestyle changes and are designed to enhance internal motivation for change.

Identifying Stages of Change

Motivation for treatment is expected to change over time for justice-involved people with CODs, who often cycle through several predictable

“stages of change” during the course of treatment and recovery. In the early stages of change, people who have CODs may not recognize the importance of substance use disorders or other psychosocial problems that complicate treatment and are unlikely to commit to changing their substance use behavior and to the goals of treatment. In the justice-involved population, with the chronic relapsing nature of recovery from substance use and mental disorders and the presence of antisocial beliefs, attitudes, and peers, movement through stages of change does not typically follow a linear pattern. For example, justice-involved individuals who have CODs frequently return to previous stages of change before achieving sustained abstinence and recovery.

Several stages of change related to addictive behaviors are described by the “transtheoretical model,” developed by Prochaska and DiClemente (1992), and include the following:

- Precontemplation (lack of awareness about addiction problems)
- Contemplation (awareness of addiction problems)
- Preparation (decision point about commitment to change)
- Action (active change behaviors related to addiction)
- Maintenance (ongoing behaviors to prevent relapse to addiction)

Another stages-of-change model has been crafted to describe motivation and readiness for treatment among people who have CODs (Osher & Kofoed, 1989) and to design “stage-specific” treatment services. This model is premised on the assumption that stage-specific interventions will enhance treatment adherence and outcomes among people who have CODs. For example, offenders who are in early stages of change are unlikely to respond to skills-based interventions that are designed to enhance abstinence if ambivalence and resistance to making lifestyle changes are not first addressed (e.g., through early engagement and motivational interviewing techniques). Similarly,

offenders who are in later stages of change but who receive treatment and supervision services that focus primarily on early recovery issues (e.g., ambivalence) may drop out of treatment. A rating scale has been developed to identify the need for stage-specific treatment services among people who have CODs, entitled the Substance Abuse Treatment Scale (SATS; McHugo, Drake, Burton, & Ackerson, 1995). The SATS scale evaluates the level of engagement in services according to the following categories: pre-engagement, engagement, early persuasion, late persuasion, early active treatment, late active treatment, relapse prevention, and remission or recovery.

In summary, stages-of-change models provide a valuable framework to guide the screening and assessment process and to identify appropriate interventions for justice-involved individuals who have CODs. These models can help design treatment services that sequentially address issues that are most salient to the offender and which the offender is willing to address. Assessment of motivation and readiness should be conducted routinely for justice-involved people with CODs to match individuals to treatment services (Lurigio, 2011). Several screening and assessment instruments have been developed that address motivation and readiness for treatment, including those that can be administered as repeated measures over time. A detailed review of motivational screening instruments is provided later in this monograph.

Cultural Issues Related to Screening and Assessment

Screening, assessment, and treatment interventions for CODs in the justice system should carefully consider the influences of ethnicity, social class, gender, sexual orientation, race, disability status, socioeconomic level, and religious and spiritual affiliation, given the large proportion of ethnic and racial minorities in these settings (Marlowe, 2013; NADCP, 2010, 2014; Pinals et al., 2004). Minority status generally serves as a barrier to treatment referral and utilization

among people who have CODs, and individuals of racial or ethnic minorities are consistently less likely than their White counterparts to seek treatment for both substance use and mental disorders (Hatzenbuehler et al., 2008). Ethnic and racial minorities also tend to have lower rates of successful treatment completion and higher rates of recidivism (Belenko, 2001; Finigan, 2009; Marlowe, 2013; NADCP, 2014). Individuals who have experienced shame and social exclusion may have reduced self-efficacy related to recovery, and may anticipate that treatment staff will judge them negatively, thus affecting treatment outcomes.

Experiences of poverty, discrimination, and involvement with the criminal justice system may also increase vulnerability and exposure to chronic stress among ethnic and racial minorities (Marlowe, 2013; NADCP, 2014) and shape underlying belief systems of individuals regarding treatment and recovery processes. One apparent consequence is that minorities who have CODs are more likely to report seeking self-help (e.g., AA/NA) services to deal with substance use problems and are less likely to seek mental health treatment (Hatzenbuehler et al., 2008). Minorities may also experience discrimination in assignment to different types of treatment and in the type of sanctions provided within the justice system and are less likely to receive certain types of rehabilitative services (Justice Policy Institute, 2011; Marlowe, 2013; Nicosia, MacDonald, & Pacula, 2012; NADCP, 2014). In some cases, discriminatory policies in justice settings have led to coercing minorities who have CODs into substance use treatment rather than specialized mental health services (Hatzenbuehler et al., 2008).

Symptoms of mental disorders may be expressed very differently among ethnic and racial minorities. Unless cultural norms are well understood and sufficient follow-up time is allowed to assess and understand the full meaning of atypical self-reported thoughts, emotions, and behaviors, these symptoms may be misinterpreted, leading to misdiagnosis, inappropriate use of medication, and placement in inappropriate levels

of care. Some minorities who have CODs may not readily understand that they have mood or anxiety disorders, in comparison to the more recognizable and less prejudicial substance use disorders (Hatzenbuehler et al., 2008).

Staff working with justice-involved offenders should actively explore expectations and beliefs that may have been shaped

by experiences of racism and discrimination and should consider these factors as they gather and interpret information during screening and assessment. Important cultural themes to consider during the assessment and treatment process include, but are not limited to, religiosity and related beliefs and customs, independent versus interdependent cultural orientations, trust versus distrust of authority figures, disclosure of personal problems, and gender roles (CSAT, 2006b; Osborne, 2008; NADCP, 2014). Some ethnic and racial minority groups are more likely to be influenced by extended family and social networks, which may influence beliefs regarding shame, guilt, and respect as they relate to CODs. These factors are particularly important to consider during initial assessment interviews, treatment planning, and in subsequent treatment engagement activities.

The extent to which justice-involved individuals are assimilated to American culture can also influence their receptiveness to treatment for CODs, particularly when an individual's beliefs are not fully consistent with the dominant culture (Brome, Owens, Allen, & Vevaina, 2000; Castro & Alarcon, 2002; Klonoff & Landrine, 2000;

Minorities may also experience discrimination in assignment to different types of treatment and in the type of sanctions provided within the justice system, and are less likely to receive certain types of rehabilitative services (Justice Policy Institute, 2011)

NADCP, 2014). One apparent example is that Latinos born in the United States are more likely to identify themselves as having CODs in comparison to their foreign-born counterparts. The likely rationale for this is not underreporting among foreign-born Latinos but rather the lack of assimilation to American culture that may serve as protective factors against developing CODs (Vega, Canino, Cao & Alegria, 2009).

Different beliefs, expectations, and levels of acculturation can influence treatment engagement and outcomes among justice-involved individuals who have CODs. Research indicates that attending to cultural beliefs through appropriate staff training improves outcomes in substance use treatment (Guerrero & Andrews, 2011; Northeast Addiction Technology Transfer Center [ATTC], 2008; NADCP, 2014). Matching ethnic and racial minorities to integrated treatment services in the justice system that are culturally sensitive can also improve treatment outcomes (Marlowe, 2013; Northeast ATTC, 2008). It should be noted, however, that few specialized CODs treatment interventions have been developed for ethnic and racial minorities, and there are few evidence-based protocols to help organize this type of specialized treatment.

Some individuals in the justice system who have CODs may not be fully candid during screening and assessment interviews because their cultural affiliation does not condone self-disclosure of problems to those outside of the immediate family. Self-disclosure may also be inhibited among individuals who have experienced discrimination from people who share the culture or ethnicity of the staff person conducting screening or assessment interviews. Some minorities may consider themselves undeserving of CODs treatment due to the combined stigma attached to endorsing a co-occurring disorder and minority status (Lawrence-Jones, 2010).

Language barriers can also influence the outcome of screening and assessment interviews among justice-involved individuals who have CODs.

Alternative strategies should be explored for individuals who do not read or comprehend English effectively. Whenever possible, screening and assessment should be conducted in the individual's language of choice and by staff from a similar cultural background. Many screening instruments are available in Spanish or other languages, and whenever possible, bilingual staff should conduct screening and assessment interviews.

Maintaining a staff of diverse ethnic or cultural backgrounds is highly important in promoting effective participation in screening, assessment, and other treatment activities. Given that this can be challenging, it is also helpful to periodically assess the cultural competencies of justice programs that serve offenders who have CODs. One approach is to use a semi-structured self-assessment protocol (Osborne, 2008) to review data collection procedures, staff training, staff diversity (e.g., diverse racial and ethnic background), multilingual abilities, availability of cross-cultural screening and assessment tools, and use of culturally sensitive treatments. Results of this self-assessment can be used to improve program services by identifying staff training needs, gaps in services, and minority groups that are underrepresented among program and treatment staff.

Staff Training

Those working in justice settings, including judges, prosecutors, defense counselors, treatment staff, case managers, court personnel, correctional officers, program directors, and community supervision staff, are often inadequately trained in identification, assessment, diagnosis, treatment, and supervision of individuals with CODs (Steadman et al., 2013). For example, screenings are often conducted by staff who lack training or experience related to mental or substance use disorders and who may be unfamiliar with related treatment services for these disorders in the justice system. In recent years, a specialized base of knowledge and set of skills have been developed

for working with justice-involved individuals who have CODs. Training in these areas should be provided for all staff who are involved in screening and assessing CODs in the justice system.

One of the challenges inherent to training is that there are often parallel sets of staff who are providing treatment, supervision, and legal monitoring of offenders who have CODs. The training needs of these staff will differ, but share commonalities related to understanding the dynamics of addiction, mental disorders, and CODs; screening approaches, risk assessment, case management and monitoring approaches that address major criminogenic needs; and therapeutic use of sanctions and incentives. The intersection of staff roles is also important to emphasize through multidisciplinary cross-training to help define each person's responsibilities relative to sharing information related to treatment and supervision and providing screening and assessment, case management, and other activities and to ensure effective collaboration in working with offenders who have CODs (Steadman et al., 2013).

Specialized multidisciplinary training in criminal justice settings should be considered in the following areas:

- Prevalence, course, and signs and symptoms of CODs
- Interaction of symptoms of mental and substance use disorders and how this can inform diagnosis and differential diagnosis of CODs
- Strategies for enhancing accuracy of screening and assessment information among offenders who have CODs
- Training in use of specialized screening, assessment, and diagnostic instruments
- Integrated treatment approaches (e.g., Integrated Dual Disorder Treatment [IDDT]) and other evidence-based practices
- Adapting court/community supervision, and use of sanctions and incentives for individuals who have CODs
- Motivational interviewing techniques for use with justice-involved individuals who have CODs
- Cultural diversity and cultural sensitivity (NADCP, 2014)
- Identification of unique training needs for justice personnel and clinical personnel

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