Challenges in Implementing Evidence-Based Treatment Practices for Co-Occurring Disorders in the Criminal Justice System

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The presence of adults with mental health and substance abuse disorders within the criminal justice system has become increasingly evident over the past decade. Interventions and treatment services have been designed and research conducted in an effort to establish evidence-based practices that effectively address the complex needs of this population. However, adopting and implementing these evidence-based interventions and practices within the real-world setting of criminal justice environments is challenging. This article reviews the research literature related to evidence-based treatment practices for offenders with co-occurring mental health and substance abuse disorders and explores the inherent challenges of fitting these interventions and services within criminal justice settings. Copyright © 2004 John Wiley & Sons, Ltd.

INTRODUCTION

An estimated 1.3 million adults were incarcerated in state and federal correctional institutions in 2001 (Bonczar, 2003). Over 160,000 juveniles are also sentenced to jails, prisons, and detention centers each year (Puzzanchera et al., 2000). Between 1974 and 2001, the number of incarcerated offenders in the U.S. increased by 3.8 million (Bonczar, 2003). Most of these offenders will eventually be released from jail and prison to their home communities, including approximately 600,000

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offenders each year (Hughes & Wilson, 2003). Offenders returning to the community have a wide variety of complex needs requiring treatment and services, including problems related to mental illness, substance abuse, and criminogenic thinking and behavior.

The National GAINS Center estimates that approximately 5% of jail detainees and 13% of prison inmates suffer from co-occurring mental health and substance use disorders (National GAINS Center, 1997). Epidemiological studies examining offender populations suggest even higher rates of co-occurring disorders (CODs). Investigators interviewing male inmates entering the Washington State prison system found that 84% who met DSM-III-R criteria for Axis I or Axis II mental health disorders also met diagnostic criteria for substance use disorders (Chiles, Von Cleve, Jemelka, & Trupin, 1990). Among jail inmates, Abram and Teplin (1991) estimated that 80% of 728 randomly selected male detainees in Cook County jail met DSM-III-R criteria for mental health and substance use disorders. Hiller, Knight, and Simpson (1996) found that 80% of probationers charged with substance-related offenses and sentenced to participate in a substance abuse treatment facility had serious mental health problems in addition to substance abuse problems. An estimated 50% of female offenders have been identified as having both Axis I and Axis II mental health and substance abuse disorders (Jordan, Schlenker, Fairbank, & Caddell, 1996). Approximately two-thirds of male juvenile detainees and three-fourths of female detainees in the Cook County Juvenile Detention Center were diagnosed as having CODs (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002).

Offenders with CODs represent one of the most challenging groups encountered in the criminal justice system. For example, offenders with mental health disorders are more likely to commit violent crime, return to custody, and report substance abuse problems ( Ditton, 1999). Patterns of impulsive, unpredictable, and sometimes erratic behavior make offenders with CODs difficult to manage while incarcerated, and to supervise after release into the community. Managing the health, mental health, drug abuse treatment, and supervision needs of this group involves a wide range of systems, institutions, and agencies that often have very different missions, values, responsibilities, organizational structures, and resources.

Another challenge in addressing the multifaceted needs of offenders with CODs is that comprehensive treatment services may not be available in some parts of the criminal justice system, and may require a level of collaboration that is difficult to achieve. For example, offenders with CODs often have serious medical conditions such as HIV, hepatitis C, cancer, and liver, heart, and kidney disorders. Female offenders with CODs may have additional problems related to prior emotional, physical, and sexual abuse, dysfunctional relationships, and parenting. Comprehensively addressing health, mental health, and substance abuse needs of this group may also deplete resources from a system that is already strained to capacity by the rapid influx of new offenders over the past decade.

The increased presence of offenders with CODs in the criminal justice system, combined with their complex treatment and service needs make this special issue of Behavioral Sciences and the Law particularly salient to criminal justice and treatment professionals, and agencies charged with the care and supervision of these offenders. In this introductory article we begin by defining CODs and what this means to professionals working within research and practice settings. Current research related

to mental health, substance abuse, and COD treatment in the criminal justice system is reviewed, and federal resources are described that are available to assist those attempting to adopt evidence-based practices related to COD treatment. In this introductory article we also explore several challenges faced by criminal justice systems that are attempting to implement evidence-based interventions and practices related to CODs. We conclude with a discussion of future directions for researchers, treatment providers, criminal justice administrators, and policy makers.

DEFINING CO-OCCURRING DISORDERS WITHIN THE CRIMINAL JUSTICE SYSTEM

The terms “co-occurring disorders” (COD), “co-morbidity”, “dual disorders”, and “dual diagnosis” are frequently used to describe problematic client populations that are in need of treatment services in the criminal justice system and other settings. These terms vary in their use and application across different settings in the criminal justice system. The way in which COD is defined has significant implications for the types of offenders who are selected to receive treatment services, the interventions provided, resources needed for these interventions, and the outcomes that can be expected. For this reason, it is important to carefully define the types of CODs that will be addressed in offender treatment programs, and to match the types of COD treatment service to the type and severity of offender problem.

Perhaps the most common definition of COD within the criminal justice system is of a concurrent DSM-IV Axis I major mental health and substance use disorder. This definition was adopted by the National GAINS Center (1997), and has been used extensively in other planning documents and monographs developed by SAMHSA, NIDA, and other agencies. The emphasis on Axis I major mental health and substance use disorders insures that treatment and supervision resources are focused on offenders who have the most profound psychosocial problems, and who are at the highest risk for criminal recidivism and readmission to jail and prison.

Other definitions of COD that have been used in the criminal justice system include the presence of two co-existing substance abuse disorders or two mental health disorders, co-existing personality and substance use disorders, co-existing sexual and substance use disorders, co-existing developmental and substance use disorders, and “criminality” coupled with either a substance use disorder or a mental health disorder. Although each of these address important focal areas for treatment, offenders who meet these definitions generally do not exhibit the same degree of psychosocial impairment as those with co-occurring mental health and substance use disorders. Even when COD treatment services in the criminal justice system are explicitly designed for co-occurring major mental health and substance use disorders, there are often pressures to refer to COD programs offenders who have severe behavioral problems. These offenders typically have more pronounced personality disorders (e.g. antisocial and borderline personality disorders) than major mental health disorders, and may prove disruptive in COD treatment programs that rely on peer involvement and group treatment services. This potential dilemma reflects the need (as stated previously) for careful definition of the “target” population for COD treatment, for the implementation of screening and referral.
procedures to accurately identify this population, and for monitoring to insure that offenders routed to COD treatment fit the intended profile.

Recent attempts have been made to classify individuals with CODs according to the severity of their mental health and substance abuse problems (National Association of State Mental Health Program Directors (NASMHPD) & National Association of State Alcohol and Drug Abuse Directors (NASADAD), 1999). Instead of focusing on diagnoses, this model defines four sub-groups, or “quadrants,” of individuals with varying levels of mental health and substance abuse problem severity. This model reflects the diversity of offenders with CODs, and can assist in developing strategies to match offenders to varying levels of intensity of treatment and supervision (Peters & Osher, 2003). For example, offenders with high severity of both mental health and substance use disorders may be more effectively placed in intensive residential treatment programs, while offenders with less severe co-occurring mental health problems may respond best to more traditional substance abuse treatment services.

RESEARCH EXAMINING COD TREATMENT IN THE CRIMINAL JUSTICE SYSTEM

Mental Health Treatment

While ethical and constitutional considerations underlie the obligation to treat the mentally ill in the criminal justice system (Lovell, Allen, Johnson, & Jemelka, 2001; Osher, Steadman, & Barr, 2003), there are also important practical and rehabilitative rationales for providing such interventions. For example, mental health intervention is a useful tool in behavioral management. Various prison studies have found that, compared with non-psychiatric populations, significantly more incident reports and or disciplinary actions were filed for inmates with psychiatric diagnoses (DiCataldo, Greer, & Profit, 1995; Jemelka, Trupin, & Chiles, 1989; Lovell & Jemelka, 1998; Toch, Adams, & Grant, 1989). In addition, such special actions are financially costly to correctional systems, and lead to demoralization of staff (Lovell & Jemelka, 1998). Research also indicates that incarcerated mentally ill persons are at increased risk for suicide and victimization, and experience high rates of psychiatric decompensation and deterioration (Rock, 2001). Conversely, there is evidence that appropriate interventions can address behavior problems by preventing deterioration that leads to harm to self or others, vulnerability and/or loss of impulse control (Godley et al., 2000; Lovell et al., 2001).

Mental health treatment and related services for offenders can help to reduce recidivism to the criminal justice system. Offenders with mental illness often experience social problems and behavioral disorders that serve as barriers to community re-entry and engagement in community treatment services. These problems include homelessness, poverty, lack of education, problems with employment, continuing substance abuse and few pro-social attachments, histories of noncompliance with treatment and of violent behavior, and multiple psychiatric and substance abuse disorders (Abram, 1990; Cohen, 2002; Draine, Salzer, Culhane, & Hadley, 2002; James, Farnham, & Cripps, 1999; Lamb & Weinberger, 1998; Solomon & Draine, 1999; Chiles et al., 1990). Interventions begun during
incarceration can help mentally disordered offenders learn prosocial skills necessary for successful community reentry (U.S. Department of Justice, 2001). Mental health treatment received while under community supervision (e.g., probation and parole) may also reduce the risk of incarceration (Solomon, Draine, & Marcus, 2002).

A significant concern is that mental health interventions in the criminal justice system are either unavailable or of inadequate quality. National studies show that more than 20% of jails have no available mental health services, and over 80% of jails report that correctional officers have either very minimal or no training related to mental health issues (Teplin, 1990; Teplin, Abram, & McClelland, 1997). Where available, the quality of services for mentally ill offenders is often far below national standards (Reed & Lyne, 2000), and non-medical staff in both jails and prisons are often unprepared to respond adequately to psychiatric crises (Fruehwald, Frottier, Matschning, & Eher, 2003).

Discharge planning is one of the most critical, but least frequently provided mental health services in jails and other criminal justice settings (Osher, Steadman, & Barr, 2003). Moreover, there are frequently inadequate aftercare services for mentally ill offenders returning to the community (Earthrowl, O’Grady, & Birmingham, 2003; Smith, Baxter, & Humphreys, 2003), and poor linkages to existing treatment services (Maden, Rutter, McClintock, Friendship, & Gunn, 1999; Teplin et al., 1997). Numerous studies (Godley, Finch, Dougan, McDonnell, McDermeit, & Carey, 2000; McGuire, Rosenheck, & Kasprow, 2003; Morris & Steadman, 1994; Peters & Hills, 1993; Steadman, Barbera, & Dennis, 1994; Teplin et al., 1997; Torrey et al., 1992) highlight the need for improved liaison to develop diversion, coordinated care, and community transition programs. Key barriers to effective discharge planning and transitional services are the fragmentation of the community health care system (Rock, 2001), lack of consensus regarding diagnoses and treatment needs, and denial of needed services (e.g., housing or employment) based on criminal justice status (Byrne, Taxman, & Taxman, 1995).

Although additional research is needed to identify and evaluate effective mental health treatment models in criminal justice settings (Trestman, 2002), several evidence-based practice approaches are described in the literature. These include the following.

(i) A case management model for offenders with CODs has resulted in the reduction of psychiatric symptoms and criminal recidivism (Godley et al., 2000).

(ii) Specialized COD treatment implemented in both maximum-security hospitals and outpatient mental health services in New York State prisons has led to positive outcomes and has highlighted the need for well integrated programs with staff who are trained in COD issues (Smith, Sawyer, & Way, 2002).

(iii) An intermediate-care program in prison that provides medication monitoring, skills training, and support for coping with prison life has led to reductions in psychiatric symptoms, staff assaults, and other infractions, and to increases in work and school participation (Lovell et al., 2001).

(iv) Community-based residential treatment has shown promising results in stabilizing offenders who have mental illness (Lovell & Jemelka, 1998).

(v) The Forensic Algorithm Project (FAP; Buscema, Abbasi, Barry, & Lauve, 2000) provides a multi-modal approach to treatment of inmates with schizophrenia, and is currently being examined to determine its effectiveness.
Pre-release intensive case management services provided by a community mental health treatment agency have led to successful outcomes among offenders (Byrne et al., 1995; Godley et al., 2000; Jemelka, Trupin, & Chiles, 1989).

Formalized collaborative arrangements between community mental health providers and federal probation are now being examined to determine the effects on retention in treatment and recidivism among offenders with mental illness (Roskes & Feldman, 1999).

Specialized mental health outreach services have been found to be somewhat effective in linking incarcerated veterans with VA health care and community rehabilitative services (McGuire et al., 2003).

A model of transition planning for offenders with mental illness has been developed through multi-site studies of jail mental health programs (Osher et al., 2003).

Computer-assisted treatment planning in a prison psychiatric facility has facilitated more effective delivery of clinical services (Chula & Craig, 2000).

Videoconferencing and tele-psychiatry services have proven successful in addressing needs of offenders who are located in remote areas (Zaylor, Nelson, & Cook, 2000).

Substance Abuse Treatment

Research indicates that offenders’ participation in substance abuse treatment reduces substance use and criminal activity (Farabee, Shen, Hser, Grella, & Anglin, 2001; Hser et al., 2001; Hubbard, Craddock, Flynn, Anderson, & Etheridge, 1997; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). In addition, coercion and pressure exerted by the criminal justice system has been found to enhance substance abuse treatment retention and participation (Farabee et al., 2001; Hiller, Knight, Broome, & Simpson, 1998). Much of this research has focused on the effectiveness of prison-based treatment. Several major studies have demonstrated long-term benefits of offender participation in substance abuse treatment, particularly when combined with community-based aftercare (Butzin, Martin, & Inciardi, 2002; Inciardi, Martin, & Butzin, 2003; Knight, Simpson, & Hiller, 1999; Pelissier et al., 2001; Rhodes et al., 2001; Wexler, DeLeon, Thomas, Kressell, & Peters, 1999). Positive outcomes noted in these studies include significant reductions in substance abuse and criminal activity. As indicated by these studies, effective prison-based treatment programs share many common features, including: (i) the use of therapeutic communities, (ii) providing substance abuse treatment to offenders at the end of their period of incarceration, (iii) isolating treatment participants from the general inmate population, (iv) use of cognitive–behavioral interventions, and (v) an a focus on criminal thinking patterns.

Recent studies have also examined the effectiveness and active ingredients of treatment-based drug courts that have been developed in over 1,000 U.S. jurisdictions. Drug courts provide collaboration between the courts, treatment, family members, and community supervision to deliver integrated services for non-violent offenders with substance abuse problems. Evaluations of drug courts indicate their effectiveness in reducing recidivism and substance abuse, promoting engagement in...
treatment and employment, and providing cost savings related to reduced costs of criminal justice processing (Belenko, 2001; Cooper, 2003; Peters & Murrin, 2000). Several recent NIDA-funded studies are rigorously examining operational components of drug courts, such as the effects of judicial status hearings (Festinger et al., 2002; Marlowe, Festinger, & Lee, in press; Marlowe et al., 2003), the utility of contingency management in reinforcing and promoting behavioral change among offenders (Burdon, Roll, Prendergast, & Rawson, 2001), employment interventions (Leukefeld et al., 2001; Staton et al., 2002), and specialized treatments for adolescents in juvenile drug courts (Randall, Halliday-Boykins, Cunningham, & Henggeler, 2001). While drug court research has not yet examined specific strategies and interventions for participants with CODs, there is growing recognition of the need to address the unique issues and treatment needs of this group (Belenko, 2001; Cooper, 2003; Peters & Osher, 2003; Turner et al., 2002).

**COD Treatment Within the Criminal Justice System**

There is a growing research literature reviewing evidence-based treatment practices for CODs, as described in several recent government reports in the U.S. and Canada (Centre for Addiction and Mental Health, 2002; President’s New Freedom Commission on Mental Health, 2003; SAMHSA, 2002). General evidence-based approaches used for CODs employ an integrated service delivery model in which substance abuse and mental health treatment are provided simultaneously by the same staff within a conceptual framework that emphasizes the relatedness of mental health and substance use disorders. Alternative models involving sequential treatment programming (i.e. treatment of one disorder, followed by the other) or parallel treatment programming (i.e. concurrent substance abuse and mental health treatments offered by different providers) are seen as appropriate for less severely impaired clients, but are not sufficiently intensive for most clients who have severe, chronic, and recurring substance abuse and mental health problems.

The research literature indicates empirical support for the use of specialized screening and assessment for CODs, staged interventions to address varying levels of impairment and functioning, pharmacological interventions, motivational interventions, a range of cognitive–behavioral strategies, use of modified therapeutic communities (TCs), assertive community treatment (ACT), comprehensive integrated treatment (CIT), and various housing and employment services (SAMHSA, 2002; Sacks, 2000). Treatment outcomes associated with these approaches include stabilization of mental illness, and reductions in substance abuse and in criminal activity. Other promising approaches that have less empirical support include psychoeducational models, contingency management, intensive case management, self-help groups developed for CODs (e.g. “Double Trouble” groups), and family-based psychoeducational models (Martino, Carroll, Kostas, Perkins, & Rounsaville, 2002; Mueser & Fox, 2002; Sacks, 2000).

Several research monographs developed by the National GAINS Center (Hills, 2000; Peters & Hills, 1997) indicate that many principles derived from the COD treatment literature can be applied successfully within the criminal justice system. Several key treatment principles drawn from this literature are also helpful in designing COD treatment programs for offenders. These include the need for
integrated services that simultaneously address mental health and substance disorders, interventions of sufficient intensity and length to meet the individualized needs of offenders with CODs, appropriate use of medication, providing a continuum of treatment services at the point of community re-entry, and community support and self-help groups. Therapeutic communities, cognitive–behavioral therapies, medication management, relapse prevention, self-help groups, transitional planning, and case management have also been described as promising interventions for offenders with CODs (Hills, 2000; Sacks, Sacks, & Stommel, 2003; Smith et al., 2002; Wexler, 2003).

Research investigating COD treatment in the criminal justice system has addressed the prevalence of CODs among offenders (Ditton, 1999; Hiller et al., 1996; Teplin, Abram, & McClelland, 1996; Teplin et al., 2002), challenges associated with treatment and supervision of this population (Abram, 1990), principles of treatment (Hills, 2000; Osher et al., 2003; Peters & Hills, 1997; Wexler, 2003), characteristics of existing correctional COD treatment programs (Edens, Peters, & Hills, 1997; Smith et al., 2002; Sacks, Sacks, & Stommel, 2003), and the unique needs of female offenders who have CODs (Goldstein et al., 2003; Staton, Leukefeld, & Webster, 2003). To date, few published research studies have gauged the effectiveness of COD treatment interventions among offenders, or have examined the impact of organizational and structural factors on treatment interventions in the criminal justice system.

As discussed in several recent literature reviews, a few treatment outcome studies have examined the impact of treatment programs designed for offenders with CODs (Godley et al., 2000; Sacks, Sacks, McKendrick, Banks, & Stommel, 2004). Godley et al. (2000) examined an intensive case management approach for non-violent offenders with CODs that included screening and assessment services, linkage to treatment providers, advocacy, housing assistance, skills training, and assistance with transportation. Findings from this study indicated that the case management services led to a significant decrease in criminal activity, and enhanced daily functioning and retention in substance abuse treatment, during a 6 month follow-up period. As reported in this special issue, Sacks et al. (2004) conducted one of the first studies to describe mental health, substance use, and criminal justice outcomes among offenders with CODs, using random assignment to correctional treatment. The study investigated the impact of participation in an intensive prison-based TC program, followed by involvement in TC treatment in the community. Results indicated that offenders participating in the prison-based COD treatment program followed by community-based treatment were less likely to be involved in substance use and criminal activity than offenders who participated in prison mental health treatment alone, or offenders who decided not to participate in the community-based follow-up treatment.

**CHALLENGES IN PROVIDING COD TREATMENT IN THE CRIMINAL JUSTICE SYSTEM**

There are many challenges in attempting to adopt evidence-based treatment practices in criminal justice settings (Deschenes, Peters, Goldkamp, & Belenko, 2003; Leukefeld, Tims, & Farabee, 2002). These challenges are augmented in
implementing COD treatment programs, which require collaboration between and integration of mental health and substance abuse services. The following section describes a number of key challenges and potential barriers that need to be addressed in implementing COD treatment within the criminal justice system.

**Contrasting Goals of Treatment and Criminal Justice Systems**

The primary goals guiding resource allocation in the criminal justice system are completion of legal processing, protection of public safety, and punishment. Although there is a substantial literature indicating that treatment helps to protect public safety both in correctional institutions and in the community, criminal justice professionals are not always aware of this literature, or convinced of these findings. Moreover, in times of fiscal cutbacks, treatment services are usually perceived as less essential than those of security and supervision. During these times, criminal justice administrators usually cut those services that are legally discretionary, without regard for strategic planning or long-term outcomes. Despite the impressive track record of substance abuse treatment in reducing criminal recidivism, substance abuse treatment is not legally mandated in most correctional settings, whereas health and mental health services are legally mandated. As a result, substance abuse (and COD) services may be among the first to be scaled back or eliminated when criminal justice budgets are cut.

Contrasting goals of the treatment and justice systems may discourage application of some evidence-based practices. The substance abuse and treatment systems often use tangible reinforcement for positive behavior, and pharmacological treatments to assist in reducing or stabilizing symptoms. These approaches may not be accepted or tolerated within some criminal justice settings. For example, methadone maintenance, although having a wide range of empirical support, is not approved for use in the vast majority of jails across the country. Efforts to reconcile these differing values and goals may include cross-training of criminal justice and treatment staff, and joint planning activities between treatment and criminal justice administrators. Treatment partnerships within the criminal justice system are time consuming, and those involving mental health and substance abuse services require additional work. However, these partnerships have advantages for all involved, and often lead to an understanding that criminal justice services enhance the effectiveness of treatment, and that treatment strengthens security and supervision. In addition, there are efficiencies achieved by addressing both criminality and CODs during the treatment process.

**Implementation of Evidence-Based Practice**

A number of unique but related evidence-based treatment practices have been developed for mental health, substance abuse, and criminal justice settings. Evidence-based mental health practices include assertive community treatment (ACT), supported employment, illness self-management training, and family education. In the substance abuse area, key practices include therapeutic communities (TCs), community case management, sanctions coupled with treatment, contingency
management, relapse prevention, and motivational enhancement strategies (NIDA, 1999). Evidence-based practices used in criminal justice settings include cognitive–behavioral approaches, social learning models, challenging antisocial values and beliefs (“criminal thinking”), and focused assessment and intervention approaches for “high risk” offenders (Gendreau, 1995; Wanberg & Milkman, 1998).

Integrating these varied evidence-based concepts and approaches may be somewhat difficult, given that treatment and criminal justice professionals are often unfamiliar with approaches outside of their discipline, and that protocols that blend these different approaches are not readily available. However, there are several common themes across these varied evidence-based practices, including (i) cognitive–behavioral approaches, (ii) relapse prevention techniques, (iii) matching treatment intensity and duration to client needs and abilities, (iv) use of peer and family supports, (v) psychoeducational skills-based approaches, and (vi) addressing antisocial issues that are interrelated with substance abuse and mental health problems. These commonalities in theory and practice can help to facilitate communication and to build working relationships between interdisciplinary staff.

Moving from Sequential to Integrated Programs

While integration of mental health and substance abuse services is empirically supported (Drake et al., 2001), and appears to be the treatment of choice for offenders with severe CODs, it may be difficult to implement in some settings. For example, just as in non-offender treatment settings, mental health and substance abuse services in the criminal justice system are often supported by different funding streams. As a result, it may be difficult for mental health and substance abuse services to share funding for COD services. In some settings, such as jails and prisons, offenders may be classified to a particular institution or housing unit within an institution on the basis of either mental health or substance abuse needs, and there may be few COD services available in these settings.

Fully integrated services are not always indicated, particularly for offenders who may be experiencing an acute co-occurring disorder (e.g. a psychotic episode unrelated to a substance abuse disorder), or who have CODs of only moderate severity. Some prison inmates may require services early in the course of incarceration to address severe mental health problems, while their substance abuse needs will not ordinarily be addressed until just prior to release. Some flexibility should be provided to insure that integrated treatment services are reserved for offenders with pronounced CODs, and that mental health and substance abuse interventions can be sequenced in a way that addresses the most urgent needs of the offender.

Designing Programs According to Site-Specific Data

Offenders with CODs vary widely in the severity of their mental health and substance abuse disorders, the degree of functional impairment, family support, vocational skills and experience, and their criminal history and antisocial values and beliefs. Despite the diversity of offenders’ problems related to CODs, there are only limited data collected in most criminal justice settings to identify these problems and
related treatment needs. One significant challenge in developing COD programs is to implement screening and assessment approaches that capture sufficient data to determine the scope and intensity of COD treatment services that are needed, so as to efficiently prioritize scarce resources. These data will also help to inform where best to provide integrated services. For example, in most criminal justice settings, at least 70% of offenders have a history of substance abuse, whereas from 5 to 16% of offenders have severe mental disorders (Ditton, 1999; National GAINS Center, 1997). These data lead to the conclusion that while there is not a good rationale for including mental health treatment in all substance abuse programs, it does appear logical to integrate substance abuse treatment services within all mental health programs.

**Building a Range of Treatment Options**

A range of mental health and substance abuse treatment services are clearly needed in criminal justice settings. Implementation of effective COD treatment means that this range of services must be further expanded. Few criminal justice settings can afford many levels and types of treatment, so creativity will be needed. One strategy to expand COD services within existing programs is to develop COD treatment components (e.g. a COD track, or group) within these programs. Another option is to provide individualized treatment plans that include a focus on COD treatment needs. Arrangements can also be made for “in-reach” services by consultants, or staff from other disciplines, to provide COD treatment services and/or staff training related to CODs.

**Continuity of Services**

Research in the substance abuse and mental health area has demonstrated a strong positive cumulative effect of treatment for offenders who are transitioning from institutional to community settings (Simpson et al., 1999; Wexler, Melnick, Lowe, & Peters, 1999). The research literature also indicates the importance of sustained involvement in treatment for individuals who have pronounced CODs (Drake, Mercer-McFadden, & Mueser, 1998). Transitional services from jails and prisons and from community-based residential treatment services clearly have a significant impact on outcomes among offenders with CODs. A major challenge is that transition services are often seen as outside the primary responsibilities of jail and prison systems or of the communities to which offenders return. As a result, funding for community linkage, transition, and aftercare services are frequently unavailable, and these services are not provided in most jurisdictions (Edens et al., 1997; Peters & Matthews, 2002). System-wide planning between mental health, substance abuse, and criminal justice agencies is needed to ensure that case management and follow-up treatment services are provided to offenders with CODs who are transitioning to the community.

**Resources and Support for COD Treatment Programs**

As mentioned previously, substance abuse treatment services are often among the first to be cut during times of fiscal austerity and budget reductions in the criminal
justice system. COD services may also be vulnerable during times of budget cutbacks, due to the fact that there is not a constitutional or judicial mandate for these services. Integrated COD treatment programs are also more expensive to operate than substance abuse programs, and may not have vocal advocates within the criminal justice system, given that these programs are often not identified as being within either the mental health or substance abuse service systems.

As offender populations grow and budgets are reduced in correctional systems, progressively more dramatic solutions are sought by administrators that may inadvertently damage COD treatment programs. As with substance abuse programs in the criminal justice system, COD programs may also be vulnerable to changes in institutional or organizational mission and leadership. Strong leadership is needed to develop advocacy for COD treatment programs within the criminal justice system, and to articulate potential consequences of budget reductions and undesirable program modifications (Torrey et al., 1992). Survival of COD treatment programs in the criminal justice system may also hinge on the availability of outcome research data indicating the cost-effectiveness of these services.

**Ethical Issues in Implementing COD Treatment Services**

Staff providing COD services in criminal justice settings must contend with issues of impaired decision-making capacity among treatment participants, in a system where relevant procedures are often unclear. In addition, the professional ethical principles of confidentiality and informed consent may be potentially compromised in criminal justice settings. COD programs in the criminal justice system should develop specific policies and procedures, participant orientation programs, in-service training and consultation opportunities, and liaison and ethics committees to help address these important issues.

**Resources to Support COD Treatment and Research in the Criminal Justice System**

Several existing resources are available to support the development of programs, services, and research for offenders with CODs within the criminal justice system. The National GAINS Center for People with Co-Occurring Disorders in the Justice System, established in 1995 and funded by SAMHSA, collects and disseminates information related to effectively treating offenders with co-occurring mental health and substance use disorders. In addition to developing publications related to critical issues, highlighting promising practices, and stimulating policy change at the local, state, and national levels, the National GAINS Center provides training and technical assistance to criminal justice, mental health, and substance abuse treatment professionals working with offenders with co-occurring disorders. Recent initiatives include the development of a publication series on women in the criminal justice system with CODs, and a technical assistance project for communities implementing jail diversion programs. The National Center for Mental Health and Juvenile Justice was recently funded by the Catherine T. MacArthur Foundation and the Office of Juvenile Justice and Delinquency Prevention, and will provide
similar services and resources to the National GAINS Center, but will focus on youth with mental health and co-occurring disorders who are in contact with the juvenile justice system.

SAMHSA’s involvement in the arena of CODs is extensive. Through the work of the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS), SAMHSA has funded a variety of projects and block grant programs dedicated to the treatment of co-occurring disorders. The Co-Occurring Center for Excellence was recently established by SAMHSA as a technical assistance center to help identify best practices in COD treatment and to support the application of these practices. The center will help identify and disseminate information regarding best practices through use of criteria identified by SAMHSA’s National Registry of Effective Programs. Recent block grant initiatives made available to states seeking to provide services to individuals with CODs include State Infrastructure Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders, Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons who are Homeless, and Homeless Families: Women with Psychiatric, Substance Use, or Co-occurring Disorders and their Dependent Children.

SAMHSA continues to be involved in policy-related activities focused on advancing the development of treatment and services for individuals with CODs, and recently published the “Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders” (SAMHSA, 2002), highlighting SAMHSA projects and providing direction for ongoing activities. SAMHSA has also compiled information describing individuals entering publicly funded substance abuse treatment with CODs in “The DASIS Report: Admissions of Persons with Co-Occurring Disorders: 2000” (SAMHSA, 2003). CSAT has published several treatment improvement protocols (TIPs) and one technical assistance publication that provide extensive information regarding assessment, treatment planning, and treatment strategies for COD issues.

NIMH and NIDA support a range of research projects examining evidence-base approaches and strategies for treating CODs, and the consequences of other related medical conditions including HIV and hepatitis C. In addition to an extensive portfolio of grants examining issues related to CODs, NIDA recently funded the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) research cooperative dedicated to developing and testing systems level strategies and interventions designed to facilitate the integration of substance abuse treatment into the criminal justice system.

**FUTURE RESEARCH NEEDS**

Effective treatment of offenders with CODs is dependent on the cross-disciplinary collaboration of the criminal justice, mental health, and substance abuse treatment systems, and other social service organizations. Much of our knowledge regarding effective treatment approaches for CODs is drawn from non-offender samples in community settings. Additional research is needed to identify, develop, and test effective treatment strategies and interventions for offenders with CODs, including the adaptation of evidence-based community treatment practices within criminal
justice settings. To insure that evidence-based practice is adopted and implemented by the field, research is needed to identify optimal strategies for blending public health and public safety approaches in the treatment and supervision of offenders with CODs.

Efforts are also needed to clarify operational elements of COD treatment in the criminal justice system, including examination of the impact of factors such as organization, management, and financing of treatment and aftercare services on treatment outcomes related to mental health, substance use, criminal behavior, physical health, housing, employment, parenting, and victimization. Little is known regarding optimal methods for screening and assessing offenders with CODs, referral and triage processes for these offenders, and for integrating treatment and supervision services in diversion settings. Research is also needed to determine the most effective timing and dosage of mental health and substance abuse treatment at various different stages of criminal justice processing and incarceration. Finally, in attempts to identify evidence-based treatment for offenders with CODs, it is important to recognize that this population is characterized by tremendous diversity in the range and intensity of psychosocial problems, and that “one size (of treatment) does not fit all”. There is also great diversity in age, gender, and cultural/ethnic background among this population that should be considered in designing effective interventions for CODs.

There clearly is a compelling case for greater focus on the needs of offenders with co-occurring disorders. Neglect of offenders’ co-occurring disorders clearly leads to poorer criminal justice outcomes, and will likely augment the historical pattern of rapid cycling between acute care settings, jails, and prisons. Although research has not yet identified the specific contours of effective interventions implemented in various different criminal justice settings, integrated services are clearly warranted that provide a dual focus on mental health and substance use disorders, and that provide a long-term approach to treatment and supervision. Federal agencies such as the National Institute on Drug Abuse are beginning to explore the effectiveness of specialized approaches for co-occurring disorders in the criminal justice system. It is important that this research continue, with the goal of identifying the most effective combination and dosage of intervention strategies, and the long-term outcomes across different settings and with different offender populations.

REFERENCES


Evidence-based practices for co-occurring disorders


