



Creating Effective Treatment Programs for Persons with Co-Occurring Disorders in the Justice System

Prepared for the GAINS Center by

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Table of Contents

I. Overview	1
A. Defining the Population of Offenders with Co-Occurring Disorders.....	1
B. Considering the Heterogeneity of Co-Occurring Disorders.....	4
II. Developing Treatment Models for Persons with Co-Occurring Disorders in the Justice System	9
A. Models of Treatment.....	9
B. Core Principles of Treatment.....	11
III. No Matter the Model: Incorporating Program Principles	15
A. Principle One: Services for Persons with Co-Occurring Disorders Must Focus on the Integration of Treatment Programming.....	15
B. Principle Two: Both Disorders Should be Treated as “Primary”.....	15
C. Principle Three: Individualized Programming Should Address Symptom Severity and Skill Deficits.....	16
D. Principle Four: Psychopharmacological Interventions Should be Utilized When Appropriate.....	17
E. Principle Five: Phases of Intervention Must be Tailored to the Setting.....	17
F. Principle Six: The Treatment Continuum Must Extend Into the Community.....	18
G. Principle Seven: Support and Self-Help Groups are Critical in Successful Reintegration to the Community.....	18
IV. Specific Models of Intervention to Address Co-Occurring Disorders	21
A. Therapeutic Communities.....	21
B. Support, Psychoeducation and the 12 Steps.....	22
C. Cognitive-Behavioral or Cognitive Skill-Building Approaches.....	23
D. Relapse Prevention and Co-Occurring Disorders.....	24
E. Case Management: Method or Model?.....	26

V. Additional Challenges: Issues Confronted in Clinical Treatment.....	29
A. Confronting Systems Issues.....	29
B. Issues in Employing Psychopharmacological Interventions.....	30
C. Breaking Down Barriers to Program Implementation: Confidentiality and the Ownership of the Clinical Record.....	31
D. Evaluating Outcomes: Challenges When Implementing and Evaluating a Program.....	32
E. Unique Conditions: Delivering Services in Criminal Justice Settings.....	33
 VI. Summary: Considerations When Initiating Services for Offenders with Co-Occurring Disorders.....	 35
 VII. References.....	 37

I. Overview

Much attention has been paid in recent years to the increasing number of incarcerated individuals who have co-occurring mental illness and substance use disorders. This monograph highlights key elements that are important to consider when developing treatment programming for persons with co-occurring disorders (mental illness and substance abuse) in the criminal justice system. Issues associated with the assessment and diagnosis of co-occurring disorders in offender populations have been covered elsewhere (Peters and Bartoi, 1997). This monograph begins by describing the population to be treated, and reviews the reasons why treatment of persons with co-occurring disorders has been so challenging. Models of treatment that have been described in the clinical and research literature are reviewed. Generic program principles, irrespective of theoretical orientation, are outlined. Challenges encountered when trying to provide improved services to offenders with co-occurring disorders are also considered.

A. Defining the Population of Offenders with Co-Occurring Disorders

What Are “Co-Occurring Disorders?”

Many terms are used to describe the population of individuals who have the concurrent experience of some form of severe mental illness along with a substance use disorder. The term “co-occurring disorders” is increasingly being used to describe the phenomena of having multiple clinical syndromes simultaneously.

The most common term that has been used to identify treatment programs for persons with co-occurring disorders is “dual diagnosis.” Though it is frequently used, the term means different things to different people. The term is most often used to describe the presence of two co-occurring mental illnesses, one being substance abuse or dependence, and the second being another severe and persistent clinical syndrome, such as major depression, bipolar disorder, or schizophrenia. It is not uncommon for a person to meet criteria for one, if not several other, less severe disorders.

The term “dual diagnosis” or “dual disorders” is, therefore, in most instances not factually correct. Many offenders with co-occurring disorders might have personality disorders, anxiety disorders, attention-deficit disorders, or eating disorders, in addition to their severe and persistent mental illness and their pattern of substance misuse. In two prison populations undergoing treatment for their co-occurring disorders, males met criteria on average for more than four Axis I diagnoses; females were found to meet criteria, on average,

for more than five Axis I disorders (Hills, 1999) when evaluated by structured clinical interview. The individual's presentation, therefore, is increased in complexity by the presence of multiple co-occurring disorders. (The term "dual diagnosis" has also been used to describe the population of individuals with mental illness and mental retardation — not the topic under consideration here)

How Many Offenders Have Co-Occurring Disorders?

The concentration of persons with mental health and substance use disorders in correctional settings has been documented during the past two decades (Abramson, 1972; Teplin, 1983). Though police officers are encouraged, and the American Bar Association mandates, to see that the mentally ill be diverted to treatment rather than incarceration, arrests still take place (Teplin, 1984; Teplin, 1990). In practical circumstances, police officers will often use arrest only as a last resort when a mental health or substance abuse service disposition is not viable. For persons with co-occurring disorders, an arrest experience may be the rule and not the exception, as they are likely to receive rejections from halfway houses, hospitals and detoxification facilities, and according to Abram and Teplin (1991), "may be arrested as a way to manage their disorders."

The complicated symptom profile of persons with co-occurring disorders and their multiple treatment needs causes them to be excluded from many treatment programs and, thus, more have found their way into the criminal justice system — with typically no better chance of receiving comprehensive care. Abram and Teplin's (1991) findings clearly demonstrate that the problem of comorbidity is a frequent occurrence. Persons with schizophrenia in prison met criteria for a lifetime prevalence of any alcohol disorder at a rate of 85.8%, and 72.4% met criteria for any drug disorder (N=715; five-site combined prison sample). These rates are more than double the lifetime prevalence rates found for persons with schizophrenia in the combined community and institutional sample (N=20,291) by the Epidemiological Catchment Area (ECA) investigators (Regier, Farmer, Rae, Locke, Keith, Judd, and Goodwin, 1990) and indicate the tremendous prevalence of co-occurring disorders in persons in the criminal justice system. Prisoners in the ECA investigation were found to have lifetime prevalence rates of substance abuse at 72% (56.2% alcohol; 53.7% other drug), while 55.7% met criteria for some other type of mental disorder. Chiles, Von Cleve, Jemelka, and Trupin (1990) reported that 88% of male offenders who volunteered to be interviewed met criteria for either a substance use or other mental health disorder diagnosis. Of the total group with any diagnosis (N = 96), 56% met criteria for both a substance use and another mental health disorder diagnosis (i.e., co-occurring disorders). Through a variety of paths, many persons with co-occurring disorders are finding their way into the criminal justice system.

How Are Disorders Related?

There are many ways in which substance abuse and psychiatric disorders can interrelate (Meyer, 1986). Use of alcohol and drugs can “create” psychiatric symptoms. Use of drugs is thought by some to precipitate the emergence of certain psychiatric disorders. Psychiatric symptoms might be “mimicked” by alcohol and drug use, which can lead to misdiagnosis and confusion in treatment planning. Psychiatric syndromes may be worsened by drug abuse, or can go undetected if they are masked by alcohol and drug use. Finally, there may be an underlying biological vulnerability to these disorders that exists within the individual (Regier, et al., 1990). Mueser, Drake, and Wallach (1998) extensively review data supporting the following four models of interrelationship:

- common factor models, in which shared risk factors across substance use and forms of severe mental illness result in high rates of comorbidity;
- secondary substance use disorder models, wherein mental illness is thought to increase risk of the development of substance use disorders;
- secondary psychiatric disorder models that suggest substance use precipitates severe mental illness; and
- bidirectional models, which propose that having one disorder can increase the vulnerability to the other disorder.

Adding to the difficult task of diagnosis and treatment planning is the awareness that disorders vary in the degree to which they are disabling. One disorder may be more severe during a given period of time, they may both be continuous and chronic, or they may both be more intermittent and episodic. One or both of them might be expressed in many symptoms at any time, or one might be very acute and the focus of clinical attention. This “instability” in presentation poses a challenge to placement evaluators who feel the press of burgeoning inmate populations and are typically left with the decision to track an offender into either mental health or substance abuse services.

The association between the use of drugs and crime is well documented. The motivation to obtain drugs to supply a habit often leads individuals to commit crimes (Lurigio and Swartz, 1994). Frequent heroin and cocaine users are two to three times as likely to commit crimes than infrequent users or nonusers (Bureau of Justice Statistics, 1992). Persons with co-occurring disorders also may be more likely to be apprehended for the commission of their crimes due to their cognitive and emotional disturbances.

Offenders with co-occurring disorders present a difficult clinical challenge; negative clinical outcomes have been more the rule than the exception. Osher and Drake (1996) summarize research findings gathered during the past decade that conclude that persons with co-occurring disorders, compared to persons with single syndromes:

- have greater vulnerability for rehospitalization;
- experience more psychotic symptoms;
- have more severe depression and suicidality;
- have higher rates of violence and incarceration;
- have more difficulty with daily living skills;
- are more noncompliant with treatment regimens;
- have increased vulnerability to HIV infection; and
- are high service utilizers.

Peters, Kearns, Murrin, and Dolente (1992) found that individuals involved in a jail-based substance abuse treatment program, who also had mental health symptoms, had more pronounced difficulties in several areas of functioning, including employment, relationships, medical difficulties, and in their baseline knowledge of treatment principles and relapse prevention skills.

Key Points

- “Co-occurring disorders” is the term being used to describe the experience of a substance use disorder and a severe and persistent mental illness occurring in the same individual.
- Rates of severe and persistent mental illness and substance use disorders observed in correctional settings greatly exceed those found in community settings.
- The presence of co-occurring disorders provides a higher risk for psychosocial problems and difficulties in treatment.

B. Considering the Heterogeneity of Co-Occurring Disorders

Individuals with very different problems may have co-occurring disorders. In this monograph the discussion is limited to those individuals with a severe and persistent Axis I disorder and a co-occurring substance use disorder. Many other groups with less severe “co-occurring disorders” may appear for treat-

ment services. Another “source” of heterogeneity is the variability in symptom presentation within a single diagnosis. Finally, an individual’s unique pattern of substance use can affect the presentation of his or her disorders. Given the varying symptoms and functional skills of persons across the full spectrum of co-occurring disorders, variations in program planning must be considered. For example, persons with psychotic-spectrum disorders will often require individualized treatment protocols that provide a long-term perspective, more structure, and a less confrontational approach than most people with substance abuse alone (Zweben, Smith, and Stewart, 1991). Therefore, different populations, settings, service configurations, and orientations to treatment must be considered when planning for services.

Many programs have attempted to exclude persons with co-occurring disorders from their service settings. Exclusionary criteria associated with some substance abuse treatment programs have been used to “screen out” persons with serious and persistent mental illness. For example, more intensive “boot camp” programs or prison-based therapeutic communities may exclude persons with a history of previous mental health treatment or current use of psychotropic medications. Questions about the use of psychotropic medications or counseling histories often fail to detect those individuals whose disorders have not yet been diagnosed or treated. Many offenders come into these programs before they have had a severe episode of their disorder, and often before they have received a diagnosis or treatment. Program expectations may have to be altered for those individuals whose disorders are revealed or potentially exacerbated due to rigorous program demands. Additionally, screening efforts often fail to detect disorders such as post-traumatic stress disorder or attention-deficit disorder when they co-occur with substance abuse. For these individuals, specialized programming for co-occurring disorders should also be considered.

Due to the disruption that unpredictable behavior can create in the therapeutic environment, it is sometimes recommended that persons with co-occurring disorders be provided service in settings separate from other individuals receiving either mental health or substance abuse treatment services (CSAT, 1994a). Depending on symptom severity, however, it may not be necessary to transfer an offender out of their current service setting. Service needs may be addressed by creating a cross-program consultation service. Though funding and space limitations may prevent the development of independent, or segregated, service settings for persons with co-occurring disorders, collaborative treatment services can be designed for persons who have a variety of presenting conditions, treated in either a mental health or substance abuse service setting.

The relationship between any two diagnoses is often very complicated and highly individualized. Some individuals may use substances to ameliorate negative symptoms such as apathy and withdrawal, whereas

others may use substances to reduce the discomfort of side effects from antipsychotic drugs, such as tremor, rigidity, and agitated pacing. Most substance use, however, does not result in the effective reduction of targeted symptoms — contrary to what the description of “self-medication” would suggest. Typically, most offenders with co-occurring disorders use substances for the same reasons that their non-mentally ill counterparts do — to be social, fight boredom, or to achieve a “high.” Types of interactive effects may vary as a function of diagnostic combinations. Below is a brief discussion of some common disorders that co-occur with substance use disorders.

Major Depression. Though many people report using substances in an attempt at symptom reduction, alcohol often acts to increase impulsivity and to increase suicidality. Data from the National Longitudinal Alcohol Epidemiologic Survey (NLAES) revealed a strong and pervasive relationship between depression and substance use disorders. The strongest association was seen between substance dependence — rather than abuse — and depression. Women demonstrated a stronger association between depression and substance abuse, especially for the use of prescription drugs, stimulants, sedatives, tranquilizers and amphetamines. Findings from the NLAES also noted the association between marijuana and hallucinogen abuse or dependence — two drugs that are not often considered as part of a “self-medication” paradigm. High doses of either of these substances can lead to anhedonia, chronic apathy, concentration difficulties and social withdrawal — all symptoms reminiscent of major depression (Grant, 1995).

Bipolar Disorder (Manic-Depressive Illness). Use of even minor stimulants, such as caffeine or ephedrine, has been reported to increase manic episodes. Bizarre and impulsive behavior often leads to arrest (e.g., trespass, worthless checks). Issues around self-medication are often discussed. However, many individuals report using stimulants during a manic period to prolong or accentuate their experience. This pattern of use would contradict the goal of using substances to reduce or ameliorate symptom experience. Reich, Davies, and Himmelhoch (1974) hypothesized that different patterns of drinking existed during different phases of the illness, with chronic, excessive drinking predominate during mania, and periodic excessive drinking during depression. Weiss and Mirin (1989) found that cocaine has been used in both phases of bipolar disorder, in increasing doses. They reported that more individuals used it during manic phases to further enhance their mood.

Schizophrenia and the Psychotic-Spectrum. Alcohol, cocaine, and marijuana are the most common drugs of abuse in populations of persons with schizophrenia (Schneirer and Siris, 1987). Self-medication in persons with schizophrenia may take place in an attempt to reduce the side effects of neuroleptic medication;

this includes nicotine, which has been found to reduce side effects (Decina, Caracci, Sandik, and Berman, 1990). They may also be used to cover or “mask” positive symptoms of psychosis (e.g., hallucinations, delusions) or to alter negative symptoms such as paucity of thought, low energy, or depression (Decker and Ries, 1993). Other work has suggested that depression is the primary associated symptom that may be the target of self-medication efforts.

Alcohol use can sometimes mask the experience of psychosis, as it may serve to make individuals less anxious about their symptoms. The withdrawal from alcohol in the presence of ongoing psychosis may lead to increased agitation and autonomic hyperactivity (Decker and Ries, 1993). Use of alcohol or other drugs may directly exacerbate the individual’s psychotic experience or can contribute to increased medication noncompliance. It has also been hypothesized that the use of cocaine may heighten the “psychosis proneness” of individuals even when they are not abusing it (Satel, Southwick, and Gawin, 1991).

Program modifications to better serve persons with co-occurring psychosis and substance use disorders have been developed. These programs are typically modifications of existing programs that take into consideration the person’s disordered cognitions and communication style. These modifications include using fewer abstract concepts, providing more structured or written program materials, and decreasing confrontational activities. There is some data to suggest (Zisook et al., 1992) that within the group of individuals with schizophrenia, those who successfully abstain after a period of use report fewer symptoms than individuals who were “lifetime” abstainers.

Anxiety Disorders. Self-medication is described as the prominent reason for use during the experience of a panic disorder or to reduce generalized anxiety. As alcohol use increases in severity, however, so does the experience of panic disorder and global anxiety experience. Post-traumatic stress disorder and substance use disorder co-occur at a “relatively high” rate and create complex treatment issues (Najavits, Weiss, and Liese, 1996). The presence of either disorder can increase the risk for the onset of the other disorder. A family history of substance use inherently increases the person’s risk for the experience of trauma. These disorders also tend to have a more enduring relationship, unlike that between substance use disorders and other Axis I disorders, where abstinence can lead to a marked symptom reduction (Brown and Schuckit, 1988).

Attention-Deficit Hyperactivity Disorder. Though thought of as a childhood disorder, there is now building evidence that in approximately 50% of those afflicted, symptoms persist into adulthood. In adulthood, this disorder often presents concurrently with other disorders, including anxiety, mood, antisocial personality and substance use disorders. Biederman et al. (1995) found that adults with ADHD were twice as likely to

have a substance use disorder than control subjects. Across several studies, the most common drug of abuse was marijuana. Differential diagnosis issues are complicated here, as impulsivity, hyperactivity, and distractibility could also be indicative of some form of substance abuse, especially stimulant abuse. Persons with these symptoms will sometimes try to avoid the diagnosis of a substance use disorder, especially if they see their use as an attempt at self-medication. Usually both substance use disorders and mood disorders, if present, will be treated before psychopharmacological treatments of ADHD are begun (Wilens, Prince, Biederman, and Spencer, 1995).

Personality Disorders. Personality disorders are found quite commonly in the population of individuals with co-occurring disorders, both in community and criminal justice settings. In defining the population of individuals who are “dually diagnosed,” most clinicians and researchers argue that the consideration of personality disorder diagnoses be done after the diagnosis of a substance use disorder and another severe and persistent Axis I disorder has been established.

Two of the most common forms of personality disorders are highly prevalent in criminal justice populations: antisocial personality disorder and borderline personality disorder. Both disorders are characterized by difficulties in impulse control, and substance use disorders are a common result. Narcissistic personality disorder is commonly found in substance abuse populations.

Mood disorders are commonly seen in persons with borderline personality disorder, with some clinicians considering the dysregulation in mood states the most prominent clinical feature. The presence of a mood or anxiety disorder in an individual with antisocial personality disorder is considered a positive indication for therapy prognosis (Woody, McLellan, Luborsky, and O'Brien, 1985).

Key Points

- Orientation to treatment must contain some flexibility; different diagnostic groups will require different interventions.
- Different levels of cognitive resources, symptom ranges and intensities, and different motivations for use will require specialized treatment consideration.
- Programs that attempt to offer groups at the same level of intensity for all of their individuals with co-occurring disorders will likely be confronted with significant attrition and decompensation.

II. Developing Treatment Models for Persons with Co-Occurring Disorders in the Justice System

A. Models of Treatment

There are several ways to conceptualize an intervention program for persons with co-occurring disorders. Historically, providers have considered: referring offenders for treatment with the “other” service system following their involvement with an initial treatment program; trying to coordinate treatment between two service systems, with the offender coming to one program for certain services and going elsewhere for others; or developing an integrated treatment service with a multidisciplinary staff representing both mental health- and substance abuse-trained personnel.

These three approaches are typically referred to as sequential, parallel, and integrated treatment models, respectively. Brief descriptions of these models are included below.

- *Sequential.* This form of treatment provides services in one system first (either mental health or substance abuse), followed by treatment in the other. Historically, a lot of “dual diagnosis” treatment was delivered this way. However, this sequencing of interventions isn’t thought to be the best approach for persons who have more severe, less episodic experiences of their co-occurring disorders. This remains a common method used in most criminal justice settings, with the focus of the interventions typically on the management of acute symptoms associated with behavior problems.
- *Parallel.* This approach involves the mental health and substance abuse treatment systems treating the individual concurrently. Significant burden is placed on the individual, and sometimes a case manager, to either coordinate or be responsive to the different service systems’ demands for appointment times and availability. Individuals in treatment are expected to negotiate different service settings, clinicians and program demands to receive service. This method of separate but coordinated intervention is also thought to work better with individuals with less severe presentations of their disorders. This approach has become more common in the past 15 years in jails and prisons, with the advent of more comprehensive mental health and substance abuse services and the development of outpatient services within institutions.

Drake, Mueser, Clark, and Wallach (1996) reviewed the course of treatment for persons with co-occurring disorders treated in the community. They concluded there is mounting evidence for the difficulties inherent in trying to accomplish parallel treatment. Rather, clients have continued to advocate for integrated treatment that “requires clinicians and programs, rather than clients, to make treatment compatible” (Drake, et al., 1996, pg. 45).

- *Integrated.* Treatment under this model is geared toward conceptualizing the treatment of both disorders simultaneously, in the same service setting, utilizing cross-trained staff. A multidisciplinary approach can then be employed, with service staff fully apprised of the entire treatment for a given individual (CSAT TIP No.9, 1994b). Programs offering integrated treatment services have existed in the community to a limited degree during the past decade; only two programs in prison settings could be identified five years ago, with that number increasing to seven in 1997 (Edens, Peters, and Hills, 1997).

As a number of integrated programs have emerged from the literature, several common elements have been identified. They include:

- assertive outreach;
- comprehensive services;
- flexibility;
- intensive case management;
- a “stage-wise” emphasis on increasing motivation for abstinence;
- specialized group substance abuse intervention for those low in motivation; and
- modifications to prescriptive practice (Drake et al., 1996; Edens, Peters, and Hills, 1997).

Nonetheless, there still remains a paucity of research literature on integrated services (versus nonintegrated), which leaves little to go on when trying to design and implement essential treatment components and intervention methods. Drake et al. (1998) concludes that “integrated treatment for dual disorders remains a working hypothesis with only modest empirical support” (pg. 602).

Key Point

- The best chance for sustained symptom remission appears to exist in a system that doesn't require the shifting of treatment goals between service settings and providers.

B. Core Principles of Treatment

A series of core principles have emerged to focus treatment providers on how to optimize treatment outcomes for offenders with co-occurring disorders. Treatment participants have to become invested in treatment, understand the need to continue their connection with treatment over time, and must be offered services that meet their evolving needs. This can be achieved by focusing on the following concepts:

- *Treatment Engagement;*
- *Treatment Continuity;*
- *Treatment Comprehensiveness; and*
- *Continued Treatment Tailoring Through Reassessment*

Treatment Engagement involves getting the offender interested in participating in treatment. Initial engagement opens the door to a commitment to treatment over the long term. This is a necessity for persons with complex, co-occurring disorders who are found to achieve better outcomes with increasing program length (Drake, McHugo, and Noordsy, 1993). There are certain conditions that are independent of the therapy content or skill-building groups that will increase a program's "attractiveness" to participants. These factors include:

- providing assistance in gaining economic benefits, housing, medical services, or other living needs;
- reductions in community supervision time, fees, or other obligations (e.g., community service) as a result of participation in treatment;
- offering opportunities for "gain time" or other credit toward the reduction of sentences for involvement in dual diagnosis treatment, similar to offenders who receive sentence reductions for work completed;
- placement in more desirable housing units in institutions;
- ability to achieve privileges for more frequent visits;
- evaluating and removing barriers to participating in treatment;

- providing access to work furlough or early release programs as a result of participation in treatment;
- making it acceptable and accessible to participate;
- offering related services, such as child care, vocational planning, and recreation; and
- using coercive means, where appropriate, including involuntary commitment or detoxification, or court-mandated treatment (Griffin, Hills, and Peters, 1996).

In many jail-based service settings, lengths of treatment contact are very brief, and engagement exercises and community re-entry and linkage activities should form the core of treatment. The goal of this engagement effort is to encourage the individual to continue treatment upon their return to the community. Despite connecting with programs, program participants are not often initially “connected” with the idea of becoming abstinent — as no reduction in substance abuse in their first year of program affiliation was found in a recent community-based study (Drake et al., 1996) — thus promoting the importance of increasing motivation for abstinence. A consistent finding across the studies reviewed by Drake et al. (1998) was that “many patients needed long-term, stage-wise interventions because they were unmotivated early in treatment to pursue abstinence” (pg. 602). Programs in correctional institutional settings need to find ways to reconcile their abstinence orientation with the reality that an acceptance of this perspective often builds over years, not days or months.

Treatment Continuity is essential as both inmates and detainees may leave an institutional program with little notice. Thus, they need be connected to the service options associated with their next phase of incarceration or their return to the community. This concept includes a professional responsibility to continue to monitor the offender’s progress as they move between programs. A Center for Mental Health Services (CMHS) report developed by the Co-Occurring Mental Health and Substance Disorders Panel encouraged all managed care entities to develop and implement integrated systems of care for prisoners, parolees, and probationers with co-occurring disorders. Case management through the parole system is encouraged, as is the use of wrap-around mental health/substance abuse services in pre-release planning and post-release residential settings (CMHS, 1998).

Treatment Comprehensiveness means the need for treatment services for persons with co-occurring disorders must be broadly defined. Comprehensiveness involves designing treatment programming that will accommodate persons with different levels of symptom severity or dysfunction, allow for a variability over time in commitment to treatment, and address people in their current state of understanding of how their disorders interact and impact their lives.

Comprehensiveness also encompasses the need to address treatment to individuals with different subtypes of co-occurring disorders and their current level of service need. This might include acute, subacute, or outpatient services. The CMHS panel on Co-Occurring Mental Health and Substance Disorders (1998) recommended the following services:

- 24-hour, integrated triage service;
- integrated crisis intervention and counseling;
- crisis stabilization beds that can accommodate substance-involved individuals in a mental health crisis;
- mental health inpatient beds that provide assessment, stabilization, and treatment for persons with co-occurring disorders, short or long term;
- psychiatrically-enhanced detoxification programs that can accommodate persons with severe and persistent mental illness, whether stable or unstable;
- integrated partial hospitalization or residential programs for persons with co-occurring disorders;
- addiction day treatment and intensive outpatient that can accommodate persons with severe psychiatric illness;
- integrated, intensive and continuous case management services for persons with all forms of co-occurring disorders (not just the severe and persistently mentally ill);
- outpatient integrated service settings that incorporate comprehensive assessment, case management, individual and group treatment, family therapy, rehabilitation counseling and peer counseling; and
- residential services that include addiction halfway houses, modified therapeutic communities, sober houses, group homes, safe havens, supported housing (which include “wet,” “damp” and “dry” housing), case-managed sober housing, all focused on the special needs of persons with co-occurring disorders (CMHS, 1998, pg. 18–19).

Treatment Tailoring Through Reassessment requires the consideration that offenders with two concurrent diagnoses may present very differently depending on length of incarceration, time since use, evolution of their expression of their disorder, and impact of treatment programming. These circumstances require that the individual be regularly reassessed to determine what is working in their treatment efforts and what still requires significant intervention. As symptoms are reduced, other issues might need to be explored, or the focus might shift to skill-building or vocational planning. Treatment tailoring moves away from the concept of

homogeneity in programming and planning (Griffin, Hills, and Peters, 1996). Treatment tailoring acknowledges the varying levels of motivation, ambivalence and treatment readiness that individuals present with and conceptualizes current treatment needs accordingly.

III. No Matter the Model: Incorporating Program Principles

A. Principle One: Services for Persons with Co-Occurring Disorders Must Focus on the Integration of Treatment Programming

Integration of treatment services maximizes intervention efforts aimed at addressing the specific symptoms and behavior patterns associated with the experience of both classes of disorder. Service integration means that all interventions provided will address the offender's psychiatric and substance use disorders simultaneously. All services provided should consider the interactive effects of their co-occurring disorders and present treatment perspectives drawn from both mental health and substance abuse programming.

Other formats for intervention have been tried in many settings, i.e., the parallel and sequential approaches to treatment described above. As noted, each of these may be adequate for serving persons with less severe co-occurring disorders, or those that occur in very circumscribed episodes. Attempts at fully integrated treatment programming should be focused on the priority populations of individuals who have severe and persistent mental illness and substance use disorders.

B. Principle Two: Both Disorders Should be Treated as "Primary"

To accomplish this programming goal, the role of cross-training is especially important. This orientation to treatment should be shared within the multidisciplinary treatment team and communicated clearly to the offender. A prominent issue in the history of mental health treatment of persons with co-occurring disorders had been the perspective that treating the "primary" disorder would be sufficient to resolve a person's substance use disorder. This strategy has ultimately proved to be both simplistic and futile, with most persons with co-occurring disorders failing to make expected treatment gains or achieve symptom remission due to their continued, therapeutically-unaddressed use of substances. Staffing with cross-trained individuals will increase the likelihood that both disorders are part of any comprehensive, individualized service plan. Cross-training in criminal justice settings must involve both clinical and criminal justice staff, including corrections officers and police departments.

This does not rule out the possibility that some individuals might have substance use disorders that developed secondary to the skill deficits or symptom experiences associated with other disorders. For example, self-medication of symptoms can quickly and easily become an addiction. However, once the disorder

has become established, no matter the etiology, programs need to address the impact of the substance use disorder on the person's functioning, current symptom experience, overall prognosis, and treatment needs.

Considering disorders as "co-primary" does not mean that each will be given equal emphasis at all times during service delivery. Both severe and persistent mental illnesses and substance use disorders often have a cyclical course with periods during which there is greater or lesser symptom intensity. For example, during a period of prolonged sobriety, symptoms of depression might occur. In this instance, the person's depression should be the focus of treatment attention. The presence of any "co-occurring" disorder should, therefore, be treated both independently and as it interacts with other disorders.

C. Principle Three: Individualized Programming Should Address Symptom Severity and Skill Deficits

Persons with co-occurring disorders are a highly heterogeneous group with varying cognitive and functional abilities and interpersonal skills. These deficits or strengths can alter treatment programming significantly, and are often more important for the developing treatment plans than diagnoses. For example, some individuals develop substance use disorders due to their difficulty with being verbally assertive, and their wish to overcome their social isolation. Once addicted, some individuals with limited cognitive skills become naively involved in criminal activity. Others may have strong interpersonal skills and rich vocational histories, prior to their disorders achieving severe and incapacitating levels. Whatever their symptom presentation, individualized programming must take symptom experience and skill levels into consideration.

Individualized service plans arise out of intensive evaluations and interactive consultation with multidisciplinary input. Conclusions generated from differing disciplinary perspectives must be reconciled so that a comprehensive, integrated treatment plan can be created. Multidisciplinary team meetings offer an opportunity to describe differing perspectives and allow for the generation of specific ideas about the onset of a person's co-occurring disorders and their interactive effects. Decisions can then be made about the initial therapy goals. These may include involvement in core programming, specialty issue or skill-building groups, vocational or educational skill-building, and self-help participation. The proposed treatment plan should be reviewed with the individual to incorporate their personal therapy goals.

D. Principle Four: Psychopharmacological Interventions Should be Utilized When Appropriate

During their initial intensive assessment, appropriately trained staff should evaluate the offender's current or recent pattern of alcohol or drug use, and how it would complicate their use of psychopharmacological interventions. During the course of their treatment program, offenders should be instructed as to their need for medication, if prescribed, and educated as to how continued drug use would compromise the medication's effectiveness — or, in some instances, may prohibit their prescription.

Offenders will also require education as to the reasons why specific medications are prescribed for them, and how to communicate their need to take medications to individuals who see this as contradictory to a "recovery" lifestyle.

E. Principle Five: Phases of Intervention Must be Tailored to the Setting

Depending on the setting (prison, jail, courts, community), different levels of intensity in treatment programming will have to be conceptualized. In prison settings, programming might include consultation between services and modified treatment goals in the context of the offender's involvement in ongoing substance abuse treatment. Alternatively, it may involve the development of a specialized, integrated treatment program with a segregated housing unit. The intensity and timing of the intervention would involve consideration of the offender's length of sentence and the opportunities for transitional programming extending into the community.

In jail settings, programming challenges include establishing the presence of co-occurring disorders while there still is an opportunity to intervene. For presentenced offenders, key services include screening, assessment, court liaison, re-entry planning, and community linkage. For offenders who have been sentenced, the brevity of their incarceration may prohibit comprehensive programming, although brief psychoeducation and coordinated transition with community agencies (e.g., "reach-in" services) may be most important.

In the community, treatment considerations often include establishing a long-term plan for treatment that meets the requirements of the legal system and promotes individuals' understanding of the relationship between their co-occurring disorders and their criminal history. For persons with severe mental illness, treatment programming will be multi-faceted and will need to include evaluation of housing requirements, transportation, and vocational skills.

F. Principle Six: The Treatment Continuum Must Extend Into the Community

As most sentenced offenders are eventually returned to the community, treatment planning must consider system linkage issues. Linkage issues for offenders coming out of prison are complicated by the often significant geographic differences between the prison and their home communities. For persons released from jail, the brevity of their contact with the system often complicates making successful links. Post-release planning must begin at the point of contact with any individual. Whenever possible, case managers or service providers from the referral site should initially contact the referred offender while he or she is still in the facility.

For prison-based offenders, a post-release plan should be developed to guide the process and to prioritize individual needs. Components of the plan would involve addressing living arrangements, reconnection with abstinence-oriented family members, vocational planning, continued participation in treatment, and self-help. A network or resource list of treatment and other service providers for offenders to refer to should be developed and provided at the time of their discharge from the facility.

Depending on the individual's current "severity" status, various recommendations for continued treatment planning may come out of a "post-release" planning meeting. Many individuals may be referred to a halfway house or other adult congregate living facility, as a transition to community care.

For individuals released from jail, the rapid transition to community care requires staff to be extremely well connected to community providers to assure that psychopharmacological and psychosocial interventions, initiated within the institution, can be continued. Difficulties often emerge when prescriptions run out before connections to community providers can be accomplished. "Forensic," or correctional case managers, are available in some areas and can serve as contacts to address difficulties in the transition from prisons or jails to community care. No matter how much linkage is planned, treatment will not go forward unless the offender is convinced of his/her need to continue. Many offenders do not wish to continue treatment once they are released, as they sometimes view treatment as a continued restriction on their freedom (Edens, Peters, and Hills, 1997).

G. Principle Seven: Support and Self-Help Groups are Critical in Successful Reintegration to the Community

Self-help and support organizations serve an invaluable role in assisting individuals in continuing to make their commitment to abstinence a daily goal, and in understanding how to cope with continued symp-

toms. Standardized formats and widespread availability in the community make these groups an integral part of the treatment continuum.

Difficulties have arisen in the past, however, when individuals with co-occurring disorders were confronted by persons in AA about their commitment to recovery, in light of their use of psychotropic medications. Offenders must be instructed as to how to address these concerns when they are confronted with them in group settings. Negative opinions about the use of psychotropic medications are almost always the feelings of individual members and do not represent the written and stated policy of the parent organization. Brochure materials are often available to support the person's position that they are acting with the full support of the organization in using their medications as prescribed. As no single format works for all individuals, several alternatives to traditional 12-step programs are now available (SMART Recovery, Rational Recovery, SOS).

IV. Specific Models of Intervention to Address Co–Occurring Disorders

Various models of treatment intervention for persons with co–occurring disorders have appeared in the literature. Typically, integrated program models involve modifying traditional substance abuse or mental health programs to address the issues of persons with co–occurring disorders. Forms of treatment that have been adapted to include integrated approaches include: therapeutic communities; cognitive–behavioral interventions; relapse prevention; and supportive/psychoeducational therapies combined with 12–step/AA models. Some emerging models are described below.

A. Therapeutic Communities

Therapeutic communities (TC) are typically comprehensive, long–term (six–24 month) programs designed to restructure the lifestyles and personalities of the participants to help them to abstain from drug use, achieve employment, and behave in a prosocial manner. These goals are achieved through a variety of treatment approaches, including remedial education, encounter groups, individual counseling and the performance of job duties (DeLeon, 1989). Therapeutic communities typically employ a predominance of recovering individuals. Though TCs have always served persons with non–drug Axis I disorders, the clinical and research findings indicate greater effectiveness with persons who have less severe (nonaffective; nonpsychotic) psychiatric disorders (DeLeon, 1993). Several therapeutic community programs for persons with co–occurring disorders have been developed during the past several years (McLaughlin and Pepper, 1991; Sacks and Sacks, 1995). Specific modifications can be made to traditional TC programs in order to accommodate the different symptomatic and functional levels of persons with co–occurring disorders, including:

- 12 months of recommended program duration with greater flexibility in continued treatment alternatives;
- Meetings or activity lengths are shorter to accommodate shorter attention spans;
- Staff play a greater role in monitoring and coordinating activities;
- Information is provided gradually with significant repetition;
- More individual counseling is provided;
- Movement through the program and specific tasks are more individualized;
- Staff try to be strong role models and provide increased assistance when required;

- Activities overlap more and the pace is slower;
- Resident job functions are more “horizontally” organized;
- Confrontational “encounter” groups are replaced by conflict resolution or “community” groups with more emphasis on affirmation of progress and individual change efforts;
- Greater emphasis is placed on teaching, training, and instruction than confrontation and compliance; and
- Rewards, both verbal and in the form of privileges, are delivered more frequently.

Successful staffing of these modified TCs will include a larger staff-to-client ratio than is found in a traditional TC, with more mental health staff integrated into the program. All staff must be cross-trained, with mental health staff educated in the self-help model of the TC, the view of community residents versus patients, and staff as guides or facilitators rather than treaters. TC staff correspondingly need to understand the concept of mental health diagnoses, pharmacotherapy, and greater variability in rates of change, energy, and responsivity (DeLeon, 1993). The effectiveness of modified TC programs for persons with co-occurring disorders is currently being studied (De Leon, 1993).

B. Support, Psychoeducation and the 12 Steps

Many programs use the AA orientation/12-step model as an integral component of their intervention. Different studies have approached the use of self-help in different ways. In their Combined Psychiatric and Addictive Disorders Program (COPAD), Rosenthal, Hellerstein, and Miner (1992) combined supportive group therapy with psychoeducation on drug use/disorder interaction, peer support and staff-moderated confrontation, attendance at AA or NA where appropriate, medication management, and urinalysis. Though abstinence is encouraged as a goal of treatment, absolute sobriety was not a required condition for entering or participating in treatment. In a seven-year follow-up of persons with severe mental illness and substance use disorders in Boston, Bartels, Drake, and Wallach (1995) delivered an integrated intervention on an inpatient unit, followed by case management with 12-step counseling and linkage with traditional substance-abuse treatment, whenever necessary. Approximately one-quarter of participants with alcohol use disorders and a third of those with drug use disorders in this intervention achieved abstinence.

Peer support programs have long been a part of substance abuse treatment but are a more recent phenomenon in mental health treatment settings. Integration of persons with dual disorders into peer groups

associated with one or the other discipline is challenging. Though the AA literature clearly supports an individual's right to take medication prescribed for a psychiatric or other medical problem, many individual group members are intolerant of this choice. Persons referred to AA meetings should be prepared in advance to address concerns that group members may have about their commitment to recovery. Role-playing or simulations can be used to rehearse for these encounters. Concepts such as powerlessness and a "higher power" can sometimes be difficult to integrate into mental health treatment and need to be communicated in a way so as to reduce confusion and contradiction (Zweben, Smith, and Stewart, 1991).

An ambivalent attitude toward abstinence is the rule and not the exception in persons with co-occurring disorders. Because they are uncertain about the impact of their substance use on their symptom experience, accepting an abstinence orientation can be a difficult task. They may have had this impression implicitly endorsed by service providers who did not address their co-occurring disorders. Recent findings suggest that in early recovery, persons with co-occurring disorders may have difficulty in affiliating with AA groups, even with facilitation (Noordsy, Schwab, Fox, and Drake, 1996).

C. Cognitive-Behavioral or Cognitive Skill-Building Approaches

Cognitive-behavioral therapy (CBT) for co-occurring disorders typically involves the teaching and application of self-control strategies designed to improve problem-solving, impulse control, anger management and identify cues and cognitions associated with the disorders (Najavits, Weiss, and Liese, 1996). CBT also works to develop skills that may not have developed due to the presence of the disorders. These skill-building strategies may focus on improving relationships through assertiveness, negotiation, asking for help, active listening, and taking care of oneself through coping self-talk and positive self-statements.

Skills related to planning adaptive activities and better problem-solving are also emphasized. To promote engagement and knowledge acquisition in CBT for persons who are dually diagnosed, some techniques from the educational literature are often employed, including:

- visual aids, including illustrations and concept mapping;
- role preparation to help prepare for unexpected circumstances;
- providing specific feedback on how to generalize therapy techniques into their lives;
- outlines for all sessions, with explicit learning objectives;
- testing for knowledge acquisition; and

- memory enhancement strategies (notes, tapes, mnemonic devices).

Jerrell and Ridgely (1995) modified the Social and Independent Living Skills (SILS) program (Lieberman, Massel, Mosk, and Wong, 1985) to create a Behavioral Skills intervention for their investigation that also compared an intensive case management intervention and a 12-Step Recovery Model. Their focus was on five skill modules:

- symptom monitoring;
- medication management;
- relapse prevention;
- leisure activities; and
- social skills.

The authors found that on nine of 24 variables on which statistically powerful findings were observed, the behavioral skills group participants achieved more favorable outcomes. These measurements included work productivity, independent living, social adjustment, role functioning, and dimensions of social relations (Jerrell and Ridgely, 1995).

Finally, CBT for persons with co-occurring disorders offers training in relapse prevention. The technique of “relapse prevention,” described below, is derived from CBT and has been used extensively in substance abuse treatment programming.

D. Relapse Prevention and Co-Occurring Disorders

Attending to longitudinal issues in the maintenance of symptom control and abstinence are increasingly issues of recovery from co-occurring mental illness and substance abuse. Models currently under investigation for the treatment of persons with co-occurring disorders rely heavily on the concept of relapse prevention (Weiss, personal communication, 1995; Hills, 1995). Marlatt and Gordon (1985) originated this model, which is rooted in social learning principles. It views addiction as a set of habit patterns that have been reinforced by pharmacological and social reinforcement contingencies. Relapse in this model is seen as the result of a predictable series of cognitive and behavioral events that lead to a return to substance abuse, recurrence of mental health symptoms, or a return to criminal behavior. Precipitants to relapse are grouped into several categories: affective; behavioral; cognitive; physiological; environmental; lifestyle; degrees of personal vulnerability; psychological; spiritual; and treatment-related and relationship-related variables (Daley,

1993).

Core features of relapse prevention programming include:

- psychoeducation;
- identifying high-risk situations and warning signs, including “criminal thinking;”
- development of coping skills;
- development of new lifestyle behaviors;
- increasing self-efficacy;
- avoiding the abstinence violation effect; and
- drug and alcohol monitoring.

For persons with co-occurring disorders, goals of psychoeducation include helping program participants understand the interactive effects of brain chemistry and how neurotransmitter systems are effected in both mental illness and substance use disorders. The role of conditioned cues and the influences of craving on the drug-taking behavior are also explored. Specific drug and alcohol effects are reviewed to allow persons to understand how their symptoms may have been masked, mimicked, or exacerbated by their substance use. The evidence for intergenerational transmission of co-occurring disorders is explored, as well as issues such as risk factors for HIV+/AIDS.

High-risk situations are thoroughly evaluated to determine all possible influences, stimuli, and decisions that may lead to relapse. Participants are asked to evaluate their former behavioral patterns (warning signs for substance use relapse), including the time of day they may have regularly used, the stimulus of having pocket money, risks inherent in idle time, and the role of continuing to relate to drug-using friends, or going to bars to socialize. Warning signs for a return to mental health symptoms include reluctance to take medication, missed appointments, increasing fatigue or dysphoria, memory or concentration difficulties, and changes in hygiene or sleep patterns. Triggers for a return to criminal behavior include associating with other known offenders, returning to neighborhoods where crimes were committed, focusing on exciting aspects of criminal activity, and not structuring time with other activities.

As program participation evolves, persons are asked to evaluate their decisions around stopping recovery activities or minimizing their recall of the negative effects that drug use had on their symptoms or experience. The role of their affective state in driving their decision to use is explored.

The development of specific coping skills is important in this therapeutic approach. Participants are typically taught and reinforced for the generation of alternative coping responses. This can be a very difficult

task for individuals who have very limited behavioral repertoires. This coping might involve learning to say no when drugs or alcohol are offered, or defending their need to take prescription medications to members of their AA group.

Inherent in this process are the development of new leisure, recreational, and employment skills. Cognitively this process requires that the person reevaluate and improve their impression of their ability to cope with challenging situations. They also should be invested in developing a view of themselves as competent in dealing with complex and stimulating environments.

Numerous clinical workbooks have been published to assist participants in identifying and coping with relapse factors. These include manuals that focus on specific symptom experiences (anxiety, depression, abstinence) and those that focus on specific skill deficits. Other workbooks focus on the identification of warning signs. A comprehensive listing of these texts can be found in Daley (1993).

Evidence for the efficacy of this model in the treatment of substance abuse has come from various sources. Gorski (1989) adapted this model to populations of persons with cocaine and alcohol abuse. Roffman and Barnhart (1987) evaluated marijuana use and found relapse prevention intervention resulted in diminished use as compared to a social support condition. For persons with severe cocaine abuse, relapse prevention was found to be more effective than interpersonal psychotherapy in reducing use (Carroll, Rounsaville, and Keller, 1991). Investigations of relapse prevention programming with offenders who have dual disorders are ongoing (Hills, 1995).

E. Case Management: Method or Model?

Case management can be thought of as both a method to provide services and as an intervention model in and of itself. In criminal justice settings, case management is often thought of as a “core” set of services for offenders with co-occurring disorders. Case managers help link community treatment staff, probation, parole, courts, and families. Use of a treatment team approach in a community corrections setting is valuable to monitor treatment progress, review critical incidents and other warning signs, and to develop sanctions. In some cases, probation plays the role of case manager, in other cases, treatment staff are assigned this role. In other areas, independent staff are assigned to provide case management services to offenders. Within correctional institutions, the key role of case managers is to develop a re-entry plan and linkage to community services. This may involve an “in-reach” model, an “out-reach” model, or some type of collabo-

ration with community service providers. Finally, case managers in the criminal justice system often act to insure that treatment information is shared across different parts of the system, e.g., from jail treatment programs to community programs, courts, and probation.

Several consistent guidelines have emerged from programs utilizing case management as a primary or adjunctive method of intervention. These include:

- use of multidisciplinary teams with shared case loads;
- engagement through assertive outreach, culturally relevant programming and use of motivational approaches;
- provision of services over the long term; and
- access to mental health or substance abuse programming in the context of an array of services.

Services provided by the case management team should be consistent with the individual's stage of treatment, as described by Osher and Kofoed (1989). This means: putting initial emphases on engaging the person to commit to treatment; persuading him or her to consider abstinence and active change; application of cognitive-behavioral and social network interventions in the active treatment phase; and focused awareness of continued risks in the relapse prevention stage.

Modifications of the Program for Assertive Community Treatment (PACT; Stein and Test, 1980) have been undertaken to focus on persons with co-occurring disorders (Drake, Antosca, Noordsy, Bartels, and Osher, 1991). The focus of this intervention is on offering an array of services, including:

- crisis intervention;
- housing support;
- skills training;
- medication monitoring;
- supportive therapy;
- family psychoeducation;
- vocational rehabilitation;
- substance abuse counseling;
- dual diagnosis groups; and
- outreach to families.

Some work has been done to evaluate the efficacy of case management with persons with co-occurring disorders. A recent investigation in New Hampshire (N = 215) evaluated persons with severe and persis-

tent mental illness and substance use disorders who had received case management services. During a three-year period, with groups with different therapist-client ratios combined (10:1 or 30:1), hospitalization rates were reduced, improvements in functional status were found, and approximately half achieved some period of abstinence by the end of the third year (Mueser, Drake, and Miles, 1997).

V. Additional Challenges: Issues Confronted in Clinical Treatment

Difficulty in establishing an effective course of treatment for offenders with co-occurring disorders is to be expected, given their pattern of relapse and symptom exacerbation, expression of violent behavior, history of incarceration, chronic homelessness, recurrent suicidal actions, or significant medical illness, including HIV+/AIDS and tuberculosis. Treatment of these individuals is, therefore, particularly challenging. Common challenges are described below; each will require consideration as treatment initiatives are planned. Many of these factors may be mitigated by a person's status in the criminal justice system or heightened due to his or her status as offenders (i.e., violent behavior, history of incarceration).

Certain other "typical" characteristics of offenders with co-occurring disorders create additional challenges for therapy. These characteristics may include a cynicism as to whether treatment will make a difference in their lives, or a belief that treatment is for people who are inherently weak. They may also view treatment as punishment, or set expectations for treatment that are unrealistic (Griffin, Hills, and Peters, 1996).

A. Confronting Systems Issues

System issues and organizational requirements place a further burden on clinicians and administrators already struggling with the clinical demands of this complex population. The clinical and administrative issues described are not unique to the criminal justice system but may be made more complex due to the additional layers of oversight or regulation that accompany the provision of treatment services to a corrections-based population. Fundamentally different values exist between the criminal justice and treatment systems; within the realm of treatment, mental health and substance abuse also possess differing values and approaches. Important implications include: cross-training and a multidisciplinary treatment approach, so that staff can appreciate the complexity of each other's roles; the need for a structured process for resolving differences, addressing critical incidents (i.e., review responses to critical incidents in advance in a community treatment team or institutional treatment team); and reviewing the complementary nature of security and treatment, while acknowledging that staff come from different cultures, have different values, differing perceptions of offenders, and differing views regarding the role of treatment.

B. Issues in Employing Psychopharmacological Interventions

Appropriate medication management of offenders with co-occurring disorders is critical to success. Physicians or psychiatrists who have specialized knowledge about the interactions of prescription and street drugs can educate their patients about that risk. Depending on the level of service being provided, medication consultation can come from a variety of sources and, though it is becoming more common to be able to access a physician with certification in Addiction Psychiatry or American Society of Addiction Medicine (ASAM) credentials, programs should routinely develop procedures that will provide guidance around treatment philosophies and will limit the amount of conflict over prescriptive practices (CSAT TIP No. 8, 1994a). Correspondingly, physicians should provide and participate in cross-training activities to reduce concerns about the addictive potential of the medications they are prescribing.

Antipsychotic Agents. The presence of psychosis symptoms should be evaluated thoroughly and the decision to use antipsychotic agents should be made primarily in the circumstance where there is significant associated distress. Judicious use of these medications in response to symptom expression serves to avoid “adding a drug to a drug” (Zweben, Smith, and Stewart, 1991). Even when evidence suggests a drug-induced etiology for a psychotic symptom, the use of antipsychotic agents may be warranted. This would include the emergency treatment of severe paranoia and agitation associated with stimulant overdose.

The interactive effects of simultaneous medication and drug use can lead to significant medical emergencies, so it must be approached with caution. A lowered seizure threshold can result from the concurrent use of haloperidol and stimulant medication. The use of neuroleptics in mania complicated by stimulant abuse can also precipitate a hyperthermic crisis (Kosten and Kleber, 1988).

Anxiolytics. Benzodiazepines are sometimes considered as nearly contraindicated for persons with a history of a substance use disorder, except in the treatment of sedative-hypnotic withdrawal. Severe anxiety or panic can be precipitated during withdrawal from benzodiazepines, even in individuals with no previous history of anxiety disorder. This may result from the unmasking or re-emergence of anxiety disorder symptoms or may be the result of actual changes in receptor sensitivity in the brain (Decker and Ries, 1993).

Antidepressant Agents. Treatment of severe symptoms of depression in the presence of a co-occurring substance abuse disorder is difficult, as ideally a clinician would like to have several weeks of abstinence from all substances in order to rule out a substance-induced mood disorder. This is rarely practical, given the other potential risks to the individual when symptom amelioration is not undertaken. It is recom-

mended that a waiting period be undertaken that is inversely proportional “to how much clinical history or evidence exists that a separate depressive disorder is present” (Decker and Ries, 1993).

Key Points

- Continued abuse of alcohol or other drugs can impact the action of prescribed medications.
- Potentially life-threatening conditions can arise when alcohol or illicit substances are used while a person is taking certain psychotropic medications, e.g., monoamine oxidase inhibitors (Sederer, 1990).
- Prescription of medications with addictive potential must be done judiciously and with great caution, and even then the prescription of these medications can be expected to be met with significant controversy.
- Offenders in treatment must have an understanding of their need to take medication and must be able to communicate that need to those who may seek to challenge the decision (Griffin, Hills, and Peters, 1996).

C. Breaking Down Barriers to Program Implementation: Confidentiality and the Ownership of the Clinical Record

Whenever programs are asked about their interaction with the “other” (mental health or substance abuse) service provider, the issue of confidentiality of record-keeping is raised as a significant issue. In most cases the issues raised appear to come from a reasonable, clinically-based concern about the appropriate use of the material in the record. In other instances, the examination or sharing of recorded material sometimes becomes the arena for a struggle among the different disciplines. When incompatibility, suspicion, or competition among and between mental health and substance service programs occurs, the clinical record and patient information may be held hostage.

Title 42 (part 2) of the Code of Federal Regulations addresses the sharing of information across programs. State laws may be more restrictive but may not override federal regulations. One issue encountered when cross-program treatments are considered is the disclosure of patient-identifying information. An exception to the rule allows information to be “disclosed within a program, or to an entity given direct administrative control over a program, if the recipient of the disclosure needs the information to provide substance abuse services to the patient” (CSAT, 1994c, pg. 3). Further, “within the program” means within the organi-

zation or organizational unit that provides substance abuse services.

This exemption emphasizes that this sharing is for the purpose of providing the individual with substance abuse treatment services. Communication with the hospital-based record-keeping or billing services, which are integral to program functioning, would be covered under this exemption. If concerns remain regarding disclosure, information can be shared pursuant to the signing of a valid consent form. These forms are readily available in most mental health and substance abuse treatment service settings. A sample of a consent form regarding the release of confidential alcohol or drug treatment information is included in the Center for Substance Abuse Treatment Technical Assistance Publication No. 13 (1994c), as are opinion letters about the release of information from the Department of Health and Human Services.

D. Evaluating Outcomes: Challenges When Implementing and Evaluating a Program

The problems inherent in the implementation and evaluation of any treatment program include planning for the treatment of individuals who are being moved and “discharged” for reasons that have little to do with clinical issues. This issue makes program planning difficult and is an important consideration when any service for offenders with co-occurring disorders is designed. Lurigio and Swartz (1994) reported their attempts to evaluate a substance abuse treatment program in the Cook County (Chicago) Jail. The three-phased program was comprised of an orientation, intervention, and aftercare phases with prescribed bed numbers associated to each component. Because of the predetermined length of the first two components, the aftercare beds were often empty and offenders waiting for treatment would often enter “aftercare” first. Overall, 34% participated in aftercare only and 17% of all offenders ultimately completed all three phases of the program as designed. The variety of program experiences that a given offender might have had led to significant difficulties in program evaluation. This variability of experience can largely be avoided if programs are planned well and supported by criminal justice agency administration, allowing program structure and client flow process to maintain their integrity.

As noted above, the issue of sharing records can be an initial impediment to program implementation and can continue to be a problem when it comes time to perform an evaluation. The location of the record and its accuracy in cataloguing the treatment experience of the offender can be integral to program evaluation efforts. Computerization of records are only as valuable as the information they hold, and often staff feel that additional measurements present a burden if they are not obviously useful for clinical purposes. The use of

multiple systems for identifying individuals, and the fact that offenders are often seen “across” services, often means that no single complete record of their treatment experience may exist (Lurigio and Swartz, 1994).

Other issues in designing programs for offenders with co-occurring disorders include the very limited access to substance abuse treatment that continues to exist in many institutional settings, especially in smaller jails (Peters, May, and Kearns, 1992). Finally, the availability of suitable aftercare is a factor that can compromise the outcomes associated with institutionally-based programs. Since the measurement of longitudinal outcomes is required to determine the efficacy of treatment programs for offenders with co-occurring disorders, inadequate “aftercare” can substantially impact estimations of program effectiveness. This aftercare might include movement from jail to the community. A further complication may be inadequate continued care when the offender moves from one level of the system to another; for example, in the case of the person who transfers from the jail to a prison setting following their sentencing (Lurigio and Swartz, 1994).

E. Unique Conditions: Delivering Service in Criminal Justice Settings

Treatment providers designing interventions to address co-occurring disorders in criminal justice populations need to consider the unique contextual issues associated with the individual’s participation in treatment. These are qualities that, while they have some parallel in the community, are unique to working in the criminal justice system. They include:

- institutional constraints and requirements, i.e., space limitations, competing demands for service delivery (GED/education), competing demands for an offender’s time and attention (e.g., work assignments, noise in institutions), and mandatory institutional activities (schedule issues such as count, meals, etc.);

Implication: Programs must be designed with sensitivity to these environmental constraints and demands;

- for pretrial jail detainees, unpredictable termination from treatment, related to release from jail;

Implication: Need for rapid and comprehensive evaluation for co-occurring disorders and immediate prerelease planning for necessary connections to community treatment;

- failure to appear for service due to court appearances;

Implication: Need for a court liaison to organize hearings or pretrial release from jail, notify judge of the need to complete treatment, or of current treatment status;

- accelerated discharges from institutions, due to system mandates regarding overcrowding;
Implication: Need for re-entry planning and linkage of services well in advance of expected release dates;
- the corrosive effect of the criminal peer culture in institutional, and some community settings, discourages participation in treatment;
Implication: Effort must be made to be sensitive to these environmental influences; the availability of isolated treatment units in jails and prisons is a necessity.

When the individual is court-ordered into treatment, there are additional considerations that impact treatment, including:

- the length of time the offender is to be in treatment;
- the length of time under criminal justice supervision;
- the exact terms of the order or condition;
- to whom the offender is accountable during any supervision period; and
- the consequences of not complying with treatment requirements (Griffin, Hills, and Peters, 1996).

Working with individuals required to participate in treatment as a condition of their criminal justice status is complex. It requires that the clinician be aware of the numerous contingencies operating that both encourage and discourage treatment involvement.

VI. Summary: Considerations When Initiating Services for Offenders with Co-Occurring Disorders

Treatment programming can take on a variety of formats, lengths and theoretical orientations depending on the setting, and population, of persons addressed. Many programs are now beginning to recognize, and program for, the heterogeneity in the populations they confront. This may mean varying approaches for different ethnic minorities, women, victims of trauma, degrees of substance abuse or dependence, etc.

Clinicians have largely worked in treatment settings in which persons with varying disorders were treated collectively, with limited attention being paid to specific deficits or disorders. Out of this environment came the awareness that not all individuals do well in this collective environment. Not surprisingly, as the complexity of individual issues increases, the likelihood that a person will thrive in a “standard” clinical program decreases. During the past 20 years, the population of individuals with co-occurring disorders were found to be less successful (i.e., failed to achieve symptom remission or abstinence, or dropped out of treatment) in many clinical environments.

This monograph has focused on the population of offenders with co-occurring disorders, specifically those individuals who have a severe and persistent mental illness in addition to a substance use disorder. This definition of “dual diagnosis” has predominated the literature during the past 15 years. Recently, other co-occurring disorders (Attention Deficit Hyperactivity Disorder and Substance Abuse Disorder; Post-traumatic Stress Disorder and Substance Abuse Disorder) have received increased attention. As other groups of individuals with complex co-occurring disorders are considered, treatment programming will necessarily be modified. Gender-specific issues will also greatly impact the content and method of program interventions; specific interventions related to gender were beyond the scope of this monograph but are tremendously important and deserve attention.

In clinical populations in criminal justice settings, to be a person with “co-occurring disorders” turns out to be more the rule than the exception. With this acknowledgment comes the awareness that individuals with this diagnostic complexity are more likely to be a challenge to traditional clinical settings. Settings attempting to address the greater complexity of the people they are seeing are struggling with designing an optimal format for service delivery.

An obvious issue that arises with this population is that of cross-disciplinary collaboration. An increasing abundance of data suggests that integrated (mental health and substance abuse) treatment is the method of choice for many persons with co-occurring disorders. Mental health and substance abuse division staffs have

both philosophical and, typically, geographic boundaries to cross to come together to treat an individual with co-occurring disorders. Systemic issues must be overcome in order to create an atmosphere of interdisciplinary collaboration. Funding streams and financial structures have to be modified to facilitate service coordination. This is a larger task than it might appear, as the weight of history predicts that programs will be slow to change. Creative managers have to evaluate what available methods exist (i.e., contractual language) that could link the programs together. Interservice competition often exists, and fears of losing program identity or funding must be addressed. Conceptually, programs have to consider how integrated services can be accomplished if they are treating individuals with severe, co-occurring disorders.

Cross-training is an essential component for successful program integration. For integrated clinical programming to have a chance at success, each team member should be “familiar with the perspective, content, and mission of one another’s discipline” (CSAT TIP No.8, 1994a, pg. 56). Cross-training should be provided at a convenient location on a predictable schedule. This may take the form of didactic lectures, case presentations and discussions, and shared clinical supervision.

Depending on the service setting, an articulation of program and individual treatment goals must be undertaken. In brief treatment, clinicians may work on helping the offender consider the interaction between their disorders and the need to commit to treatment for the long term. Early in their treatment process, individuals with co-occurring disorders may demonstrate little investment in thinking about themselves as requiring any service, and less interest still in considering a lifestyle of abstinence from drug use. Throughout the process of developing an integrated treatment program, differential skills and symptom experience must be considered. The heterogeneity of people with co-occurring disorders must be recognized. When a program model is developed, significant consideration must be given to determining who is likely to do well in the treatment environment, and who may be unlikely to benefit from the cognitive tasks or interpersonal challenges encountered.

Finally, working with individuals who may be resistant to treatment and who challenge the boundaries of professional disciplines is difficult. Linking systems across community and institutional boundaries is imperative. Strong leadership and comprehensive, coordinated planning are essential components of any service system that wishes to improve its outcomes for persons with co-occurring disorders.

VII. References

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