Evidence-Based Practice

A GUIDE TO EVIDENCE-BASED PRACTICES

for **INDIVIDUALS WITH MENTAL ILLNESS, CO-OCCURRING SUBSTANCE USE DISORDERS, AND CRIMINAL JUSTICE SYSTEM INVOLVEMENT**

SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

This report was produced with the support of the Saginaw County Community Mental Health Authority for the Michigan Prisoner Re-entry Initiative in Saginaw, Bay, and Midland Counties

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FOREWORD

This document was prepared as a resource for service delivery planning targeted to persons with mental illnesses and co-occurring substance use disorders released from correctional institutions and served through the Michigan Prisoner Re-entry Program Initiative partnership of Saginaw, Bay, and Midland counties. It is designed to provide guidance to facilitate the reintegration of individuals on probation or parole into the community following incarceration using practices that have shown to be beneficial for this population.

A review of relevant literature was conducted to compile the information contained in this report. It is derived primarily from research in the fields of mental health, criminal justice, and substance use disorder treatment. Much of the content can be found in previous evidence-based practice reports (on individuals with mental illness and substance use disorders) published by the Saginaw County Community Mental Health Authority and available on the Web at http://sccmha.org/quality.html.

The electronic version of this report has hyperlinks to web sites and sections within it (denoted by blue underlined text) embedded within the document so that the reader can find additional information quickly. A variety of resources are provided in Appendix B for readers who wish to pursue more information on topics of interest. Hyperlinks to web sites for programs and interventions discussed within the report are included where available.

It should be noted that this report is a snapshot in time and depicts practices currently available. As this area of study develops, and new evidence accumulates, revisions and updates will be needed.

 The writer gratefully acknowledges the support and sponsorship of SCCMHA in the production of this report and commends the organization for its endeavors to offer the highest quality services and supports to the community.

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INTRODUCTION AND OVERVIEW

Individuals with psychiatric and substance use disorders are significantly overrepresented in the criminal justice system. Arrest has become a common experience for persons with severe mental illness. Studies have found that thirty-eight to fifty-two percent of persons with severe mental illness have been arrested at least once. Studies of jail populations indicate that six to fifteen percent of detainees have a mental illness and seventy five percent of these have a co-occurring substance use disorder. In addition, prevalence rates for persons under community supervision (i.e., probation or parole) are estimated to be at least as high as those found among detainees. More individuals with mental illnesses are under community supervision than any other place within the justice system.

Individuals with mental illnesses on probation or parole have been found to be highly likely to fail on supervision and have their probation or parole revoked for a violation or the commission of a new offense. Studies have found that parolees with mental illness are twice as likely to have their parole suspended and significantly more likely to have their parole revoked without the commission of a new offense. Rearrest rates for people with mental illnesses who are on probation are almost double that of their peers who do not have such illnesses.

In response to the burgeoning population of persons with mental illnesses under community supervision and the frequency of failure on supervision, jurisdictions have been developing specialized services and supports to meet their needs in the community, reduce parole/probation violations, and prevent re-incarceration. There is only a small body of research on this population and evidence-based practices are scant. However, the literature does offer some suggestions for designing services and supports to reduce the risk for supervision failure.

UNDERSTANDING EVIDENCE-BASED PRACTICE CONCEPTS

The search for and use of evidence-based practices in the field of mental health treatment has become a significant endeavor at national, state, and local levels. Driven by shrinking resources and increasing demand for services and supports, the public sector has been focused on investing in practices that have been proven effective (and moving away from those that have not). The use of evidence-based practices has the potential for improving consumer and system-level outcomes as well as producing economic efficiencies.

Evidence-based practices constitute interventions that have been scientifically researched, studied, successfully replicated by various investigators, and demonstrated to have measurable and sustained beneficial outcomes. They also have theoretical underpinnings that explain why they work, procedures to evaluate outcomes, standards for conducting and evaluating staff training, procedures for maintaining quality and fidelity to the model of treatment delivery, and written manuals that detail protocols for practitioners and clinical research replications. An evidence-based practice is comprised of three components:

1. The highest level of scientific evidence[2]

[2] The strength of evidence for any given practice is referred to as the level of evidence. The highest level of evidence is based on a research methodology that is known as the randomized clinical or controlled trial (RCT). RCTs use sufficiently large number of participants (usually a minimum of thirty), or "subjects", who are randomly assigned to a specific intervention (the experimental group), or to a group that receives a routine or another intervention (the control group). In some studies, the control group does not receive any intervention (e.g., they are put on waiting list). Randomization reduces the potential for bias in the results. Outcomes from RCTs that are then replicated in typical clinical settings are assigned the highest level in the hierarchy of evidence.

❷ The clinical expertise of the practitioner
❸ The choices, values and goals of the consumer

It should be noted that evidence-based practices are not available for all needs and problems. Moreover, even when evidence-based practices are available, they do not always produce beneficial outcomes for all consumers. This has fostered the promulgation of emerging and promising practices as well as those that are culturally-driven or are adaptations of evidence-based practices that incorporate culture. In situations where services and supports do not meet the gold standard for evidence-based practice (i.e., randomized, controlled studies in everyday practice settings), promising and emerging practices should be considered as alternatives.

The following criteria can be used to ascertain whether an intervention is promising:

- The intervention has a basis in established theory
- The model of treatment is well articulated
- The practice has the capacity to address multidimensional problems
- The intervention is based on quality evaluative research
- The practice has the potential to be replicated and/or implemented in everyday practice settings

Sparse empirical evidence is available to guide the development of re-entry programs for individuals with mental illness and co-occurring substance use disorders. However, a number of practices show promise and can be considered for implementation. Others, while not specifically directed to this population per se (e.g., Supported Employment, Illness Management & Recovery, Assertive Community Treatment, and Family Psychoeducation) incorporate elements that are of benefit.

EXECUTIVE SUMMARY

The first section of this document is comprised of an overview of issues confronting individuals with serious mental illnesses and/or co-occurring substance use disorders returning to the community following a period of incarceration. The second section presents information regarding the need for prerelease planning and models for facilitating this process. Also included in this section is a discussion of diversion options to prevent re-incarceration. This is followed by a review of practices that can be beneficial for this population. It contains information on various interventions, services, and supports including trauma-informed and gender-specific programs, cognitive-behavioral approaches to treating criminogenic behaviors, and pharmacotherapies. A review of various service delivery models and a section on crisis intervention are offered in the next sections which contain some information that has not been covered in previous reports in the SCCMHA evidence-based practices report series. The last sections consist of appendices that list references and resource materials, an overview of the Michigan Implementation of Medication Algorithms (MIMA), and an overview of the MPRI.

RE-ENTRY CHALLENGES AND RISKS FOR RELAPSE

Research consistently indicates that individuals with mental illness and justice system involvement are at significantly higher risk for failure in community supervision. Recent efforts have focused on identifying risk factors that can be targeted for intervention to promote beneficial outcomes for supervision (i.e., parole and probation).

Mental Illness is a risk factor for supervision failure. For example, individuals with active psychosis who shout obscenities at neighbors and display threatening behavioral gestures can be arrested. Parolees with co-occurring disorders can be arrested for resumption of illicit substance use. Persons with mental illnesses are especially vulnerable to the effects of substances and experience more severe symptoms and behavioral disturbances (e.g., aggression and violence). Neurocognitive impairments associated with certain mental illnesses can interfere with adherence to conditions of probation (e.g., maintaining employment, completing community service, and paying supervision fees). Studies have demonstrated that the intensive monitoring conducted by supervision agents of persons with mental illness and co-occurring disorders is associated with increased discovery and punishment of unwanted behaviors. Threats of incarceration have been shown to adversely impact this population due to engendered fear and anxiety.

Lack of immediate access to community-based services and supports such as medical care, family and social supports, gainful employment/income, and treatment, following release from correctional institutions can result in relapse, homelessness, re-incarceration, and other adverse outcomes. Studies show that gains made in institution-based treatment can dissipate when there is a lack of continuity of treatment subsequent to release.

Lack of safe, accessible, affordable housing can be a serious problem. Access to public housing can be limited or restricted. Restricting access to public housing or public assistance limits access to an important source of support for many and increases dependence on families or charitable organizations. People with mental illness often have limited social networks on which to draw, increasing their dependence on the limited resources of community-based organizations. Moreover, the triple stigma attached to having a mental illness, a substance use disorder and a criminal record affect reintegration into the community and social support network development. In addition, the work of recovery, challenging enough with one disorder, has to focus on two disorders.

Most women who are incarcerated are parents; incarceration is disruptive to maintaining relationships with children (as well as spouses/partners). Children's protective services agencies take children subsequent to arrest, and, a significant percentage of mothers lose custody of their children on a permanent basis due to incarceration. Many of these women have suffered various forms of abuse (e.g., domestic violence, sexual abuse, and violence) resulting in posttraumatic stress disorder symptoms.

Many people who have been incarcerated have inadequate or outdated job skills, limited educational attainment, and can face rejection by colleges/universities and potential employers due to having a criminal record. Unemployment is likely among people with severe mental illness whether or not they have a criminal conviction, but those with a criminal conviction are even more likely to be unemployed and dependent on public assistance for support. Restrictions on types of employment, in combination with employers' ability to ask and screen for criminal convictions, can further limit their employability.

According to the Bureau of Justice Statistics, an estimated sixteen percent of adult prisoners report having either a mental disorder or an overnight stay in a psychiatric facility, yet only a fraction of those who need treatment actually receive it while incarcerated. It is further estimated that approximately two thirds of these individuals are under the influence of alcohol or drugs at the time of the offense. Moreover, stricter and more durable restrictions are associated with drug-related convictions, and people with substance abuse problems are more likely to have these types of convictions and conviction labels are enduring/cannot be expunged.

TRANSITION PLANNING AND DIVERSION ALTERNATIVES

Individuals in the justice system who have mental health needs face multiple barriers to community re-integration as noted previously. These persons may require housing, employment, mental heath and substance use disorder treatment, and independent-living services in order to prevent their return to custody. It is recommended that the parole/probation and mental health systems coordinate care, share treatment histories, and collaborate on discharge planning. There is significant evidence that coordinated services increases participation in treatment services and reduces recidivism rates.

Successful transition practices entail access to post-release services and supports (e.g., substance abuse treatment, medical care, mental health treatment, vocational and employment services, and educational programs) according to findings from studies of the National Institute of Corrections' Transition from Prison to Community Initiative (TPCI) and others. The provision of comprehensive post-release services are closely associated with reductions in recidivism, relapse of psychiatric and substance use disorders, and costs, as well as enhanced public safety.

APIC Model

While outcomes studies on transition planning procedures are sparse, a number of investigations have shown that specific elements lead to improved benefits. One model that is gaining acceptance is the APIC Model which promotes collaboration between the criminal justice, mental health and substance abuse treatment systems. It is not known which of the elements of the APIC model are most critical to beneficial outcomes.

APIC MODEL	
Assess	Assess psychosocial, medical, behavioral needs and strengths, motivation for treatment, capacity for change, and public safety risks
Plan	Plan for the treatment and services required to address immediate and long-term needs including community resources (e.g., family support, housing, medication, integrated treatment for co-occurring disorders, case management and outreach, medical care, income supports and entitlements, food and clothing, transportation, and child care)
Identify	Identify required community and correctional programs responsible for post-release services, ensuring that the intensity of supervision and treatment match the severity of criminal behavior and history, level of disability, motivation for change, and availability of community resources
Coordinate	Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services through case management and inreach services from community-based providers

The most effective models of transition start planning ninety days prior to release and incorporate case management to link individuals with resources. Transition coordinators working in tandem with case managers have been found to be effective in providing assistance with access to needed resources during transition from incarceration to the community. A number of

jurisdictions use probation and parole officers who have behavioral health expertise and receive cross-training with behavioral health clinicians to foster collaborative working relationships.

Outreach, reach-in, and third party are the three types of **program models** that are used to provide transitional services. In the outreach model correctional institutions designate staff to create linkages to services and supports within the community. Here the institution assigns a case manager to coordinate treatment and other services and supports in the community. The reach-in model, on the other hand, entails the initiation of transitional services by community-based programs. In the reach-in model community-based programs initiate treatment and transitional services and supports prior to the inmate's release. A case manager is assigned from the program. This model has been found to be most effective for jail settings due to shorter stays necessitating rapid engagement.

In the third party model an independent entity provides coordination of transitional services. The independent agency functions as a liaison, identifying and matching the individual with transitional services and supports, coordinating (but not delivering) services and supports, and is exemplified by the Treatment Accountability for Safer Communities (TASC) program described below. The third-party entity provides ongoing case management and is accountable to both supervision and treatment agencies. It provides reports on the parolee's treatment progress. This model has been found to be most effective in situations where services and supports are fragmented and multiple programs and services are located within the community.

DIVERSION ALTERNATIVES

Diversion to treatment can occur at several points in the justice system continuum. The **Sequential Intercept Model** can be used to guide collaborative efforts between the mental health, substance abuse treatment, and criminal justice systems. The five points of intercept are:

- Law enforcement/emergency services
- Initial detention/initial hearings
- Jails, courts, forensic evaluations, hospitalizations
- Re-entry
- Community corrections and community support

Diversion and rediversion[3] programs are designed to reduce the presence of persons with mental illnesses and co-occurring substance use disorders in jails. They focus on referrals to treatment either prior or subsequent to arrest and are mostly targeted to defendants charged with nonviolent misdemeanors or low-level felonies, although some programs allow defendants charged with higher-level felonies to participate. Mental health and drug courts are examples of postbooking diversion. Although these courts vary considerably in structure and operating procedures, they have some features in common including court dockets devoted entirely to persons with mental illness/substance use disorders, nonadversarial court proceedings, and voluntary participation. Participants are linked to community treatment resources and monitored by the court to encourage adherence to treatment. More information on diversion programs can be found in *A Guide to Evidence-Based Practices for Individuals with Mental Illness* and *A Guide to Evidence-Based Practices for Individuals with Substance Use Disorders*.

[3] Rediversion takes place when a former or current diversion program participant is booked into jail on a new charge and diverted once again through the same diversion program.

INTEGRATION OF CRIMINAL JUSTICE SANCTIONS INTO TREATMENT PROGRAMS

The criminal justice system uses a number of mechanisms to engage individuals in treatment including diversion of offenders who are not violent into treatment, making treatment a condition of pretrial release or probation, and drug courts that mandate, arrange for, and monitor treatment and other services as an alternative to incarceration. The most effective models involve the integration of criminal justice and substance abuse treatment systems in screening, referral, testing, monitoring, supervision, and the systematic use of graduated sanctions and rewards. Successful system integration hinges on cross-training efforts that focus on developing a shared understanding of how both systems operate.

Diversion programs employ sanctions commensurate with the degree of noncompliance with treatment and conditions of parole/probation and are aimed at reparation and restoration. Consequences can range from termination of diversion contracts, petition to the justice system for adjudication, renewal of suspended proceedings, intensive supervision, or detention/incarceration. Successful completion of diversion programs can result in rewards such as dismissal of all charges and expungement of case records. Completion of treatment is characterized by the achievement of specific goals/behaviors (e.g., skill acquisition and demonstration). Rewards are used for adherence to treatment, progress in treatment, and compliance with conditions of parole.

INTERMEDIATE SANCTIONS

- **Means-based fines (or day fines)** calibrated by a court to both the severity of the crime and the discretionary income of an offender and in contrast with traditional fines imposed at the discretion of a judge according to ranges set by legislatures for particular offenses. Defendants with more income (and/or fewer familial obligations) pay a higher overall fine than those with lower incomes (and/or more obligations) for the same crime. This approach to setting the fine amount is typically coupled with expanded payment options and collection procedures that are tighter than usual.
- **Community service** is the performance of services or manual labor for governmental, private, or nonprofit organizations for a set number of hours with no payment. Community service can be arranged for individuals, case by case, or organized by corrections agencies as programs. For example, a group of offenders can serve as a work crew to clean highways or paint buildings.
- **Restitution** or the payment of the costs of victims' losses or injuries and/or damages to victims. In some cases, payment is made to a general victim compensation fund; in others, especially where there is no identifiable victim, payment is made to the community as a whole (with the payment going to a municipal or state treasury).
- **Special needs probation programs or caseloads** wherein officers with special training carry restricted caseloads. These approaches are typically used with offenders who have committed some categories of domestic violence, sex offenses, driving under the influence, and with those who have a mental illness, developmental disability, or substance use disorder. Supervision in a specialized caseload usually entails more intensive or intrusive supervision, the provision of enhanced psychosocial services, and/or specific training or group activities (e.g., anger management classes or victim impact meetings).
- **Outpatient Treatment**

- **Day centers or residential centers for other types of treatment or training** (e.g., skills training to enhance employability).
- **Intensive supervision probation** involving closer supervision and greater reporting requirements than regular probation that can range from more than five contacts a week to fewer than four per month. Supervision usually entails other obligations (to attend school, have a job, participate in treatment, or the like).
- **Intensive supervision parole** which is similar to intensive supervision probation, but is usually provided by parole agents subsequent to completion of a prison term to offenders serving the balance of sentences in the community.
- **Brief jail incarceration** (e.g., for one to three days) is often used with offenders who have committed major program infractions in other diversion programs. It provides respite from temptations to use drugs and reinforcement of the importance of sobriety and treatment. However, incarceration can be used counterproductively if it is lengthy and prevents the offender from reengaging in treatment activities.
- **Day reporting centers**[4] to which offenders must report for a certain number of hours each day, and/or report by phone throughout the day from a job or treatment site, as a means of monitoring and incapacitating them.
- **Curfews or house arrest (with or without electronic monitoring)** entails restricting offenders to their homes for various durations of time, ranging from all the time to all times except for work or treatment hours, with a few hours for recreation. Frequently, the curfew or house arrest is enforced by means of an electronic device which can alert corrections officials to unauthorized absence from the house.
- **Halfway houses or work release centers** which offenders can leave for work, school, or treatment but are otherwise restricted to. Such facilities are in the community or attached to a jail or similar institution.

[4] Studies show that the use of day reporting centers leads to decreases in recidivism, time to re-offense, and costs, especially when combined with case management.

EVIDENCE-BASED PRACTICES

INTEGRATED DUAL DISORDER TREATMENT (IDDT) FOR CO-OCCURRING DISORDERS (COD)

Substance abuse is the most common and clinically significant comorbid disorder among adults who have a serious mental illness. Estimates are that at least fifty percent of consumers who have schizophrenia are affected by substance use. About thirty percent of individuals with anxiety and depression experience a substance use disorder at some point. Moreover, these co-occurring disorders are associated a number of negative outcomes including increased rates of relapse, hospitalization, violence, legal problems, incarceration, suicide attempts, homelessness, and serious infections such as HIV and hepatitis. Consumers with co-occurring disorders challenge traditional service delivery systems, frequently are high utilizers of costly services, and rarely fit into the parallel substance abuse and mental health systems where they are often extruded or drop out. Studies show that these separate systems do not deliver appropriate services for this population and are ineffective.

Principles of Treating Co-occurring Mental Health & Substance Use Disorders

- Comorbidity should be expected, not considered an exception.
- Psychiatric and substance use disorders should be regarded as primary disorders when they coexist, each requiring specific and appropriately intensive assessment, diagnosis and treatment, in accordance with established practice guidelines.
- Serious psychiatric and substance use disorders are chronic, relapsing illnesses that can be conceptualized by using a disease and recovery model, with parallel phases of treatment or recovery.
- Within each subtype of the treatment population, consumers are in different stages of change with regard to their illness. Thus a comprehensive array of intervention that are phase and stage specific is required.
- Whenever possible, treatment of persons with complex comorbid disorders should be provided by individuals, teams, or programs with expertise in mental health and substance use disorders.
- The system should promote a longitudinal perspective on the treatment of consumers with dual diagnoses, emphasizing the value of continuous relationships with integrated treatment providers, independent of participation in specific programs.
- Admission criteria should not be designed to prevent consumers from receiving services, but rather to promote acceptance of consumers at all levels of motivation and readiness and with any combination of comorbid disorders.
- The service system should not begin or end at the boundaries of formal treatment programs; rather, it should include interventions to engage the most detached individuals (e.g., those who are homeless).
- The fiscal and administrative operation of the system should support the accomplishment of the system's mission and the implementation of these principles.
- Assessment for either disorder should begin as early as possible, without the imposition of arbitrary waiting periods of sobriety, and without a requirement of psychiatric stabilization, on the basis of data collection for an integrated, longitudinal history.
- For each disorder, assessment should include a definition of the stage of change or level of motivation.
- When mental illness and a substance use disorder coexist, each disorder should be considered primary, and integrated dual primary treatment should be provided; the treatment for each disorder should be matched to the diagnosis and the stage of change.

- Medication for known serious mental illness should never be discontinued on the grounds that the consumer is using substances.
- Benzodiazepines and other medications with addiction potential are not recommended in the ongoing treatment of consumers with known substance dependence with or without a comorbid psychiatric disorder. If a prescriber believes that an exception is warranted, this belief should be considered an indication for peer review, expert consultation, or a second opinion.

The core components of the integrated approach are as follows:

- Interventions are **staged**:
  - *Engagement* is the first stage when the consumer is in a *precontemplation* stage and the practitioner endeavors to form a trusting relationship with the consumer.
  - The next stage is *persuasion*, which entails helping the consumer develop the motivation to become involved in recovery-oriented interventions.
  - The third stage is *active treatment* wherein the consumer acquires the skills and supports for controlling both illnesses and pursuing their goals.
  - The last stage is *relapse prevention*, which is aimed at helping the consumer develop and use strategies to maintain recovery.

    Relapse prevention includes designing a relapse prevention plan, supporting and using previously acquired skills for sobriety, foster social skills to enhance friendships with persons who are sober, fostering social and leisure pursuits, exploring opportunities for employment, and encouraging and facilitating participation in self-help groups (e.g., Alcoholics Anonymous, Rational Recovery, Narcotics Anonymous, Double Trouble and Dual Recovery Anonymous).
- It should be noted that consumers do not necessarily move through these stages in a linear progression and they may be in different stages with respect to substance abuse and mental illness.
- Since many individuals with dual disorders have had trouble engaging with the service system, providers use assertive outreach and meet with consumers and their support systems in the community to offer services.
- **Motivational interventions** are used to help consumers during the engagement and persuasion stages when they are not yet exhibiting readiness to reduce substance use or become abstinent to achieve their goals. They are matched to the individual's stage of recovery.

  The five key principles of motivational enhancement are:
  - Expressing empathy
  - Noting discrepancies between the consumer's current behavior and their stated desired behavior
  - Avoiding arguments
  - Refraining from directly confronting resistance
  - Encouraging the consumer's belief in their ability to change

Motivational interviewing differs from traditional substance abuse treatment in that confrontation is avoided. If a consumer does not want to move on a certain path, or exhibits what has typically been termed "resistance" or is in "denial", the practitioner does not challenge it. Instead, the practitioner "rolls with it" allowing the consumer to express their opinions and views. The practitioner focuses on magnifying the discrepancy between what the consumer's goals are and their behavior. The consumer is helped to identify their goals, break them down into realistic steps, and ascertain that, in order to attain one's goals, one must manage the illnesses.

PRINCIPLES OF MOTIVATIONAL INTERVIEWING	
Express empathy (i.e., acceptance of the individual's perspectives without judgment) through reflective listening	• Acceptance facilitates change • Skillful reflective listening is fundamental • Ambivalence is normal
Develop discrepancy between consumers' goals or values and their current behavior	• The consumer rather than the counselor should present the arguments for change • Change is motivated by a perceived discrepancy between present behavior and important personal goals or values
Roll with resistance (i.e., avoid argument and direct confrontation)	• Avoid arguing for change • Resistance is not directly opposed • New perspectives are invited, but not imposed • The consumer is a primary resource in finding answers and solutions • Resistance is a signal to respond differently
Support self-efficacy and optimism; focus on consumers' strengths to support optimism and hope needed for change	• An individual's belief in the possibility of change is an important motivator • The consumer, rather than the clinician, is responsible for selecting and carrying out change • The clinician's own belief in the person's ability to change becomes a self-fulfilling prophecy

- Social support enhancement. Working with families and other supporters is extremely important for an individual with a dual disorder. Interventions include providing education and information about the illnesses, family therapy, helping them get involved in family support groups and involvement in treatment planning.
- Since recovery tends to occur over months or even years and it often takes many attempts to achieve stable remission or abstinence, effective programs take a long-term perspective.

  Recovery in the context of co-occurring disorders means that the individual becomes skilled at gaining mastery over both illnesses in order to pursue meaningful goals.

- The service system incorporates integrated intervention into all aspects of service delivery from medication management, laboratory screening, hospitalization, assessment, crisis intervention, and all other services.

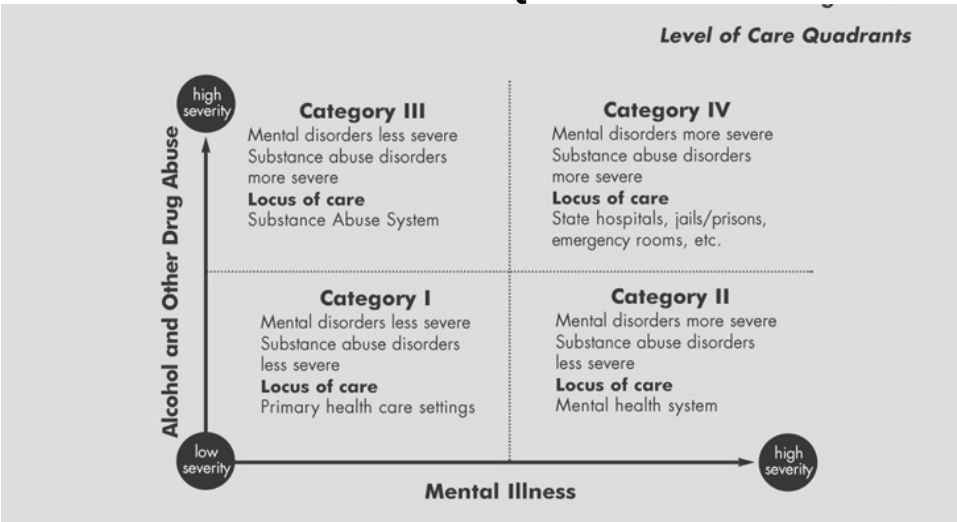
A number of behavioral interventions are used to reduce or stop substance use. These include conversational skill development, assertive training, relaxation skills development, and enjoyable leisure activities development.

Since the majority of individuals who have a substance use disorder have experienced traumatic events, and many have posttraumatic stress disorder, all individuals with co-occurring disorders need to be screened for PTSD. Support groups and trauma education groups are used along with cognitive-behavioral therapy as interventions.

It is important to work with the families of individuals with co-occurring disorders since many have very limited social networks. They are often cut off from family and lack social supports. Interventions for families include involvement in treatment planning, education about the illnesses, family therapy, and support groups.

The four-quadrant model of care developed by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) is a useful paradigm for delineating a continuum of responsibility for the provision services and supports for individuals with co-occurring disorders.

Level of Care Quadrants



Quadrant I: This quadrant includes individuals with low severity substance abuse and low severity mental disorders. These low severity individuals can be accommodated in either intermediate outpatient mental health or substance abuse treatment settings with consultation or collaboration between settings, if needed. Alternatively, some individuals will be identified and managed in primary care settings with consultation from mental health and/or substance abuse treatment providers.

Quadrant II: This quadrant includes individuals with high severity mental disorders who are usually identified as priority consumers within the mental health system and who also have low severity substance use disorders (e.g., substance dependence in remission or partial remission). These individuals typically receive continuing care in the mental health system and are likely to be served in a variety of intermediate level mental health programs using integrated case management.

Quadrant III: This quadrant includes individuals who have severe substance use disorders and low or moderate severity mental disorders. They are generally well accommodated in intermediate level substance abuse treatment programs. In some cases there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders.

Quadrant IV: Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive,

comprehensive, and integrated services for both disorders. The locus of treatment can be specialized residential substance abuse treatment programs such as modified therapeutic communities, state hospitals, jails, or even in settings that provide acute care such as emergency rooms.

BRIEF INTERVENTION

Brief intervention focuses on the reduction or elimination of substance use to minimize or prevent the harm associated with such use either via the technique itself or through referral for treatment. It is conducive to primary care and other opportunistic settings because it can be conducted within a limited number of (three ten to fifteen-minute) sessions that encompass assessment and motivational counseling to decrease substance abuse or promote entry into treatment.

Brief intervention incorporates five basic steps irrespective of the number of sessions or length of intervention:

1. Introduction of the issues within the context of the individual's health
2. Screening, evaluation, and assessment
3. The provision of feedback regarding screening results, impairment, and risks
4. Discussion of change strategies and goal-setting
5. Summarization and reaching closure

There are six components of brief intervention designed to alter substance use behavior captured in an acronym called **FRAMES**:

- **Feedback** regarding personal risk or impairment is given in a non-confrontational manner following assessment of substance use patterns and associated problems. Such feedback usually entails presenting information from standardized instruments and compares consumers' scores with normative data from the general population or groups receiving treatment.
- **Responsibility** for change is placed directly and explicitly on consumers in a manner that respects their rights to make choices for themselves in order to empower them so they are more invested in the process of change. Consumers are thus deemed the leading experts regarding their own needs.
- **Advice** regarding changing (i.e., reducing or stopping substance use) is given clearly in a nonjudgmental manner. This is best accomplished via suggestions rather than directives. Research indicates that educational advice based on scientific evidence is effective.
- **Menus** of self-directed change options and treatment alternatives are offered. A menu of options contributes to enhancing the effectiveness of treatment and reducing premature termination from treatment and resistance to change.
- **Empathic** counseling offered in a warm, respectful, and understanding manner using reflecting listening skills. Positive outcomes are associated with this style.
- **Self-efficacy,** or optimistic empowerment, is engendered to encourage change.

The 5 As of Brief Intervention for Tobacco use
Ask about tobacco use. Identify and document tobacco use status for every patient at every visit.
Advise to quit. In a clear, strong, and personalized manner urge every tobacco user to quit.
Assess willingness to make a quit attempt. Is the tobacco user willing to make a quit attempt at this time?
Assist in quit attempt. For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit.
Arrange follow-up. Schedule follow-up contact, preferably within the first week after the quit date.

Brief intervention has been demonstrated to be effective in reducing or eliminating alcohol consumption and associated problems in adolescents, adults, and older adults in a variety of settings. Studies have found that a reduction in drinking occurs after the first follow-up visit, and, even without repeated follow-up sessions, discernible behavior change occurs immediately. Some research indicates that individuals who experience recurrent and significant substance use difficulties that have lead to social, interpersonal or legal problems, and have previous histories of substance abuse treatment are less apt to be responsive to brief intervention.

SUPPORTED EMPLOYMENT (SE)

The philosophy of supported employment is that everyone with a mental illness is capable of attaining competitive employment if the right "fit" is found. It emphasizes jobs that pay competitive wages and are in integrated settings that include co-workers who do not have disabilities. Supported employment de-emphasizes prevocational assessment and training. The importance of rapid job searches and placements for anyone who expresses a desire to work are stressed. These programs have a zero exclusion policy; consumers are not excluded due to symptoms, substance abuse, prior work history or because they are "not ready" to work.

Supported Employment for People with Serious Mental Illnesses	
Goal	To secure employment quickly and efficiently for people with mental illness.
Features	An employment specialist on a mental health treatment team. The employment specialist collaborates with clinicians to make sure that employment is part of the treatment plan. Then the specialist conducts assessments and rapid job searches and provides ongoing support while the consumer is on the job.
Outcomes	In general, about 60% to 80% of those served by the supported employment model obtain at least one competitive job, according to three randomized controlled trials in New Hampshire; Washington, DC; and Baltimore. Those trials found the supported employment model far superior to traditional programs that include prevocational training. The cost of the supported employment model is no greater than that for traditional programs, suggesting that supported employment is cost-effective.
Sites	30 states in the USA, Canada, Hong Kong, Australia, and 6 European countries.

In this model, employment specialists work with the consumer's treatment team. Employment specialists can accommodate caseloads of twenty to twenty-five people. They provide follow-along supports on an indefinite basis; individualized supports continue for as along a consumer wants assistance. Employment specialists need to work full time without the diversions of other roles (e.g., case manager). They also need to be fully integrated into the treatment team and participate in team meetings. Their performance is the most productive when they are members of a vocational unit where staff can provide backup for each other.

While concern has been expressed that competitive work may increase stress for the consumer, studies indicate that supported employment does not lead to increased symptoms, distress, or other negative effects. Supported employment has been successfully implemented in many different types of communities, both urban and rural. There does not appear to be any specific consumer characteristic that affects outcome. In other words, supported employment has been successful irrespective of age, gender, diagnosis, symptomatology, prior hospitalization, education, and racial or ethnic group. However, a very depressed labor market may affect job availability.

The research on supported employment shows that consumers who participate in supported employment programs are more successful in obtaining competitive employment, work more hours,

earn more wages from work than those in traditional vocational programs. While participation does not generalize to non-vocational outcomes, there is evidence that when consumers find competitive work, their self-esteem improves, as does their satisfaction with finances and symptoms. As noted, outcomes indicate that, on average, twenty-one percent of individuals with mental illnesses who participate in traditional vocational rehabilitation programs secure competitive employment, compared to fifty-eight percent of those who participated in the individual placement and support model of supported employment.

The estimated costs of supported employment range from $2000 to $4000 per participant on an annual basis, which is comparable to those of traditional vocational programs. Moreover, employer accommodations (e.g., adaptive work schedules, supervisory orientation, and on-site support services) for persons with a mental illness appear to be quite inexpensive.

SUPPORTED EDUCATION (SED)

Research indicates that almost fifty percent of individuals with a mental illness have had some college education and sixty two percent have a desire to start or finish an education program. Many individuals with a mental illness have had their education interrupted by the illness. It has been estimated that almost five percent of individuals who drop out of college have a mental illness. Completion of secondary education has become more important in attaining upward occupational mobility. Studies have shown that participation in supported education is the most prominent and consistent predictor of successful employment. Individuals who do not obtain degrees can find themselves relegated to lower paying jobs and underemployment.

Supported education provides an array of services and supports to adults with mental illness to assist them in returning to school in order to complete their academic career and ultimately attain degrees and secure gainful employment. It is an evidence-based program with significant research showing that the vast majority of participants successfully complete their educations. It is recognized by SAMHSA as an exemplary practice.

The first supported education program began in 1983 at Boston University and there are now well over thirty supported education programs throughout the country, including the Michigan Supported Education Program at the University of Michigan (known as SECAG, or the Supported Education Community Action Group).

Core services include: pre-admission assessments, financial aid planning, school enrollment help, career planning, on-site campus support groups and mentorships, coordination with community mental health agencies and other community resources.

There are three basic models of supported education:

Mobile support:	Services and supports are delivered by community-based providers and are not tied to a specific educational institution.
Classroom support:	A pre-set curriculum that focuses on academic skill building, career goals, and support is used.
On-site support:	Services are housed in existing campus programs and provided by the school's staff.

To date no longitudinal studies have been conducted to ascertain outcomes in terms of attainment of degrees and economic upward mobility. However, the data available suggest supported education is successful in helping individuals integrate into the post secondary educational milieu. Students who participate in supported education programs are able to complete ninety percent of classes they enroll in. They maintain a grade point average of 3.14. In addition, they report increased self-esteem, levels of satisfaction with their living situation, finances, family and social relationships, and daily activities when compared to individuals who are not attending school.

ILLNESS MANAGEMENT & RECOVERY (IM & R)

Illness Management and Recovery consists of psychoeducation which includes the provision of information to consumers about their illnesses, including symptoms, stress management strategies, side effects of medications, and warning signs of impending relapse.

Illness Management and Recovery uses individual and group formats, as well as combinations of both formats, depending upon need. The individual format is easier to tailor to the specific needs of the individual, allowing for more time on specific elements, whereas the group format has the advantage of providing more sources for feedback, role modeling, and social support. The program consists of a series of weekly sessions designed to help consumers develop and implement strategies for the management of their illness and moving forward with their lives. It generally lasts for three to six months and can be provided in the community, the person's home, or can be office-based.

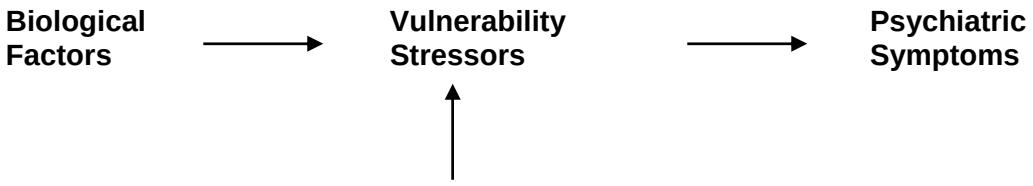
The goals of Illness Management and Recovery are to:

- Instill hope that change is possible
- Develop a collaborative relationship with a treatment team
- Help people establish personally meaningful goals to strive towards
- Teach information about mental illness and treatment options
- Develop skills for reducing relapses, dealing with stress, and coping with symptoms
- Provide information about where to obtain needed resources
- Help people develop or enhance their natural supports for managing their illness and pursuing goals

The following topics are covered in nine educational handouts:

1. Recovery Strategies
2. Practical Facts about Schizophrenia/Bipolar Disorder/ Depression
3. The Stress-Vulnerability Model and Strategies for Treatment
4. Building Social Support
5. Using Medication Effectively
6. Reducing Relapses
7. Coping with Stress
8. Coping with Problems and Symptoms
9. Getting Your Needs Met in the Mental Health System

The stress-vulnerability model is used to teach relapse prevention by disputing beliefs that relapses occur randomly and cannot be prevented. It suggests that vulnerability to relapses may be reduced by biological factors (such as by taking medications as prescribed and avoiding drugs and alcohol), environmental factors (such as enhanced social supports and reduced stress), as well as personal factors (such as meaningful structure and improved coping skills).



According to this model, a person has a biological vulnerability for a particular mental illness. The person with a biological vulnerability to the illness may develop that illness spontaneously or when

experiencing stress. When the illness develops under the latter condition, it may recur intermittently. Vulnerability appears to increase with repeated recurrences for some individuals.

Illness Management and Recovery practitioners incorporate a number of cognitive-behavioral techniques designed to help the consumer learn to cope with symptoms and develop skills to deal with stress and relapses. Behavioral tailoring for using medications as prescribed encompasses teaching consumers strategies to incorporate medication use into their daily lives. This entails the use of cues as reminders to minimize forgetting to take medications. Examples include placing medication next to a toothbrush or deodorant, on the kitchen counter (to pair them with meal preparation), and wearing a watch with an alarm. Coping skills training is comprised of cognitive-behavioral interventions to cope with symptoms. For example, distraction techniques (e.g., listening to music) are used to cope with auditory hallucinations. Relaxation training teaches muscles relaxation and breathing techniques paired with relaxing thoughts, which can be used when the person is in situations that evoke anxiety. Relapse prevention is also a significant element of the program. A discussion of this intervention is included in the section on prevention. Cognitive restructuring is also part of the program and used on a formal as well as informal basis. Information on cognitive restructuring can be found in the section on psychotherapeutic interventions. The practitioner uses a number of behavioral interventions to help people master skills including reinforcement, shaping, modeling, role-playing, and practice. Skills are practiced during sessions and homework assignments are given so that the person can practice techniques in vivo. Family members are encouraged to become involved and assist the consumer.

The more than twenty-five studies conducted on Illness Management and Recovery indicate that psychoeducation is effective in improving consumers' knowledge about their illness, but does not affect other outcomes. On the other hand, cognitive-behavioral interventions are effective in helping those consumers who elect to take medication incorporate it in their daily lives. Consumers are able to learn to recognize and respond to early warning signs of relapse and thus prevent relapse and hospitalization. Cognitive-behavioral interventions are successful in assisting consumers to develop more effective coping strategies for dealing with symptoms which leads to reduced symptom severity and distress.

FAMILY PSYCHOEDUCATION (FPE)

Family Psychoeducation is an evidence-based practice that reduces relapse rates and facilitates recovery by partnering with families and providing education about the illness and teaching specific problem-solving strategies for dealing with difficulties arising from the illness. It is derived from theories of expressed emotion (EE), which are based on observations that individuals with schizophrenia discharged home from hospitalizations to families with high expressed emotion are more likely to suffer a relapse. Expressed emotion has two components: criticism (CR) and emotional overinvolvement (EOI). Expressed emotion is characterized unsupportive, critical, negative interactions. It has been shown to be a significant and strong predictor of relapse with studies demonstrating that individuals living in household with high levels of EE are much more likely to relapse than those living in households with low-EE.

Family Psychoeducation is designed to replace individual meetings with consumers. It is an approach to working with families in a partnership to help them acquire coping skills for dealing with difficulties posed by mental illness in the family and supporting the recovery of a family member with a mental illness. The partnership is engendered by collaborating with families as consultants to help with the management of the illness. Family Psychoeducation is not family therapy; the focus of intervention is the illness (or illnesses for consumers with co-occurring disorders), not the family.

Family Psychoeducation can be provided in the home, community settings, mental health offices, hospitals, or other settings. In the context of Family Psychoeducation, family is defined as anyone the

consumer designates as such. It does not have to be a relative, and can be anyone committed to the support of the person including friends, relatives, landlords, neighbors, etc. The requirement is that at least one person in the consumer's life participates as a "sponsor" or "supporter".

Families meet every two weeks for the first months, then once a month for as long as they choose to meet. Programs last from nine months to five years. There are both single[5] and multi-family formats. The multifamily format consists of six to eight families and consumers. Both entail referrals and encouragement to participate in family support groups such as NAMI's Family-to-Family Education Program to reduce social isolation and stigma. Both formats aim to reduce expressed emotion, with multifamily models addressing stigma and social isolation as well.

The initial costs of providing Family Psychoeducation are estimated to be about $350 per year per consumer in staff time for an ongoing multi family group using a master's prepared practitioner (based on East Coast salaries). The single-family format costs about twice that of the multifamily format. The initial implementation costs are approximately $250 per practitioner.

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

Solution-focused therapy is a form of brief therapy that builds upon individuals' strengths by helping them evoke and construct solutions to their problems. It has been refined over the years since its development and applied in a number of settings (e.g., hospitals, residential treatment settings, outpatient office settings), and for a variety of problems (e.g., substance abuse, panic attacks, phobias, eating disorders, family relationship problems). The therapy focuses the future rather than the past or present, and on hope and achievement, rather than problems and their causes. It entails developing a solution to a problem and discerning the resources to accomplish the solution. A central aspect of solution-focused therapy is the active exploration of the person's strengths and resources, and acknowledgement of them. It is not driven by diagnostic formulations or problem exploration.

The first session entails four therapeutic tasks as depicted below:

Task of therapist	***Examples of opening questions***
Find out what the person is hoping to achieve from the meeting or the work together	What are your best hopes of our work together? How will you know if this is useful?
Find out what the small, mundane and everyday details of the person's life would be like if these hopes were realized	If tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow?
Find out what the person is already doing or has done in the past that might contribute to these hopes being realized	Tell me about the times the problem does not happen When are the times that bits of the miracle already occur?
Find out what might be different if the person made one very small step towards realizing these hopes	What would your partner/doctor/friend notice if you moved another 5% towards the life you would like to be leading?

(Iveson 2002)

A zero to ten scale is used to assist the person to rate their achievements. It is used to distinguish different characteristics of the problem, as well as the solution. A ten indicates that all of the identified goals have been achieved. A zero signifies that none of the person's goals have been achieved.

[5] Researchers have found African American families with low expressed emotion and consumers who have a good response to medication benefit more from the single-family format.

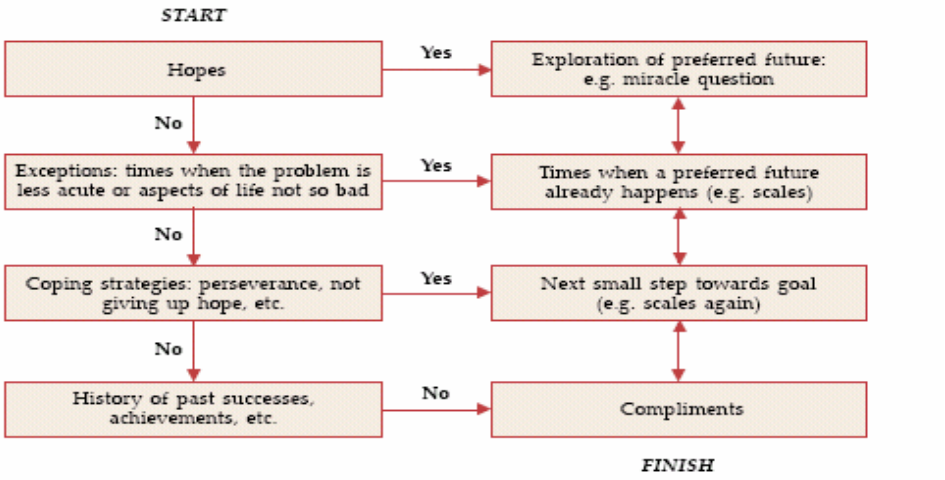
Scaling is used to determine progress during each session in response to the therapist's opening question: "What is better?" The therapist verbally commends the person's reports of progress.

	Points to mark	*What to explore*
10	The perfect solution	The miracle question as a means to encourage creative thinking
7	A good but realistic outcome	A realistic description of the consumer getting on with his/her life without the problem interfering too much. The more concrete and realistic the better, since it is the small, mundane aspects of living that go together to make a acceptable life
3	Where the consumer is now	Everything the consumer is doing that has helped him/her reach this point on the scale and/or everything he-she is doing to prevent matters getting worse
0	The worst scenario	Best not to delve into

(Iveson 2002)

The average duration of solution-focused therapy is five (to eight) forty-five minute sessions. If there is not demonstrable improvement after three sessions, it is unlikely that this therapy will prove effective for the person. The time between sessions is typically extended as the person makes progress so that a five-session course of treatment takes place over several months. It should also be noted that there are reports in the literature of effective single-session successes, but these typically involve individuals who are "stuck" in a problem and can be assisted to see a clear way out through the explication of a desired future, or have already solved their problem, but do not realize it.

Most sessions start with the top left of the flow chart, then move down through the right column. Subsequent sessions are more likely to focus on the second and third boxes in each column, more to the left if progress is minimal and more to the right if progressing well.



(Iveson 2002)

There are more than thirty published research studies on solution-focused brief therapy demonstrating successful outcomes in sixty-five to eighty-three percent of cases. However, due to the lack of diagnostic specificity, and the fact that most of these outcome studies rely on subjective reports from consumers or referral sources, they have limited objective validity. A large multi-site research project using more rigorous scientific methodologies is currently being conducted in Europe. The European Brief Therapy Association (EBTA) has developed a training manual. It is available on the web at http://www.ebta.nu/.

COGNITIVE BEHAVIORAL THERAPY (CBT)

Cognitive behavioral therapy (CBT) has a strong evidence base for a number of mental illnesses including anxiety disorders, depressive disorders, eating disorders, and personality disorders. Cognitive behavioral therapies are also used to ameliorate the neurocognitive deficits of some serious mental illness and various CBTs are employed as part of many of the SAMHSA evidence-based practice protocols (e.g., behavioral tailoring, motivational interviewing, relapse prevention, psychosocial skill enhancement, relaxation training, and so forth). A multimodal approach that involves the combination of CBT and medication has been shown to enhance outcomes. CBT can be provided in either individual or group therapy sessions.

Cognitive–behavioral therapy for panic attacks, phobias and PTSD, addresses the individual's threat appraisal process through repeated exposure. It is combined with stress inoculation training using breathing exercises, relaxation training, thought stopping, role playing and cognitive restructuring to desensitize the person to trauma related triggers. Homework exercises are given so that the techniques can be practiced and used in vivo where triggers are encountered. It is usually a brief intervention typically lasting for twelve to twenty weeks. According to the research, cognitive-behavior therapy has more long-lasting effects than medication. In other words, individuals who have been treated with CBT are less likely to become symptomatic following treatment cessation than those previously treated with medication. Studies have also shown that stress inoculation appears to be more effective in the short run, while prolonged exposure therapy appears to be more effective on a long-term basis.

EXPOSURE THERAPY FOR PTSD

Prolonged Exposure Therapy (PE) is a cognitive behavioral therapy for individuals suffering from PTSD with a significant research base to support its effectiveness in reducing symptoms of PTSD, anger, depression, and general anxiety. It is a SAMHSA model program.

The standard treatment protocol consists of nine to twelve ninety-minute individual therapy sessions conducted in accordance with a manual that specifies the agenda and content for each session. It includes three components:

- Psychoeducation about common reactions to trauma and the cause of chronic post trauma difficulties
- Imaginal exposure: repeated recounting of the traumatic memory (emotional reliving)
- In vivo exposure gradually approaching trauma reminders (e.g., situations, objects) that, despite being safe, are feared and avoided.

Research shows that PE reduces intrusive thoughts, nightmares and flashbacks, irritability, avoidance, emotional numbing, excessive avoidance, sleep disturbances, attention and concentration difficulties, sleep disturbances, and hypervigilance which are the hallmarks of PTSD.

A number of studies have also demonstrated that PE is very effective in reducing symptoms of PTSD in female victims of rape, aggravated assault, and childhood sexual abuse. It has been shown to be very beneficial for both men and women whose PTSD symptoms are related to combat exposure,

traffic and industrial accidents, and violent crime. Finally, PE is effective for individuals with mental illness and co-occurring substance use disorders when it is combined with substance abuse intervention.

DIALECTICAL BEHAVIOR THERAPY (DBT)

Dialectical Behavior Therapy (DBT) is a cognitive behavior therapy for the treatment of borderline personality disorder and self-harm behaviors. It is conducted by therapists working together in a team approach.

The theoretical basis for DBT is that individuals with borderline personality disorder have a pervasive deficit in their capacity to regulate emotions. This deficit is thought to originate in and be maintained by negative social interactions that are invalidating to the individual. In DBT, the practitioner takes a nonjudgmental approach in relation to the individual which eliminates the typical tendency of others to blame the person for their own maladaptive behaviors.

Treatment begins with establishing a collaborative relationship between the consumer and practitioner who then jointly construct a list of prioritized targeted behaviors to change. This list guides the rest of sessions which are divided into four stages. Stage one focuses on mastery skill development and behavioral control. Stage two focuses on resolving posttraumatic stress. Stage three is comprised of addressing issues of self-regard and individual goals. Stage four is aimed at enhancing the person's capacity to experience pleasure. The consumer monitors his or her own progress with a diary card that is reviewed with the therapist.

DBT uses a number of modalities and requires a treatment team that is trained in the approach. There are five treatment components. The first consists of a two-hour and a half weekly skills training group using a DBT skills training manual. The second consists of individual psychotherapy on a weekly (or twice weekly in some instances) basis aimed at enhancing motivation for treatment and behavior change. The third component consists of consumer telephone calls to their therapists between sessions for coaching and skill generalization in vivo. The fourth component is comprised of weekly consultative meetings of individual therapists and group skills trainers aimed at improving their skills and maintaining their motivation. The fifth consists of the structure of the treatment environment provided by DBT program directors and case managers' provision of assistance to consumers to help them structure their environments.

Research findings across studies indicate that DBT reduces target severe maladaptive behaviors and increases treatment retention. It has also been found to reduce hospitalization. Outcome data suggests that improvements are maintained for a year following termination of treatment. Information on DBT can be obtained from http://behavioraltech.org/.

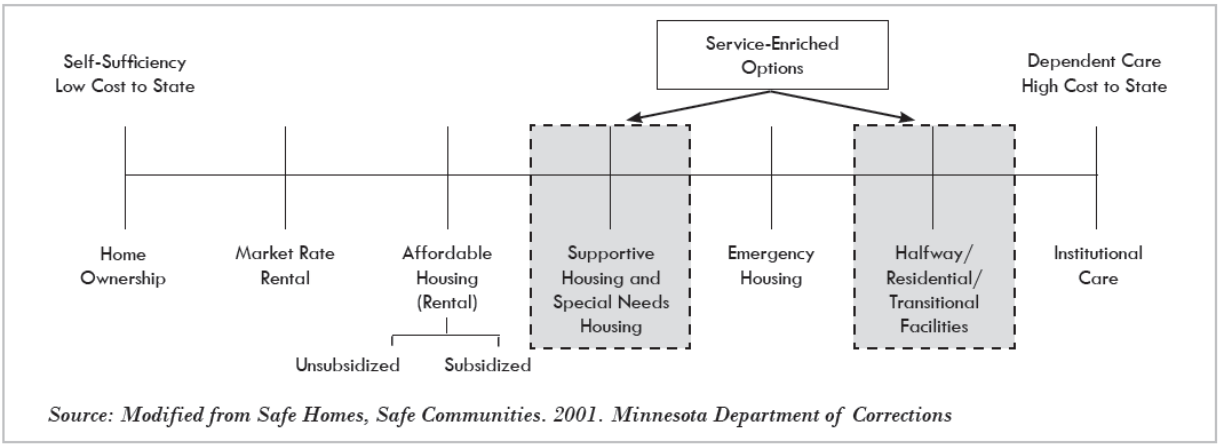
SUPPORTED HOUSING

There does not appear to be a single model of supported housing that meets the needs and preferences of all individuals with mental illness. Safe, affordable, permanent housing of one's choice with flexible, responsive community supports has been demonstrated to contribute to housing stability.

Supported housing denotes a movement away from models that "place" consumers in housing "slots" that vary in levels of services in accordance with the level of disability and use transitional settings and standardized supports. The supported housing paradigm centers on a permanent home, integrated into the community, that is self-selected, and fosters the development of daily living skills with the provision of flexible supports provided in accordance with what the person needs and wants.

Research has demonstrated that success in supported housing requires two critical ingredients: consumer choice and subsidized funding.

The Continuum of Housing Options for Persons with Mental Illness Who Have Had Contact with the Justice System



Source: Modified from Safe Homes, Safe Communities. 2001. Minnesota Department of Corrections

The **housing first** approach offers the direct placement from the street (or an institution) to housing with support services available, but not required. Although some evaluation studies have found that housing with low-demand service provision may work well for persons with mental illness and co-occurring substance use disorders, low demand services might not be an option when individuals are under high levels of correctional supervision. Correctional supervision-related coercion (e.g., mandatory drug testing) has been shown to work well in many circumstances for individuals with substance use disorders who are involved in the criminal justice system. Little is known regarding how coercion works for those who have a mental illness.

GENDER-SPECIFIC SERVICES FOR WOMEN

Effective treatment for women includes components that address specific issues such as child care, parenting skills, establishing healthy relationships, trauma/abuse, avoiding domestic violence, preventing HIV infection and other sexually transmitted diseases, reproductive health, and enhancing self-esteem. The importance of relationships with their children has been found to be a significant motivator. Research indicates that women experience more beneficial outcomes from single-gender treatment groups that are specific to women.

A number of elements have been identified as critical to the promotion of recovery for females involved with the justice system:

- Longer term treatment
- Graduated series of intermediate sanctions
- Clear sanctions and rules in treatment programs
- Comprehensive services and supports
- A continuum of community-based care accessed immediately upon release
- Gender-based, trauma-sensitive supports (e.g., TREM, Seeking Safety)
- Inclusion of children in programs
- Parenting skills development/enhancement

TRAUMA-INFORMED APPROACHES

SEEKING SAFETY

Seeking Safety is a present-focused manualized intervention with twenty-five topics that integrates treatment for PTSD and substance use disorders that can be combined with trauma-processing techniques. It can be used for men or women, in individual or group formats, and within outpatient or residential treatment facilities. Sessions focus on skills designed for both substance use problems and PTSD (e.g., distraction techniques that can be used to subdue the triggers for both disorders) to help consumers attain a sense of self-control and avert engagement in high risk behaviors, relationships, ideation and behaviors. Seeking Safety covers five areas:

❶ Safety, the priority of treatment.
❷ Integrated treatment of both disorders including helping participants understand the two disorders and why they frequently co-occur, teaching safe coping skills that apply to both disorders, exploring the relationship between the two disorders in the present (e.g., using a substance to cope with trauma flashbacks), and teaching that recovery from each disorder requires attention to both disorders.
❸ A focus on ideals; the title of each session is framed as a positive ideal that is the opposite of the negative characteristics of PTSD and substance abuse.
❹ Four program components: cognitive, behavioral, interpersonal, and case management. The interpersonal domain deals with issues regarding trust of others, confusion regarding expectations in relationships, avoidance of reenactments of abusive power, and dealing with the perpetuation of substance abuse in relationships. The case management component offers help obtaining referrals for problems such as housing, job counseling, HIV testing, domestic violence, and child care.
❺ Attention to clinician processes.

Seeking Safety is comprised of twenty-five topics. Seven interpersonal topics are: Asking for Help; Honesty; Setting Boundaries in Relationships; Healthy Relationships; Community Resources; Healing from Anger; and Getting Others to Support Your Recovery. The seven behavioral topics are: Detaching from Emotional Pain: Grounding; Taking Good Care of Yourself; Red and Green Flags; Commitment; Coping with Triggers; Respecting Your Time; and Self-Nurturing. The seven cognitive topics are: PTSD: Taking Back Your Power; Compassion; When Substances Control You; Recovery Thinking; Integrating the Split Self; Creating Meaning; and Discovery. In addition, four combination topics are: Introduction to Treatment / Case Management; Safety; The Life Choices Game (Review); and Termination.

Studies of the program show that it leads to significant reductions in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, depression, and cognitions related to substance use, as well as improvements in social adjustment, family functioning, problem solving, and didactic knowledge related to the treatment. The Seeking Safety website, http://www.seekingsafety.org/, provides sample topics, articles, and other materials that can be directly downloaded in English and Spanish.

TRAUMA RECOVERY AND EMPOWERMENT (TREM)

TREM is a group intervention designed for women survivors of trauma that addresses issues of physical, sexual, and/or emotional abuse. It consists of thirty-three seventy-five-minute sessions conducted over a nine-month period led by female clinicians that usually includes between six to

eight participants. It is provided in outpatient mental health settings, homeless shelters, welfare-to-work programs, and correctional facilities (prisons). The session topics are divided into the following sections:

Part I: Empowerment (eleven topics): introduces themes of gender identity, sexuality, interpersonal boundaries, and self-esteem without specifically addressing abuse issues.

Part II: Trauma Recovery (ten topics): focuses on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and current relationships.

Part III: Advanced Trauma Recovery Issues (nine topics): examines additional trauma issues such as blame, responsibility, and the role of forgiveness in recovery.

Part IV: Closing Rituals (three topics): allows group members to assess their own progress and plan for continued healing either on their own or as part of a community of other survivors.

Part V: Modifications or Supplements for Special Populations: addresses issues related to specific populations (e.g., women who have a serious mental illness, women who are incarcerated, women who are parents, women who engage in abusive behaviors, and male survivors).

Each session also includes an experiential exercise (physical activity, poetry, singing, drawing, and storytelling) to promote group cohesiveness and foster the inclusion of less verbal members.

Pilot studies of TREM have demonstrated that this is a promising model that leads to improvements in overall functioning and, psychiatric symptoms as well as reductions in the use of emergency services, HIV risk behavior, and substance use. Variations of the model have been developed for adolescent girls (G-TREM) and for men (M-TREM). Information can be obtained from http://www.communityconnectionsdc.org/trauma/trem.htm.

GROUNDING

Grounding (also referred to as centering, looking outward, distraction, and healthy detachment) has been found to be of benefit to individuals with co-occurring disorders who have experienced trauma from sexual abuse. It is often used for posttraumatic stress disorder symptoms, substance abuse cravings, panic, intense anxiety, and rage. Grounding consists of techniques that soothe and distract individuals from strong emotions and assist them in anchoring in the present and, hence, in reality. The technique must be practiced on a frequent basis in order to be most effective.

Grounding Techniques:

- **Anchoring/grounding** entails sitting in a relaxed posture in a chair with eyes closed (or open if uncomfortable closing them), focusing on breathing. The person is asked to concentrate on feeling the chair supporting their weight and the floor underneath their feet. The person is helped to recognize how grounded they are in the present and that despite anxiety experienced from reliving moments from the past, they remain safe and grounded in the present.
- **Mirroring** entails practicing breathing techniques and synchronizing breathing with that of the therapist.

- **Timeout** entails allowing the person to leave the room for a few moments in order to stop a current activity or behavior pattern that is disruptive.

Mental grounding entails describing one's environment in detail (e.g., the color of the walls, types and kinds of furniture, temperature, etc.), playing category games with oneself (e.g., names of composers, cars, television shows, novels, etc.), age progressions starting at a younger age and working one's way to the present, describing an everyday activity in detail (e.g., cooking a meal), using imaginal exercises to obtain a mental picture of change (e.g., driving away from a painful situation); using humor to alter mood, counting or saying the alphabet slowly, and self talk using safety statements. Physical grounding includes activities that alter sensation. These include physical movement, touching objects, exercise, eating, and focusing on breathing. Soothing grounding includes coping self-statements, planning a safe treat (e.g., a nice meal), recollections of a safe place, thinking of things one is looking forward to, etc.

COGNITIVE-BEHAVIOR THERAPIES FOR CRIMINOGENIC BEHAVIOR

Structured and intensive cognitive-behavioral approaches that address criminogenic thinking and behaviors can be effective in developing and enhancing life management, problem-solving, and self-control skills; developing affiliations with prosocial peers and role models; promoting closer family ties and enhancing positive family structures; and managing and altering antisocial thoughts, attitudes, and feelings. A number of programs have been developed to address criminogenic ideation and behavior including Moral Reconation Therapy (MRT), Thinking for a Change (TFAC), and Reasoning and Rehabilitation (R&R). However, while these programs are in use in numerous jurisdictions, studies of them are generally methodologically weak and equivocal with regard to rates of recidivism.

THINKING FOR A CHANGE (TFAC)

TFAC is a cognitive-behavioral program for offenders developed by the National Institute of Corrections (NIC) of the U.S. Department of Justice in 1997 that is used in state correctional systems, jails, community-based corrections programs, and probation and parole departments. The curriculum uses problem-solving, cognitive restructuring, and social skills development to increase awareness of self and others. It is comprised of twenty-two core lessons and ten additional lessons that can be provided on an indefinite basis. Role plays and in vivo practice sessions (i.e., homework) are used as teaching methods. TFAC is conducted in closed-ended groups of eight to twelve individuals and sessions are held twice per week for one to two hours.

TFAC starts with instruction of an introspective process for examining ways of thinking, feelings, beliefs, and attitudes which is reinforced throughout the program. Social skills training is provided as an alternative to antisocial behaviors. Participants are taught to report situations that could lead to criminal behavior, and identify thoughts, feelings, attitudes, and beliefs that might lead to the commission of offenses. They document and use a thinking report as a way of determining awareness of risky thinking that leads to difficulties. The social skills component of the program entails practice in role plays followed by group discussion and assessment of how well each participant adheres to the steps of the social skill being learned. Participants apply problem-solving steps to problems in their own lives. The program culminates by integrating the skills learned into steps for problem-solving to work through challenging situations without engaging in criminal behavior. Lesson plans and manuals for the program can be found on the web at http://www.nicic.org in English and Spanish.

REASONING AND REHABILITATION (R&R)

Reasoning and Rehabilitation is an educational program designed to teach juveniles and adults who have committed offenses prosocial cognitive skills and values. It is used throughout the Canadian correctional system, as well as in a number of jurisdictions in the United States. The program teaches skills aimed at ameliorating social and cognitive deficits that are linked to criminal behavior. Participants are taught to think prior to acting, anticipate problems and plan for reactions, focus more on problems and solutions, consider others' points of view, and maintain a more flexible, open, rational and reflective manner of thinking. The program consists of thirty-five two-hour sessions delivered two to four times per week to groups of four to ten participants. It uses role playing, video-recorded feedback, modeling, group discussion, games, and homework review to inculcate skills. Didactic presentations are not used.

The program focuses on:

- Interpersonal problem solving (to enhance problem awareness, problem definition, information gathering, distinguishing facts from opinion, alternative thinking, means end testing, consequential thinking, decision-making, and perspective taking)
- Self-control and self-management (to counteract anger and impulsive behaviors, substance use, moods swings, and low motivation) to reduce impulsivity
- Assertiveness and social interaction (to ameliorate social isolation, lack of social skills, and dominance or submissiveness)
- Social perspective taking (to counteract lack of understanding of others' points of view and low levels of empathy for others)
- Critical reasoning (to counteract being easily influenced and easily led and failure to question or analyze)
- Cognitive style and values reasoning (to promote basic values orientation and counteract interpersonal hostility, cognitive distortions, and rigid beliefs)

Research studies on Reasoning and Rehabilitation indicate contradictory results and are thus inconclusive regarding its effects on re-incarceration. The program is under copyright to T3 and Associates (http://www.t3.ca/).

MORAL RECONATION THERAPY (MRT)

MRT is a cognitive-behavioral program that uses education, group and individual counseling, and structured exercises to alter decision-making and promote moral reasoning. The program is conducted in classes of five to twelve participants on a weekly basis. Open-ended ongoing groups that meet from once per month to five days a week for ninety minutes with five to six participants (and up to twenty or more) are also part of the program. MRT contains twelve to sixteen steps depending on the treatment population and focuses on seven treatment issues:

- Confrontation and assessment of self (i.e., beliefs, attitudes, behavior, and defense mechanisms)
- Assessment of current relationships, including planning to restore those that have been damaged
- Reinforcement of positive behavior and habits to increase awareness of moral responsibility
- Facilitation of positive identity formation through exploration of the inner self and personal goals
- Enhancement of self-concept

- Reduction of hedonism to develop the ability to delay gratification and control pleasure-seeking behaviors
- Development of higher stages of moral reasoning to enhance concern for others and the social system

During group sessions, participants present/share exercise assignments from the MRT Workbook which each participant receives. MRT steps begin with relatively simple tasks (i.e., exercises) that progressively increase in complexity. Lower level steps are concerned with issues of honesty, trust and acceptance, while higher steps move toward active processes of repairing damaged relationships and long-term planning.

While outcomes studies indicate this program leads to reductions in behavioral and disciplinary problems, anger, depression, and increases in self-esteem, they tend to be methodologically weak which undermines the ability to draw conclusions regarding its effects on re-incarceration. MRT workbooks cost $25.00 each, and the classes cost $20.00 per session. Participants who earned less than $30,000.00 during the year previous to participation can qualify for a fifty percent reduction in session fees. The program is copyrighted and trademarked. Information is available from http://www.moral-reconation-therapy.com/.

PHARMACOTHERAPIES

The evidence base that supports the effectiveness of medication for severe mental illness greatly exceeds all other interventions. However, the rapid development of new medications creates challenges for prescribers attempting keep up to date with those developments and incorporate them into clinical practice. This has been addressed by the development of practice guidelines and algorithms based upon research and expert consensus. Despite the availability of these guidelines and algorithms, evidence indicates that medications are often used inconsistently. In particular, antipsychotic medication prescribing patterns have been shown to lack adherence expert recommendations. Moreover, it has also been shown that medication is often poorly documented in the clinical record and often does not adequately address residual side effects and symptoms. The Michigan Implementation of Medication Algorithms (MIMA) consists of medication algorithms for major depression, bipolar disorder, and schizophrenia adapted from the Texas Implementation of Medication Algorithm (TIMA). Highlights of MIMA are presented in Appendix C.

MEDICATIONS FOR SUBSTANCE USE DISORDERS

Pharmacotherapy for substance use disorders is utilized:

- To replace a harmful substance with a safer drug of the same class (e.g., methadone)
- To suppress symptoms of withdrawal
- To discourage continued substance use by precipitating an unpleasant reaction or reducing the euphoric effects of a substance (e.g., disulfiram and naltrexone)
- For agonist substitution therapy (which replaces an illicit drug with a prescribed medication)
- To treat co-occurring psychiatric disorders
- To decrease potential relapses

Generic	Brand
Alcohol	
Alcohol withdrawal agents	
benzodiazepines (e.g., lorazepam)[5]	Ativan
anticonvulsants (e.g., carbamazepine, divalproex sodium, gabapentin)	Tegretol, Depakote, Neurontin
barbiturates	
Alcohol relapse prevention agents	
disulfiram	Antabuse
naltrexone hydrochloride	ReVia, Depade
acamprosate	Campral
nalmefene hydrochloride	Revex
topiramate[6]	Topamax
Opioids	
Opioid withdrawal agents	
buprenorphine	Subutex
buprenorphine and naloxone	Suboxone
clonidine	Catapres
methadone hydrochloride	Methadone
nalmefene hydrochloride	ReVia, Depade
naltrexone hydrochloride	Revex
Opioid maintenance agents	
buprenorphine	Subutex
buprenorphine and naloxone	Suboxone
LAAM (levo-alpha-acetyl-methadol)[7]	
methadone hydrochloride	Methadone
Nicotine	
Nicotine replacement agents	
Nicotine	Nicoderm CQ, Nicotine Transdermal System, Nicotrol Inhaler, Nicotrol NS
nicotine polacrilex	Commit, Nicorette, Nicotine Gum
Nicotine cessation agents	
bupropion SR[8]	Zyban
varenicline tartrate	Chantix

[5] Baclofen (gamma-aminobutyric acid B (GABA(B)), a receptor agonist used for spasticity) has been found to be as effective as diazepam in treatment of uncomplicated alcohol withdrawal syndrome and is a promising pharmacological compound for use in the treatment of alcohol dependence. It has been found to reduce cocaine use.

[6] There is some evidence indicating topiramate (an anticonvulsant) is effective in reducing craving and heavy drinking and improving abstinence among people with alcohol dependence. It may also be effective for cocaine addiction.

[7] While LAAM has been shown to be as effective as methadone and buprenorphine in decreasing opioid use and enhancing treatment retention, it is no longer available due to adverse effects.

[8] Bupropion for nicotine dependence appears to have an effect on reward pathways associated with nicotine use and, when combined with nicotine replacement therapies, tends to result in better outcomes than either alone.

MEDICATIONS USED TO TREAT MENTAL ILLNESSES

Trade Name	Generic Name
Combination Antipsychotic and Antidepressant Medication	
fluoxetine & olanzapine	Symbyax (Prozac & Zyprexa)
Antipsychotic Medications	
Abilify	aripiprazole
Clozaril	clozapine
Geodon	ziprasidone
Haldol	haloperidol
Lidone	molindone
Loxitane	loxapine
Mellaril	thioridazine
Moban	molindone
Navane	thiothixene
Orap (for Tourette's syndrome)	pimozide
Permitil	fluphenazine
Prolixin	fluphenazine
Risperdal	risperidone
Serentil	mesoridazine
Seroquel	quetiapine
Stelazine	trifluoperazine
Taractan	chlorprothixene
Thorazine	chlorpromazine
Trilafon	perphenazine
Vesprin	trifluopromazine
Zyprexa	olanzapine
Antimanic Medications	
Cibalith-S	lithium citrate
Depakote	valproic acid, divalproex sodium
Eskalith	lithium carbonate
Lamictal	lamotrigine
Lithane	lithium carbonate
Lithobid	lithium carbonate
Neurontin	gabapentin
Tegretol	carbamazepine
Topamax	topiramate
Antidepressant Medications	
Adapin	doxepin
Anafranil	clomipramine
Asendin	amoxapine
Aventyl	nortriptyline
Celexa (SSRI)	citalopram
Desyrel	trazodone
Effexor	venlafaxine
Elavil	amitriptyline
Lexapro (SSRI)	escitalopram
Ludiomil	maprotiline
Luvox (SSRI)	fluvoxamine
Marplan (MAOI)	isocarboxazid

Nardil (MAOI)	phenelzine
Norpramin	desipramine
Pamelor	nortriptyline
Parnate (MAOI)	tranylcypromine
Paxil (SSRI)	paroxetine
Pertofrane	desipramine
Prozac (SSRI)	fluoxetine
Remeron	mirtazapine
Serzone	nefazodone
Sinequan	doxepin
Surmontil	trimipramine
Tofranil	imipramine
Vivactil	protriptyline
Wellbutrin	bupropion
Zoloft (SSRI)	sertraline
Antianxiety Medications	
(All of these antianxiety medications except BuSpar are benzodiazepines)	
Ativan	lorazepam
Azene	clorazepate
BuSpar	buspirone
Centrax	prazepam
Librax, Libritabs, Librium	chlordiazepoxide
Klonopin	clonazepam
Paxipam	halazepam
Serax	oxazepam
Tranxene	clorazepate
Valium	diazepam
Xanax	alprazolam

PHARMACOLOGY FOR CO-OCCURRING DISORDERS

In general, it is recommended that individuals with co-occurring disorders receive the most clinically effective psychopharmacologic interventions available for their mental illnesses irrespective of the status of comorbid substance disorders, and that comorbid substance use disorders be treated with appropriate psychopharmacologic intervention (e.g., disulfiram, naltrexone, and opiate maintenance therapy) irrespective of the status of comorbid psychiatric disorders.

The most common agents used to treat anxiety disorders are benzodiazepines (e.g., alprazolam and lorazepam) and antidepressants. Because benzodiazepines can cause significant problems they are generally not recommended for people with substance use disorders or for the long-term treatment of anxiety or depressive disorders. Selective serotonin reuptake inhibitors (SSRIs) for the treatment of co-occurring depressive disorders and buspirone (a partial 5-HT1A agonist) for anxiety disorders are examples of psychoactive drugs with low abuse potential.

Abuse Potential of Common Psychiatric Medications

Medication Class	High Abuse Potential	Moderate Abuse Potential	Low Abuse Potential
Sleep medications	Benzodiazepines: • Diazepam • Flurazepam • Chlordiazepoxide • Clonazepam (Klonopin) and others • Chloral hydrate • Barbiturates • Meprobamate	• Diphenhydramine • Hydroxyzine (Vistaril) • TCAs	• Trazodone (Desyrel)
Antianxiety	• Benzodiazepines	None	• TCAs • Buspirone
Antidepressants	• Methylphenidate • Dextroamphetamine	None	• Fluoxetine and others • SSRIs • TCAs • Bupropion • Venlafaxine (Effexor) • Nefazodone (Serzone) • Mirtazapine
Mood stabilizers	• Clonazepam	None	• Lithium carbonate • Carbamazepine • Sodium valproate (Depakote) • Gabapentin (Neurontin) • Phenytoin (Dilantin)
Antipsychotics	None	None	All, for example: • Chlorpromazine • Thioridazine • Haloperidol • Risperidone (Risperdal) • Olanzapine (Zyprexa)
Anti-Parkinsonian medications	None	• Trihexyphenidyl (Artane) • Benztropine (Cogentin)	None
Agents for treating substance abuse	• Methadone • LAAM • Buprenorphine	• Clonidine (Catapres) (should be prescribed with caution since it can be used to self-administer for heroin withdrawal and can cause a rapid drop in blood pressure.)	• Naltrexone (ReVia) • Disulfiram (Antabuse) • Bupropion (Zyban)

(SAMHSA TIP # 37)

Buspirone has been found to be effective for patients with alcohol abuse/dependence and co-occurring anxiety disorders. When combined with cognitive behavioral therapy, it leads to reductions in symptoms of anxiety and increases in treatment retention. It also appears to exert modest effects on decreasing the frequency of alcohol consumption and the risk for resumption of heavy drinking. Fluoxetine has been shown to be effective for people with co-occurring alcohol disorders and major depression. Venlafaxine and bupropion have shown promise in pilot studies for comorbid depression and substance use disorders. In addition, studies of desipramine and imipramine have shown improved mood and reduced risk of relapse.

Bipolar disorder can be complicated by the use of substances with resulting increased likelihood for episodes of depression, mania, and rapid cycling. A manic state can be produced by stimulants (e.g., cocaine) during intoxication and from depressants (e.g., alcohol) during withdrawal. A period of confirmed abstinence, generally one to two weeks, is usually required

prior to initiating treatment with mood stabilizers in order to assess the role of substances in inducing manic symptoms. Anticonvulsant mood stabilizers, (e.g., divalproex sodium and carbamazepine) have been shown to be effective in controlling mania and in treating co-occurring substance use disorders.

Medications used to treat HIV/AIDS (e.g., protease inhibitors) can interfere with the metabolism of medications used for the treatment of psychiatric and substance use disorders (e.g., methadone), as well as with that of substances that are abused. Medications that have anticholinergic effects (e.g., tricyclics and antipsychotics) block saliva flow, produce dry mouth, cause or exacerbate oral candidiasis, other mouth infections, and dental caries. The stimulation from antidepressant medications can trigger mania or hyperactivity, particularly in individuals with co-existing HIV infection and substance use disorders who may have mild central nervous system impairment from HIV. Individuals with HIV infection are more sensitive to extrapyramidal symptoms produced by antipsychotic medications (e.g., haloperidol). Second generation antipsychotics (e.g., risperidone, olanzapine, and quetiapine), with the exception of clozapine (which should not be used due to the potential for agranulocytosis), are recommended. Sedative-hypnotics and other central nervous system depressants can cause confusion, memory impairment, and depression. In addition, some medications used to treat HIV/AIDS and its complications can affect treatment for hepatitis since a number of HIV/AIDS treatment drugs are processed through the liver; their effects can be either increased or decreased due to hepatitis or chronic alcohol use.

COMBINED BEHAVIORAL & NICOTINE REPLACEMENT THERAPY

It is estimated that ninety percent of persons entering substance abuse treatment programs and fifty to ninety-five percent of individuals with co-occurring psychiatric disorders use nicotine. Individuals with serious mental illnesses, who smoke display more positive symptoms, are prescribed more medications, experience more side effects from medications, and are hospitalized more frequently than those who do not smoke. The literature recommends that nicotine addiction be addressed in all programs.

Combined Behavioral and Nicotine Replacement Therapy consists of the use of a transdermal nicotine patch or nicotine gum to reduce symptoms of withdrawal for initial abstinence and a concurrent behavioral component to provide support and reinforcement for coping skills. The latter component consists of behavioral skills training designed to help individuals learn to avoid high risk situations for smoking relapse early on and plan strategies to cope with such situations later on. Participants practice skills during treatment and in social and work settings. Other coping techniques (e.g., cigarette refusal skills, assertiveness, and time management) are also taught.

MEDICAL MANAGEMENT OF PAIN

People with substance use disorders are often under treated for acute pain. Reluctance to provide adequate pain treatment is usually based on the erroneous belief that maintenance doses of opioid addiction treatment medication also relieves acute pain. Patients in MAT programs have been shown to have high rates of acute pain, and thirty to sixty percent experience chronic pain. Long-term opioid pharmacotherapy produces substantial tolerance to the analgesic effects of opioid treatment medications so typical maintenance doses afford little to no pain relief and, due to tolerance for narcotics, higher doses of narcotic analgesia and more frequent dosing intervals are generally required for effective pain control.

It is recommended that patients with substance abuse problems be prescribed drugs with a low potential for: (1) abuse, (2) exacerbation of the effects of substances that are abused, and (3)

lethality in overdose. It is also recommended that medications be dispensed in limited amounts and be closely monitored. In general, a hierarchical approach to prescribing is recommended to minimize the potential for abuse. In this approach, the lowest doses of safer, less abusable medications are prescribed first, and the most potentially abusable medications are used only when other agents have not been effective. Dispensing medication in small amounts helps limit overuse, misuse, or abuse of medications with the potential for abuse. In addition, it is recommended that one prescriber be assigned to write all prescriptions and that patients be requested to sign a contract to this effect. Nonopioid alternatives (e.g., nonsteroidal anti-inflammatory drugs, COX-2 inhibitors, physical therapy, or surgical intervention) are often recommended prior to treatment with opioids for pain management to minimize the risk of exacerbation of addiction posed by analgesics containing opioids. In fact, relapse to illicit opioid use has been shown to occur when opioid analgesics are given to people in recovery.

It is recommended that shorter acting narcotics be used for time-limited periods while methadone is continued at usual doses for pain control. Methadone doses several times per day can be used for individuals with opioid addictions who have severe chronic pain. Acute pain is managed with adequate doses of alternative mu opioid agonists (e.g., morphine, hydromorphone, or oxycodone), while continuing the maintenance dose of methadone. Partial agonists such as buprenorphine, butorphanol tartrate, and nalbuphine, as well as mixed opiate agonist-antagonists (e.g., pentazocine [Talwin]), are contraindicated because they can precipitate withdrawal. Certain types of pain have been found to be relieved by anticonvulsant adjuvant medications such as carbamazepine or phenytoin, but both are potent CYP 450/3A inducers that can lead to a sharp reduction in serum methadone levels. Gabapentin, effective for neuropathic pain, does not alter CYP 450/3A isoenzymes and thus does not change methadone levels.

SERVICE DELIVERY MODELS

Community forensic team models have emerged in recent years to assist consumers of mental health services with criminal justice involvement. Integrated models consist of forensic specialists working within community mental health teams while parallel models consist of forensic specialists working on separate specialist teams. However, the long-term outcomes of either model have yet to be established.

CRIMINAL JUSTICE-INFORMED CASE MANAGEMENT

In the criminal justice system, case managers link individuals with needed resources, track progress, monitor court-imposed conditions, and report information to supervisory authorities. Case management has been shown to be an effective means of dealing with the fragmentation of the criminal justice system as well as social service, mental health, substance use disorder, and health care systems.

As noted previously, accessing community resources can be challenging for individuals subsequent to incarceration. In addition to assuming responsibility for meeting one's daily needs, the stresses of finding housing, health care, transportation, employment, child care, and meeting the requirements for supervision and treatment, can increase the potential for relapse. Treatment schedules can conflict with parole mandates, and job-seeking, school, or employment can compete for the time allocated to treatment. Coordinated transition planning can reduce such conflicts and help the person surmount problems in meeting all demands. In addition, help can be provided in applying for social security, Medicaid, veterans' entitlements, and other benefits (and applications can be initiated prior to release).

Core Functions of Case Management
❶ Assessment
❷ Planning
❸ Linking
❹ Monitoring
❺ Advocacy

In the criminal justice system, case managers link individuals with needed resources, track progress, monitor court-imposed conditions, and report information to supervisory authorities. Many jurisdictions use case management services in an effort to decrease recidivism and address mental health, substance use disorders, developmental disabilities, HIV/AIDS and other serious medical conditions, and domestic violence affecting juveniles and adults who have been arrested, and are on probation or parole. The case management model most often used is a mixture of clinical and brokered models. Studies have suggested that case management in the justice system leads to reductions in recidivism and relapse as well as the promotion of social integration and public safety at significant cost savings. Case management has been shown to be an effective means of dealing with the fragmentation of the criminal justice system as well as social service, mental health and health care systems.

SPECIALTY PROBATION/PAROLE

Specialty agencies have been developed in response to the need to better support individuals with psychiatric co-occurring disorders in community supervision. Standards have yet to be scientifically established for these programs; they are deemed promising practices. Prototypic models share a number of features:

- Exclusive mental health caseloads of probation officers rather than mixed caseloads (that include general probationers or sex offenders)
- Significantly reduced caseloads of probation officers (e.g., forty five rather than the typical one hundred thirty five cases per officer) to:
    - Enhance their ability to function as boundary spanners who develop knowledge regarding mental health and community resources
    - Establish and maintain relationships with community agencies and clinicians
    - Provide advocacy
    - Provide active supervision for persons on their caseloads
- Sustained probation officer training (e.g., twenty to forty hours of mental health training annually to enhance knowledge of mental illness and co-occurring disorders)
- Integration of external and internal resources wherein probation officers work in teams with treatment providers attending treatment team meetings and advocating for treatment and supports (e.g., income and housing) rather than functioning merely as referral agents and monitors
- Use of effective problem-solving strategies that collaboratively address noncompliance issues by working with probationers to identify and overcome obstacles (e.g., dealing nonadherence to medication regimens due to side effects by helping with seeking medication changes and creating new compliance agreements based on the medication changes) rather than the use of rule reminders or threats of incarceration

Studies from this nascent area of research indicate that specialty agencies are more effective than traditional agencies in linking probationers with treatment services, reducing risk for probation violations, and increasing the well-being of probationers. Evidence is mixed regarding reductions in longer term rearrests, however.

One key element found to influence outcomes is the quality of the relationship between the officer and parolee/probationer; trust, caring, and fairness are associated with fewer parole/probation violations, while confrontation and use of negative pressure (e.g., threats of incarceration) are associated with increased parole/probation violations. It is recommended that officers maintain a balance between dual roles of surveillance/control and therapeutic caring and avail themselves of nontraditional approaches to addressing noncompliance (e.g., problem-solving to collaboratively resolve issues) which are promising strategies for working with this population.

TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES (TASC)

TASC was initially designed to identify appropriate offenders in the criminal justice system, assess their needs for substance use treatment, refer them to treatment, monitor their progress in treatment (including conducting regular and random urinalysis testing), and report progress back to the criminal justice system. The model has since been expanded to include offenders throughout the criminal justice system, including specific populations such as women or adolescents. In addition, it has been adapted and incorporated into drug courts. Some jurisdictions use TASC programs to create collaborative relationships between prosecution, probation, parole, and substance abuse treatment programs to provide a range of services and supports (e.g., screening and assessment, referral to community-based services, monitoring of treatment progress and compliance, case management, and liaison with courts). These

programs can be integrated into substance abuse treatment programs, court services departments, or function as freestanding organizations.

TASC programs offer an alternative to incarceration or supplement criminal justice sanctions. They are designed to deal with multiple needs including parenting skills, medical care, family relationships, counseling, education and employment, and legal issues. TASC programs initiate case management services as early as possible including during pretrial, pre-sentence, post-adjudication, or prerelease.

TASC Program Components:

- Coordination between criminal justice and substance disorder treatment systems
- Screening, early identification, assessment, and prompt referral
- Access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
- Frequent clinical status monitoring via drug testing
- Client monitoring
- Use of legal sanctions as inducements to remain in treatment
- Case management
- Client advocacy
- Clinical interventions
- Relapse prevention
- Staff training
- Data collection and management

Evaluations of TASC programs indicate that, while they have been shown to be effective in identifying offenders who have substance abuse problems and issues and referring them to treatment programs, outcomes in terms of recidivism to criminal behavior and relapse have been equivocal. Some studies indicate positive outcomes while others show only rather modest reductions in substance abuse. Other studies indicate inconclusive results with regard to criminal recidivism. Nonetheless, individuals involved in TASC programs have been shown to remain in treatment longer than other clients involved in the criminal justice system (as well as those who participate in treatment on a voluntary basis).

FORENSIC INTENSIVE CASE MANAGEMENT (FICM)

Intensive Case Management (ICM) mirrors ACT with regard to assertive, in vivo, and time-unlimited services, but differs in that it uses case managers with individual case loads, lacks a self-contained team, and brokers access to psychiatric treatment rather than delivering it directly. In other words, the focus of ICM is on linking and coordinating services rather than treatment for the consumer. **Standard case management**, in comparison, is much less intensive due to larger caseloads, more office-based service delivery, and less frequent consumer contact.

Studies effectiveness of FICM show mixed and conflicting results leading to difficulties drawing any firm conclusions. Some studies show reductions in criminal justice involvement with diversion to FICM postbooking but no appreciable decrease in psychiatric symptoms, while others indicate reductions in psychiatric symptoms.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Assertive Community Treatment is a service delivery model in which a transdisciplinary team that is comprised of ten to twelve practitioners including psychiatrists nurses, master's and doctoral level professionals, consumers (i.e., peer support specialists), employment specialists, substance abuse

specialists, and a program assistant, who serve approximately one hundred consumers. The ratio of staff to consumers is recommended to be one to ten. ACT teams work together in a highly integrated fashion across professional boundaries to the maximum extent possible to support a consumer's life in the community. They are available twenty-four hours a day, seven days a week. Services are provided in vivo rather than office-based settings, allowing for the delivery of supports in natural contexts where problems arise and skills are needed. The team provides care coordination on a continuous basis, including when the consumer is in the hospital.

TEN PRINCIPLES OF ASSERTIVE COMMUNITY TREATMENT
❶ Services are targeted to a specified group of individuals with severe mental illness.
❷ Rather then brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team.
❸ Team members share responsibility for the individuals served by the team.
❽ The staff-to-consumer ratio is small (approximately 1 to 10).
❾ The range of treatment and services is comprehensive and flexible.
❾ Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings.
❽ There is no arbitrary time limit on receiving services.
❽ Treatment and support services are individualized.
❾ Services are available on a 24-hour basis.
❿ The team is assertive in engaging individuals in treatment and monitoring progress.

An extensive research base for ACT exists. Studies show that it is very effective in reducing hospitalization and improving housing stability. Its effects on quality of life, social functioning, and symptoms are similar to those of other interventions such as case management. Reduced levels of substance abuse are found when a substance specialist is part of the team. Higher rates of competitive employment are achieved when employment specialists are part of the team. Most studies have also shown that consumers and their families are more satisfied with ACT than other types of services.

It is estimated that the per-consumer annual cost of ACT is about $9,000 to $12,000 per annum. It is cost effective for individuals with extensive hospital utilization. This is why it is generally reserved for a specific subset of consumers who experience the most serious and intractable symptoms, have the greatest difficulties in activities of daily living, and have not responded well to services that are more traditional. Typically, such consumers have been extensive users of inpatient hospitalization services, have a co-occurring substance use disorder, involvement in the criminal justice system, as well as experiences of homelessness, and unemployment.

To date, the evidence is unclear regarding the effectiveness of ACT as an evidence-based practice for forensic populations.

FORENSIC ACT (FACT)

Forensic ACT is an emerging model for preventing arrest and incarceration of adults with severe mental illness who have substantial histories of involvement with the criminal justice system. There is yet little standardization of program practices and staffing although core elements that distinguish FACT from ACT have been identified: (1) the goal of preventing arrest and incarceration; (2) requiring that all consumers admitted to the team have criminal justice histories; (3) accepting the majority of referrals from criminal justice agencies; and (4) the development and incorporation of a supervised residential treatment component for high-risk

consumers, particularly those with co-occurring substance use disorders. FACT has disseminated more rapidly than high-fidelity ACT teams for criminal justice populations. FACT is considered a hybrid ACT program and includes a criminal justice team member (i.e., a probation and parole officer).

The rather limited research base on FACT indicates significant reductions in jail days, arrests, hospitalizations, hospital days, and service costs per consumer. Further research is needed to establish the structure, function, and effectiveness of this developing model of service delivery. A fidelity scale has been developed for the model and can be found on the Web at http://www.mhmraharris.org/LocalPlan/documents/7-FACTOutcomeMeasureGuidelines.pdf.

CRISIS INTERVENTION

Crisis intervention can be provided by mobile teams or in crisis centers, emergency rooms of hospitals, and crisis residential facilities. Alternatives also include home-based care, family-centered crisis intervention, and crisis care. ACT teams also provide crisis intervention. Research shows that such programs are as effective, and at times more effective, than hospitalization in terms of increasing consumer and family satisfaction, promoting continuity of services, alleviating family stress and costs. Studies have demonstrated that crisis intervention is associated with reduced hospital readmission rates, reduced symptoms, and preservation of role functioning. Additional support comes from the benefits of early response and intervention since delays in treatment can increase the duration of psychotic episodes. It is recommended that relapse prevention interventions should be part of crisis intervention programs.

Appropriate training for law enforcement officers shows promise and can lead to improved ability to work with people with mental illnesses in ways that avoid violent confrontations, encourage beneficial relationships, and result in referrals for treatment rather than jail (i.e., prebooking diversion).

MEMPHIS CRISIS INTERVENTION TEAM (CIT)

The Memphis Police Department's crisis intervention team is a specialized unit within the police department and is considered the most noteworthy prebooking diversion program in the country. Other crisis intervention teams have been based on the CIT model (e.g., Waterloo, Iowa; San Jose, CA Portland, Oregon; Albuquerque, New Mexico; and Seattle, Washington). The program, the first of its kind in the country, was developed under the aegis of the Memphis mayor's office, and is the result of a partnership between the police department, the Memphis chapter of the Alliance for the Mentally Ill, the University of Memphis, and the University of Tennessee. Police officers receive forty hours of specialized training from mental health providers, family advocates, and mental health consumer groups who provide information about mental illness and techniques for intervening during a crisis. The officers are issued crisis intervention team medallions that allow immediate identification of their role in a crisis situation and, upon arrival at a scene, are the designated officer in charge. They transport individuals they suspect of having mental illness to the University of Tennessee psychiatric emergency service after the situation has been assessed and diffused. The team officers' specialized mental health responses are additional to their regularly assigned patrol duties. They cover four overlapping shifts in each precinct, and are available on a twenty four-hour basis.

BIRMINGHAM COMMUNITY SERVICE OFFICERS PROGRAM

In Birmingham, Alabama a community service officer team is assigned to the police department. Community service officers assist police officers in mental health emergencies by providing crisis intervention and some follow-up assistance. They participate in a six-week pre-service

classroom and field training program. These officers are civilian police employees with professional training in social work or related fields. They dress in civilian clothes, drive unmarked cars, and carry police radios and are not sworn police officers, do not carry weapons, or have the authority to make arrests. Community service officers are based in each of the city's four major police precincts and are available Monday through Friday from 8 a.m. to 10 p.m. Twenty-four-hour coverage is provided by these officers rotating on-call duty during weekends, holidays, and off-shift hours. The officers respond to mental health emergencies and various social service types of calls involving domestic violence, needs for transportation or shelter, and other requests for general assistance. Studies of the program indicate too few community service officers are available to respond to calls resulting in a low percentage of specialized responses to mental health emergencies.

Another program is the Knoxville, Tennessee mobile crisis unit that responds to calls in the community, handles telephone calls, and deals with referrals from the jail (because the jail does not have an inpatient mental health program). The mobile unit is responsible for covering five counties, including the city of Knoxville. Studies show that lengthy response times pose a significant barrier to use of the service by police officers. Data indicates police officers often experience delays and frequently make disposition decisions to jail individuals, transport them to services, or drop them off somewhere without calling the unit.

The Los Angeles County **Mental Evaluation Team (MET)** takes a different approach, pairing an officer and a mental health professional to respond to police calls involving individuals with a mental illness. This arrangement allows for more people to be directed into treatment rather than incarceration.

Two key factors have been identified as crucial to the success of these types of crisis intervention programs:

- A psychiatric triage or drop-off center where police can transport individuals in crisis which reduces officers' down time and immediately places the person in crisis within the purview of the mental health system rather than the criminal justice system.
- Community partnerships wherein police departments view these programs as part of their community policing initiatives; a philosophy that police agencies should join with the community in solving problems.

APPENDIX A: SELECTED REFERENCES

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APPENDIX B: SELECTED RESOURCES

JUSTICE SYSTEM:

Michigan Prisoner ReEntry Initiative (MPRI): http://www.michpri.com/
Bureau of Justice Assistance (BJA): www.ojp.usdoj.gov/BJA/
Residential Substance Abuse Treatment for State Prisoners Formula Grant Program: www.cfda.gov
Treatment Accountability for Safer Communities (TASC): http://www.ojp.usdoj.gov/bjs/
National Evaluation Data and Technical Assistance (NEDTAC): http://www.calib.com
The National Drug Control Strategy: www.whitehousedrugpolicy.gov/
This program has encouraged the development of treatment and rehabilitation services for offenders who use drugs (e.g., Treatment Accountability for Safer Communities, formerly Treatment Alternatives to Street Crime; drug court programs; prison treatment programs).
Serious and Violent Offender Reentry Initiative: www.ojp.usdoj.gov/reentry/learn.html
In conjunction with several federal partners, the U.S. Department of Justice is spearheading this initiative to provide funding to promote successful reintegration of serious, high-risk offenders into the community. The Initiative seeks to address all obstacles to successful reentry, including substance abuse.
Parenting Programs for Male Offenders: www.vera.org/publication_pdf/fathers.pdf
SAMHSA GAINS Center: http://gainscenter.samhsa.gov/html/
This is a federal initiative for the development of resources for individuals with co-occurring substance and mental health disorders in the criminal justice system.
National Institute of Corrections: http://www.nicic.org/

DRUG COURTS:

National Association of Pretrial Services Agencies: www.napsa.org/
National TASC Conference (for case managers, assessment staff, clinicians): (www.nationaltasc.org/)
National Drug Court Institute: www.ndci.org/aboutndci.htm
Provides targeted training for all disciplines involved in drug courts; judges, prosecutors, defense attorneys, probation officers, treatment professionals
National Association of Drug Court Professionals Annual Training Conference: www.nadcp.org/home.html
The National GAINS Center: www.gainsctr.com/
The National GAINS Center for People with Co-occurring Disorders in the Justice System provides an online information source of value to those who work with offenders. The GAINS Center collects and analyzes information, and develops materials specifically for people who work with offenders with mental illness, and provides technical assistance to help localities plan, implement, and operate appropriate, cost-effective programs.

TRAINING RESOURCES FOR WORKING WITH THE CRIMINAL JUSTICE SYSTEM:

Working with Criminal Justice Clients. www.neattc.org
Designed to familiarize substance abuse treatment counselors to work with criminal justice clients, the curriculum includes material on intersystem teamwork and relapse issues. **Training for Professionals Working with MICA (Mentally Ill Chemical Abusing) Offenders**. www.neattc.org
This one-day course module serves as cross-training for staff in law enforcement, mental health, and substance abuse settings.

Orientation to Therapeutic Community. www.mattc.org
Developed to introduce administrators and ancillary staff to the history, theory, and current research on the therapeutic community model, this training provides a fundamental framework for therapeutic communities. This training curriculum is not intended for front-line workers.
Therapeutic Community Experiential Training. www.mattc.org
Intended for frontline staff of start-up therapeutic communities, this five-day intensive experiential training provides participants with the knowledge, expertise, and attitudes that have been used effectively by professionals in the field.
Criminal Justice/Substance Abuse Cross Training: Working Together for Change. www.mattc.org
This program is designed to help administrators and professionals integrate criminal justice and substance abuse services systems to coordinate treatment and recovery services and overcome barriers to collaboration.
National Institute of Corrections (NIC): www.ncic.org
The Think Curriculum: Cognitive Interventions Program Manual and The Options Manual.
Virginia Substance Abuse Technology Transfer Center (VATTC): www.views.vcu.edu/vattc
Offers a criminal justice and substance abuse cross-training curriculum called Working Together for Change.
Bureau of Justice Assistance (BJA) Substance Abuse Programs:
www.ojp.usdoj.gov/BJA/programs/substance_abu.html
Bureau of Justice Statistics (BJS) Statistics on Drugs and Crime:
www.ojp.usdoj.gov/bjs/drugs.htm
Federal Bureau of Prisons (BOP) Substance Abuse Treatment:
www.bop.gov/inmate_programs/substance.jsp
National Criminal Justice Reference Service: www.ncjrs.gov
National Institute on Alcohol Abuse and Alcoholism (NIAAA): www.niaaa.nih.gov
National Institute of Corrections (NIC): www.nicic.org
National Institute of Justice (NIJ): www.ojp.usdoj.gov/nij
National Institute of Mental Health (NIMH): www.nimh.nih.gov
Office of Applied Studies (OAS) Substance Abuse and Mental Health Services Administration: www.oas.samhsa.gov
Office of Justice Programs (OJP): www.ojp.usdoj.gov
The Office of Juvenile Justice and Delinquency Prevention (OJJDP): www.ojjdp.ncjrs.org
Drug Strategies: www.drugstrategies.org
Re-Entry Policy Council: www.reentrypolicy.org
University of Washington Alcohol and Drug Abuse Institute:
www.adai.washington.edu/instruments
American Society of Addiction Medicine: www.asam.org
TASC (Treatment Accountability for Safer Communities): www.nationaltasc.org
National Drug Court Institute: www.ndci.org
Bureau of Justice Statistics (BJS) Statistics on Drugs and Crime:
www.ojp.usdoj.gov/bjs/drugs.htm
Drug Abuse Treatment Cost Analysis Program (DATCAP): www.datcap.com

CULTURE:

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care developed by the U.S. Office of Minority Health published in 2001 and available at www.omhrc.gov.
National Center for Cultural Competence at Georgetown University's Child Development Center: www.georgetown.edu/research/gucdc/nccc/index.html

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI): www.ncadi.samhsa.gov
The NCADI Web site provides access to publications on specific populations. Click on *Audience* to access information on African Americans, American Indians, Alaska Natives, Asians and Pacific Islanders, individuals with disabilities, Hispanic and Latino populations, and lesbian, gay, and bisexual individuals.
Hawaii AIDS Education and Training Center: www.hawaii.edu/hivandaids/links_culture.htm.
This site provides links to resources on clients who are homeless, have disabilities, or are members of minority groups. The information and links discuss HIV/AIDS, health care, and other relevant issues.
Effective Therapies for Minorities: Meeting the Needs of Racially and Culturally Different Clients in Substance-Abuse Treatment:
BeattySeptember/October2000;www.counselormagazine.com. This journal article includes basic steps that programs can take to move toward cultural competence.
Cultural Competence in Substance Abuse Treatment, Policy Planning, and Program Development: www.attc-ne.org/pubs/ccsat.pdf. This annotated bibliography of resources has sections on African Americans, Asian and Pacific Islanders, Native Americans, and Hispanics/Latinos, compiled by the Addiction Technology Transfer Center of New England, at Brown University's Center for Alcohol and Addiction Studies.
The Provider's Guide to Quality and Culture:
erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English. This Web site provides descriptions of attributes and beliefs of many cultural groups, with links and references, as well as information on cultural diversity and self-assessment tools.
Cultural Competence Standards in Managed Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups: Center for Mental Health Services 1997; www.mentalhealth.org/publications/allpubs/SMA00-3457. This book discusses guiding principles for cultural competence in the context of treatment for African-Americans, Asians and Pacific Islanders, Hispanic populations, Native Americans, Alaska Natives, and Native Hawaiians.
Develop Your 'Ethnocultural Competence' and Improve the Quality of Your Practice: www.counselormagazine.com. This journal article provides a good introduction to ethnicity and culture and how both affect treatment.
Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings: Implications for Policymakers and Administrators:
http://www.mchgroup.org/nccc/documents/Getting_Started.html. This checklist from the National Center for Cultural Competency helps organizations implement policies and practices that support cultural competence.
A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs: www.ncfy.com/pubs/culguide.htm. This guide presents tools for assessing and enhancing cultural competence in youth-serving organizations. Assessment questionnaires that focus on the community, clients, and the program itself are included in appendix A. The tools and information can be adapted for drug treatment programs.
Cultural Competence Self-Assessment Instrument: www.cwla.org/pubs.
This resource provides tools for assessing cultural competence of policies, programs, and staff and guidelines for strengthening cultural competence.
Health Resources and Services Administration. *Study on Measuring Cultural Competency in Health Care Delivery Settings: A Review of the Literature:*
www.hrsa.gov/culturalcompetence/measures. This report details a comprehensive review of the cultural competence theoretical and methodological literature.
Cultural Competency Tool (order forms at www.ahaonlinestore.com): Available from the Society for Social Work Leadership in Health Care for $15.00 for members and $20.00 for

nonmembers, this instrument assists in evaluating the cultural competence of staff and can be used for performance assessment, evaluation of pre-diversity and post-diversity efforts, or compliance with Medicaid/Medicare conditions or JCAHO cultural competence standards.
Toolkit for Cross-Cultural Communication: www.awesomelibrary.org/multiculturaltoolkit.html: These materials compare patterns of communication across diverse groups and discuss myths that impair cultural competence, including a table of communication norms and values across cultures.
Intercultural Communication Institute: www.intercultural.org. This organization conducts an annual Summer Institute for Intercultural Communication.
The National Center for Cultural Competence: www.georgetown.edu/research/gucdc/nccc
Diversity Training Associates of Portland:
This organization provides consultants and trainers.
(800-484-9711, ext. 8250)

DOMESTIC VIOLENCE, ABUSE, AND NEGLECT:

National Domestic Violence Hotline: (800) 799-SAFE and (800) 787-3224 (TDD)
The National Domestic Violence Hotline links individuals and services using a nationwide database of domestic violence and other emergency shelters, legal advocacy and assistance programs, and social services programs. The hotline provides crisis intervention, information about sources of assistance, and referrals to battered women's shelters.
Rape, Abuse, and Incest National Network (RAINN): (800) 656-4673
RAINN links six hundred twenty eight rape crisis centers nationwide. Sexual assault survivors who call will be automatically connected to a trained counselor at the closest center in their area.
American College of Obstetricians and Gynecologists (ACOG): http://www.acog.org/
ACOG has patient education pamphlets and bulletins for medical professionals on both domestic violence and substance abuse.
American Medical Association (AMA): http://www.ama-assn.org/
The AMA educates physicians through publications, conferences, and by serving as a resource center for physicians and other concerned professionals. Among its publications are six diagnostic and treatment guidelines on child physical abuse and neglect, child sexual abuse, domestic violence, elder abuse and neglect, mental health effects of domestic violence, treatment and prevention of sexual assault, and media violence.
National Clearinghouse on Child Abuse and Neglect: nccanch@calib.com
This clearinghouse offers child abuse and neglect information in the form of manuals, research reports, studies, directories, grant compendia, literature reviews, annotated bibliographies, fact sheets, database searches, CD ROM databases, and on-line services. It is sponsored by the National Center on Child Abuse and Neglect.
National Coalition Against Domestic Violence: http://www.ncadv.org/
The National Coalition Against Domestic Violence serves as an information and referral center for the general public, the media, battered women and their children, and agencies and organizations. Among its purposes are to enhance coalition-building at the local, state, and national levels; support the provision of community-based, nonviolent alternatives such as safe homes and shelters for battered women and their children; provide information and referral services, public education, and technical assistance; and develop public policy and innovative legislation. The coalition maintains a public policy office in Washington, DC and a National Directory of Domestic Violence Programs.
National Sheriffs' Association: http://www.sheriffs.org/home.shtml
The National Sheriffs' Association has developed a handbook on victim's assistance for law enforcement officers who deal with all types of victims, including those of domestic violence. It

provides training in dealing with victims sensitively, finding resources in one's community to help them, and setting up a victim assistance program.

National Victim Center (NVC)/INFOLINK: www.nvc.org

NVC operates an information and referral program called INFOLINK, which provides a toll-free source of comprehensive crime and victim-related information as well as referrals to over eight thousand victim assistance programs across the nation. Each caller can receive up to five of the seventy information bulletins free of charge. In addition, all INFOLINK bulletins, as well as other important information, are available on NVC's website.

FaithTrust Institute (formerly the Center for the Prevention of Sexual and Domestic Violence): http://www.faithtrustinstitute.org/

This is a national organization working with and within religious communities on issues of sexual and domestic violence. Although the center's constituency includes those in the fields of law, health care, social services, counseling, and other fields, the center primarily targets religious professionals and teaches them how to effectively respond to and prevent sexual abuse and domestic violence. Services and products include trainings, workshops, and seminars; consultations; videos; specialized curriculum materials; and publications.

Colorado Coalition Against Domestic Violence: http://www.ccadv.org/

This group does public policy work and provides community education and training, information in the form of statistics and brochures, and technical assistance to domestic violence programs.

Family Violence and Sexual Assault Institute: fvsai@e-tex.com

To improve networking among researchers, practitioners, and agencies, the Family Violence and Sexual Assault Institute maintains an international clearinghouse, reviews its materials, and disseminates the information through its *Family Violence and Sexual Assault Bulletin*. This independent, nonprofit corporation helps crisis centers, agencies, universities, and counseling clinics develop treatment programs for partner and sexual abuse and has published several books and bibliographies as a result of this research. The institute also provides training and consultation in the form of program evaluation, research, and technical assistance.

National Clearinghouse on Marital and Date Rape: http://members.aol.com/ncmdr/index.html

The National Clearinghouse on Marital and Date Rape provides fee-based phone consultations for information, referrals, strategies, and advocacy. The website contains fee and membership information.

National Criminal Justice Reference Service (NCJRS): askncjrs@ncjrs.org

NCJRS, an extensive source of information on criminal and juvenile justice, provides services to an international community of policymakers and professionals. NCJRS is a collection of clearinghouses supporting all bureaus of the U.S. Department of Justice, Office of Justice Programs. It also supports the Office of National Drug Control Policy. Information is available through information specialists, online services, or its CD ROM database. NCJRS does not provide counseling or legal advice.

Health Resource Center on Domestic Violence: http://www.fvpf.org/health/

The Health Resource Center, which focuses on strengthening the health care response to domestic violence, provides resources and training materials, technical assistance, and information and referrals to health care professionals and others who help victims of domestic violence. Its products and services include comprehensive resource manuals providing the tools for an effective multidisciplinary response; multidisciplinary protocols emphasizing routine screening and identification of domestic violence; assistance with health care training programs and protocol development; models for local, state, and national health policymaking; a national network of experts for public speaking, training, and consultation; and educational materials specifically developed for health care providers.

Battered Women's Justice Project (BWJP): http://www.bwjp.org/

The BWJP serves as a resource center and national toll-free information line regarding domestic violence issues in the criminal and civil justice systems. A collaboration of three

organizations, the BWJP responds to specific requests for information or technical assistance from people who work with battered women.

HOUSING AND HOMELESSNESS:

Health Care for the Homeless Information Resource Center
Health Care for the Homeless (HCH) is the only Federal program with the sole responsibility of addressing the critical primary health care needs of homeless individuals.
National Health Care for the Homeless Council
The National Health Care for the Homeless Council is a membership organization comprised of Organizational Members and hundreds of individuals who are organized as the HCH Clinicians' Network. Members of the National Council work together for reforms of the health care system to best serve the needs of people who are homeless.
National Resource Center on Homelessness and Mental Illness (NRC), Policy Research Associates, Inc.
As one of CMHS's national technical assistance centers, NRC is the only national center specifically focused on the effective organization and delivery of services for people who are homeless and have serious mental illnesses.
Projects for Assistance in Transition from Homelessness (PATH), Policy Research Associates (PRA) and Advocates for Human Potential (AHP)
Congress created the Projects for Assistance in Transition from Homelessness (PATH) formula grant program in 1991 to help states and territories provide flexible, community-based services for people who are homeless and have serious mental illnesses. As one of CMHS' national technical assistance centers, AHP provides onsite technical assistance and other activities to help states/territories and the local organizations that receive PATH funds operate and monitor the program.
The Corporation for Supportive Housing
CSH brings together people, skills, and resources and provides high-quality advice and development expertise, by making loans and grants to supportive housing sponsors, by strengthening the supportive housing industry, and by reforming public policy to make it easier to create and operate supportive housing.
Technical Assistance Collaborative: www.tacinc.org
HUD: www.hud.gov (summaries of ConPlans are available on line)
Center for Community Change: www.communitychange.org
HUD SHP Desk Guide:
http://www.hud.gov/offices/cpd/homeless/library/shp/shpdeskguide/dgintro.cfm
Enhancing Shelter Plus Care Operations
http://www.hud.gov/offices/cpd/homeless/library/spc/shelterplusguide.PDF
Understanding Shelter Plus Care
http://www.hud.gov/offices/cpd/homeless/library/spc/understandingspc/index.cfm
Understanding SRO
http://www.hud.gov/offices/cpd/homeless/library/sro/understandingsro/index.cfm
HUD's guide to PHAs
http://www.hud.gov/offices/pih/pha/policy/pha-plan-guide.pdf

Co-Occurring Psychiatric and Substance Use Disorders:

SAMHSA's Co-Occurring Center for Excellence (COCE): http://coce.samhsa.gov/
Dual Diagnosis Recovery Network (DDRN): www.dualdiagnosis.org
Support Together for Emotional/Mental Serenity and Sobriety (STEMSS)
Michael G. Bricker, Executive Director
STEMSS Institute and Bricker Clinic

140 E. Dekora Street
Saukville, WI 53080
(414) 268-0899
STEMSS is a psychoeducational group intervention. The model has been developed to train facilitators to initiate, implement, and maintain support groups for consumers. The six steps of the program and the support groups are intended to complement participation in traditional twelve-step programs.

Consumer Organization and Networking Technical Assistance Center (CONTAC): www.contac.org
CONTAC distributes a list of names and contacts for resources and information on substance addictions, co-occurring disorders, services, and mutual help support. CONTAC also offers the Leadership Academy, a training program that is designed to help consumers learn how to engage in and develop consumer services. Recently, a training component focusing on substance abuse/dependence was developed and incorporated into the program.

National Council on Alcoholism and Drug Dependence (NCADD): www.ncadd.org
NCADD has a nationwide network of nearly one hundred affiliates that provide information and referrals to local services, including counseling and treatment. NCADD also offers a variety of publications and resources.

National Empowerment Center: www.power2u.org
The National Empowerment Center has prepared an information packet, which includes a series of published articles, newspaper articles, and a listing of organizations and federal agencies that provide information, resources, and technical assistance related to substance abuse and dependence, co-occurring disorders, services, and mutual help support.

National Mental Health Association: www.nmha.org
The National Mental Health Association has expanded its mission to encompass substance abuse/addictions and co-occurring disorders. The organization continues to develop resources, documents, and publications. A designated section on the organization's Web site is dedicated to co-occurring disorders.

National Mental Health Consumers' Mutual Help Clearinghouse: www.mhselfhelp.org
The organization has developed and offers a resource kit, which provides the names and contacts for resources and information on substance addictions, co-occurring disorders, services, and mutual help support.

SUBSTANCE USE DISORDERS:

National Alcohol & Drug Addiction Recovery Month
Recovery Month is sponsored SAMHSA's Center for Substance Abuse Treatment (CSAT). An annual observance that takes place during September that highlights the societal benefits of substance abuse treatment, lauds contributions of treatment providers, and promotes the message that recovery from substance abuse in all its forms is possible.

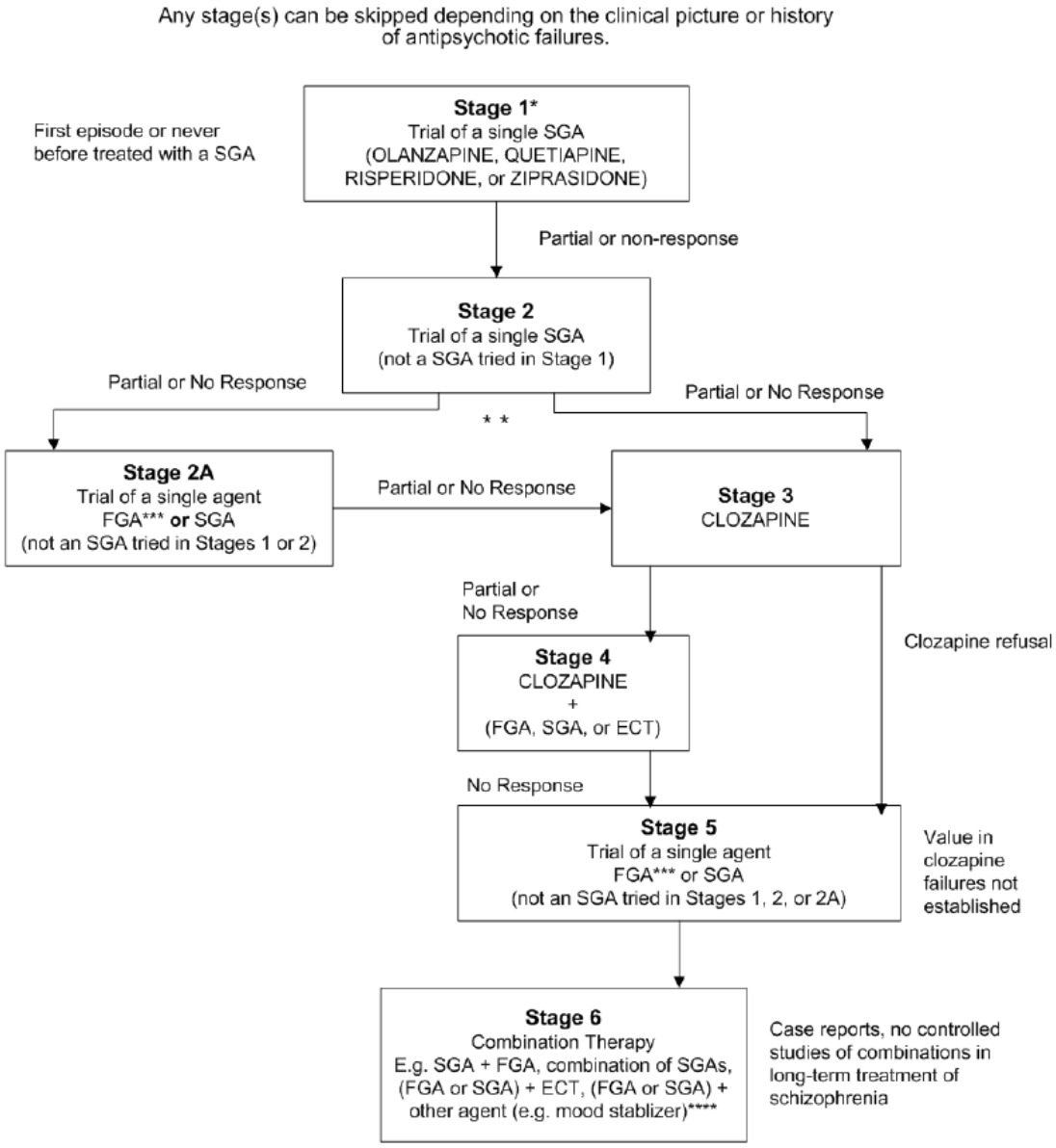
National Clearinghouse for Alcohol and Drug Information (NCADI), SAMHSA
SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) a resource for information about substance abuse prevention and addiction treatment.

The National Center on Addiction and Substance Abuse (CASA), Columbia University
A unique think/action tank that engages all disciplines to study every form of substance abuse as it affects our society.

APPENDIX C: MIMA HIGHLIGHTS

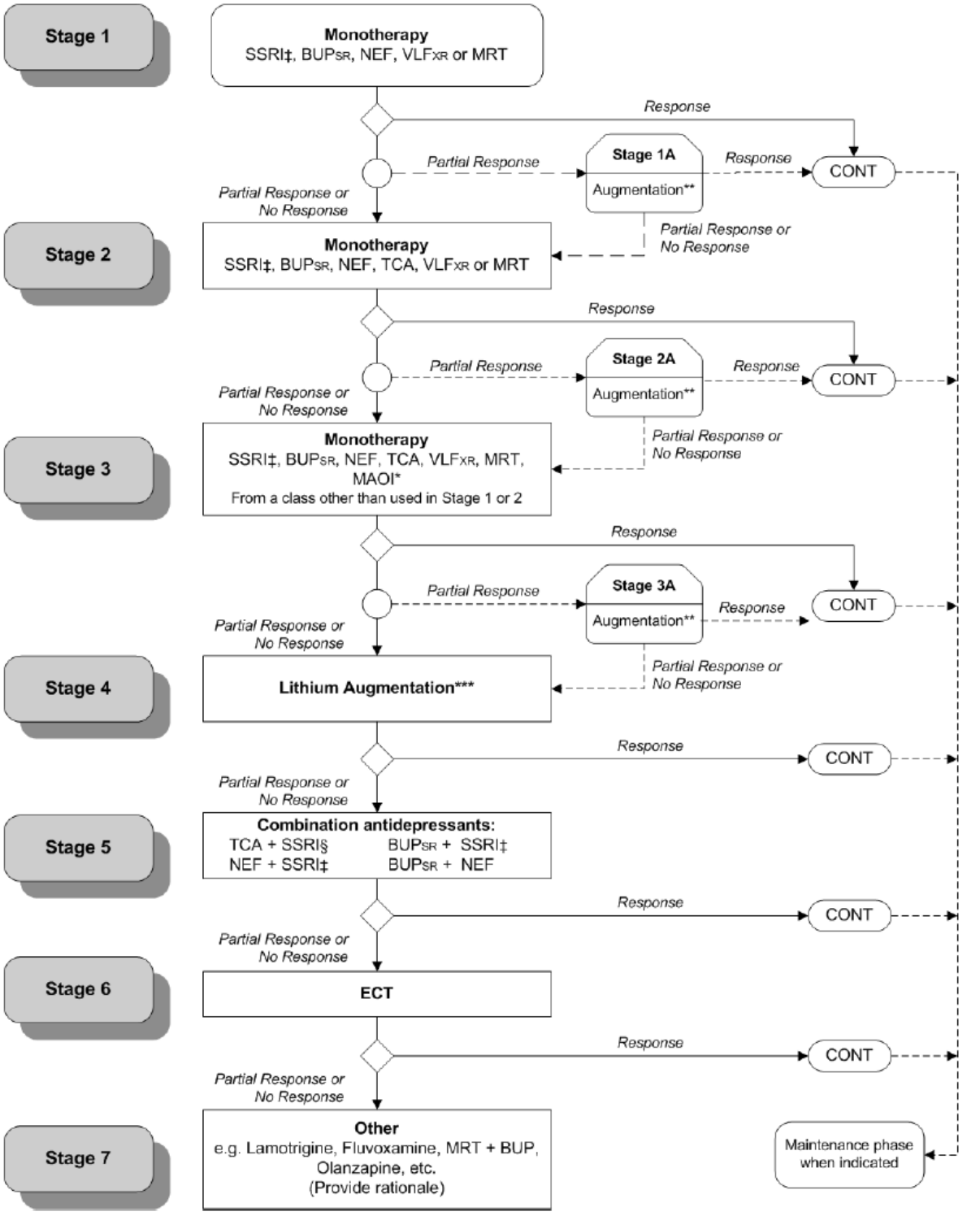
An overview of the algorithms for the treatment of schizophrenia, major depression, and bipolar is presented in the following diagrams taken from the Michigan Implementation of Medication Algorithms (MIMA).

Algorithm for the Treatment of Schizophrenia



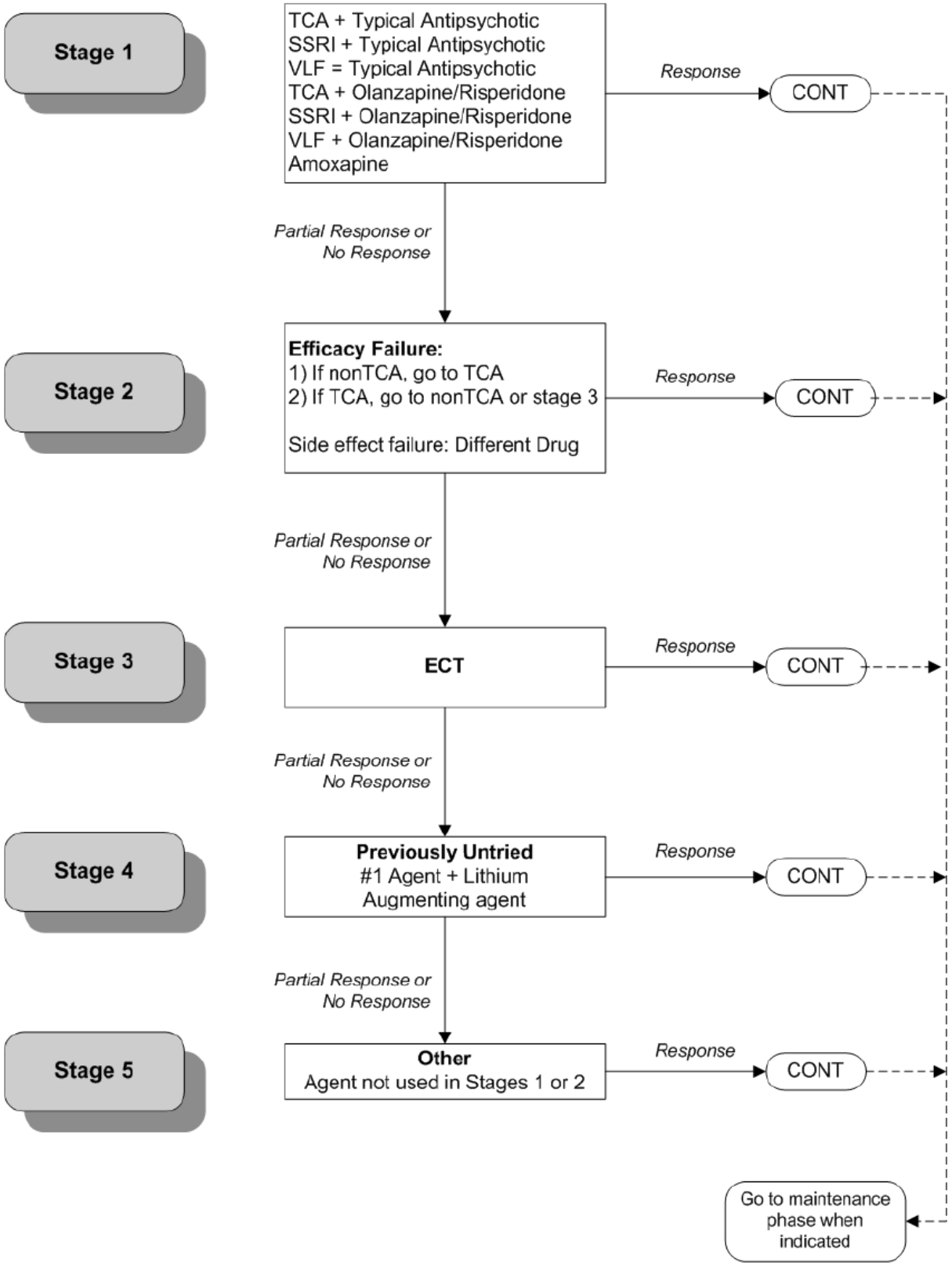
*If patient is nonadherent to medication, the clinician may use haloperidol decanoate or fluphenazine decanoate at any stage, but should carefully assess for unrecognized side effects and consider a different oral AP if side effects could be contributing to nonadherence.
** See text for discussion. Current expert opinion favors choice of clozapine.
***Assuming no history of failure on FGA.
****Whenever a second medication is added to an antipsychotic (other than clozapine) for the purpose of improving psychotic symptoms, the patient is considered to be in Stage 6. See Description of Tactics and Critical Decision Points section for more explanation.
FGA = First generation AP
SGA = Second generation AP

Algorithm for the Treatment of Major Depression (Nonpsychotic)



*Consider TCA/VLF if not tried.
**Lithium, thyroid, buspirone.
***Skip if Li augmentation has already failed.
§ Most studied combination
‡ SSRI = Fluox, Sert, Parox, Cital.

Algorithm for the Treatment of Major Depression (Psychotic)



Strategies for Acute Phase Treatment of Major Depressive Episodes

Stage	Nonpsychotic depression	Psychotic depression
Stage 1	Monotherapy[a]	Antidepressant + Antipsychotic
	SSRI,[b] Bupropion (BUP), Nefazodone (NEF), Venlafaxine (VLF), Mirtazapine (MRT) (A evidence[c])	TCA + Antipsychotic (A-B evidence)[d] SSRI + Antipsychotic (B-C evidence) Amoxapine (B evidence) VLF + Antipsychotic (B-C evidence)
Stage 2	Monotherapy	Antidepressant + Antipsychotic
	SSRI, BUP, NEF, VLF, Mirtazapine (MRT) **OR** a TCA **EFFICACY FAILURE:** Switch to another antidepressant. **SIDE EFFECT FAILURE:** Switch classes, or consider staying within the class if a contrasting SE profile is available or expected.	**EFFICACY FAILURE:** If nonTCA used in Stage 1, switch to TCA. If TCA used, try an antidepressant from a different class. **SIDE EFFECT FAILURE:** Switch to an agent from a different class.
Stage 3	Monotherapy	ECT
	SSRI, BUP, NEF, VLF, MRT, TCA or MAOI Choose a medication from a different class than used in Stage 1 or 2.	If the patient refuses ECT or does not respond, go to the next stage or repeat an earlier stage with a different agent.
Stage 4	Augmentation	Augmentation
	Previously untried antidepressant + lithium, thyroid,[e] or buspirone Begin medications simultaneously.	Previously untried treatment + lithium, thyroid, or buspirone Begin medications simultaneously.
Stage 5	Combination Therapy	Other
	TCA + SSRI, SSRI + BUP, SSRI + NEF, BUP_{SR} + NEF	Any antidepressant + antipsychotic not tried in Stage 1 or 2
Stage 6	ECT	Other
	If patient refuses ECT or does not respond, go to next stage or repeat an earlier stage with a different agent.	Any antidepressant + antipsychotic not tried previously
Stage 7	Other	Other
	Any antidepressant or combination not previously tried	Any antidepressant + antipsychotic not tried previously

[a] Acceptable antidepressants for Stage 1: Discuss treatment options with the patient and depending on prior treatment history, patient's clinical presentation, life style, and personal preferences, etc., assess the relative advantages of Stage 1 medications and make an initial treatment selection.

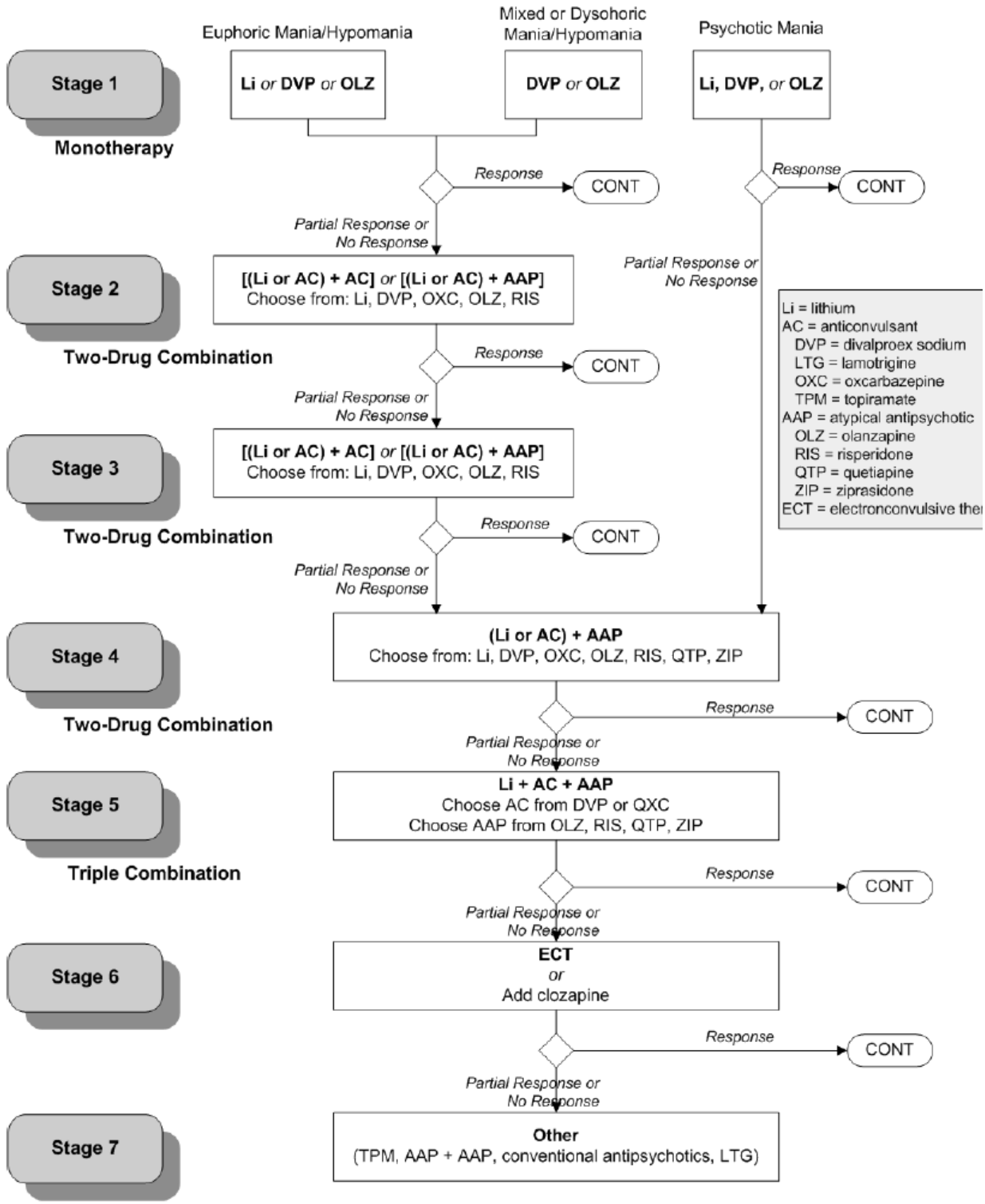
[b] FDA-approved SSRIs for depression include: fluoxetine (FLU), paroxetine (PRX), sertraline (SERT), and citalopram (CIT).

[c] Evidence level: A = controlled clinical trials; B = open trials and retrospective data analyses; C = clinical consensus and/or case reports.

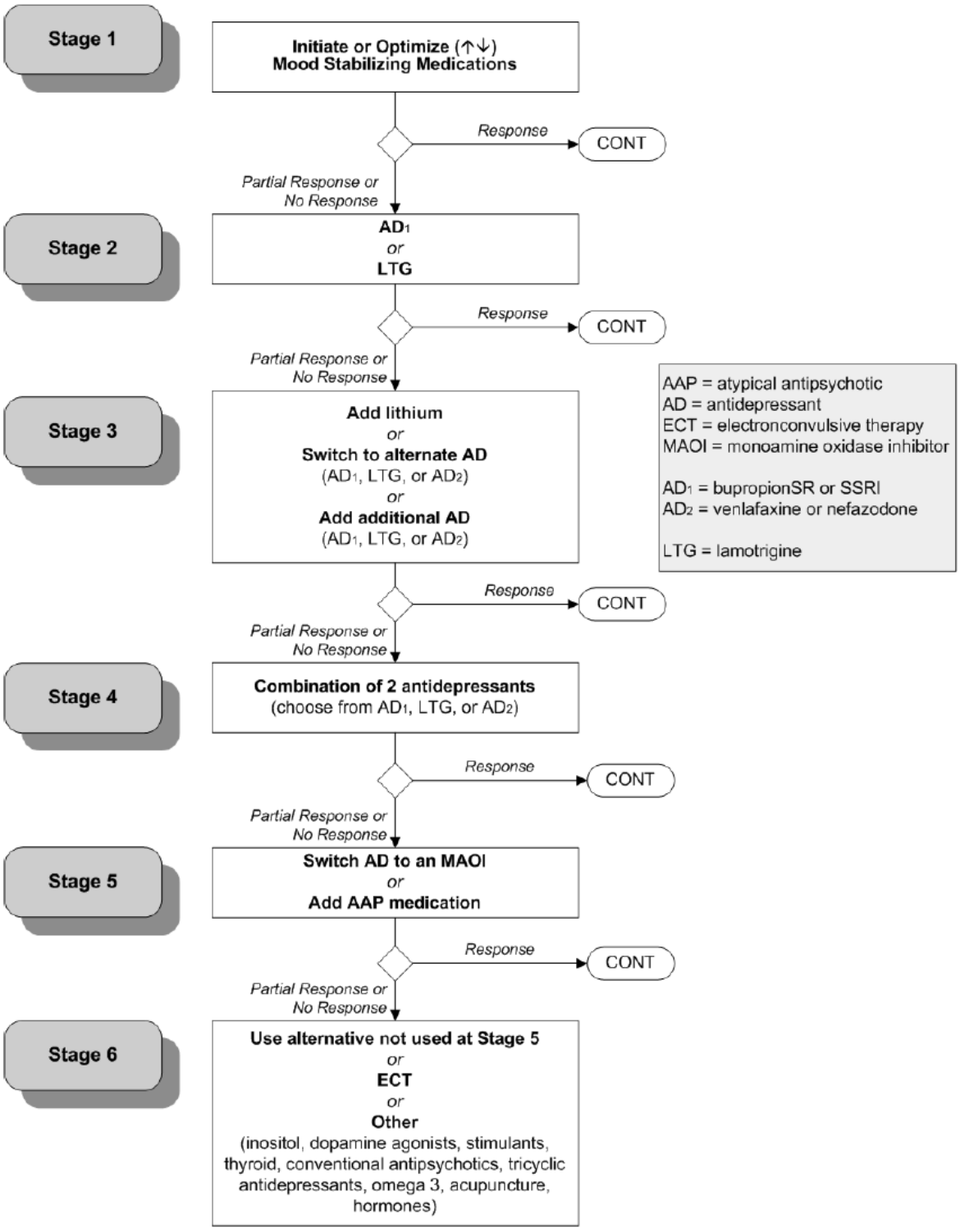
[d] Acceptable TCAs for psychotic depression include: desipramine (DMI), nortriptyline (NT), amitriptyline (AMI), clomipramine (CMI), or imipramine (IMI).

[e] T_3 thyroid medication Cytomel (triiodothyronine) is suggested before T_4 Synthroid.

Algorithm for the Treatment of Mania\Hypomania



Algorithm for the Treatment of Depression in Bipolar Disorder*



*To be used in conjunction with primary treatment algorithm.

APPENDIX D: MPRI MODEL

The MPRI Model begins with the three-phase re-entry approach of the Department of Justice's Serious and Violent Offender ReEntry Initiative (SVORI); further delineates the transition process with the seven decision points of the National Institute of Corrections' Transition from Prison to Community Initiative (TPCI) model; and incorporates into its approach the policy statements and recommendations from the Report of the ReEntry Policy Council coordinated by the Council of State Governments. The principles of Evidence Based Practice (EBP) are one of the cornerstones of MPRI model implementation.

The **VISION** of the Michigan Prisoner ReEntry Initiative is that every inmate released from prison will have the tools needed to succeed in the community.

The **MISSION** of the Michigan Prisoner ReEntry Initiative is to reduce crime by implementing a seamless plan of services and supervision developed with each offender—delivered through state and local collaboration—from the time of their entry to prison through their transition, reintegration, and aftercare in the community.

The **GOALS** of the Michigan Prisoner ReEntry Initiative are to:

- **Promote public safety** by reducing the threat of harm to persons and their property by released offenders in the communities to which those offenders return.
- **Increase success rates of offenders** who transition from prison by fostering effective risk management and treatment programming, offender accountability, and community and victim participation.

Building Safer Neighborhoods & Better Citizens: A Comprehensive Approach

Michigan is a leader in prisoner re-entry and is the first state in the nation to converge the three major schools of thought on prisoner re-entry to develop and fully implement a comprehensive model of inmate transition planning. The MPRI Model:

- Begins with the three-phase re-entry approach of the Department of Justice's Serious and Violent Offender ReEntry Initiative (SVORI).
- Further delineates the transition process by adding the seven decision points of the National Institute of Corrections' Transition from Prison to Community Initiative (TPCI) model.
- Is now incorporating into our approach the policy statements and recommendations from the Report of the ReEntry Policy Council that is coordinated by the Council of State Governments.

THE THREE-PHASE, SEVEN DECISION-POINT MPRI MODEL

The MPRI Model involves improved decision making at seven critical decision points in the three phases of the custody, release, and community supervision/discharge process.

PHASE ONE—GETTING READY

The **institutional phase** describes the details of events and responsibilities which occur during the offender's imprisonment from admission until the point of the parole decision and involves the first two major decision points:

1. ***Assessment and classification*:** Measuring the offender's risks, needs, and strengths.
2. ***Prisoner programming*:** Assignments to reduce risk, address need, and build on strengths.

PHASE TWO—GOING HOME

The **transition to the community or re-entry phase** begins approximately six months before the offender's target release date. In this phase, highly specific re-entry plans are organized that address housing, employment, and services to address addiction and mental illness. Phase Two involves the next two major decision points:

3. ***Prisoner release preparation*:** Developing a strong, public-safety-conscious parole plan.
4. ***Release decision making*:** Improving parole release guidelines.

PHASE THREE—STAYING HOME

The **community and discharge phase** begins when the prisoner is released from prison and continues until discharge from community parole supervision. In this phase, it is the responsibility of the former prisoner, human services providers, and the offender's network of community supports and mentors to assure continued success. Phase Three involves the final three major decision points of the transition process:

5. ***Supervision and services*:** Providing flexible and firm supervision and services.
6. ***Revocation decision making*:** Using graduated sanctions to respond to behavior.
7. ***Discharge and aftercare*:** Determining community responsibility to "take over" the case.

CASE MANAGEMENT AND TRANSITION ACCOUNTABILITY PLANS

The lynchpin of the MPRI Model is the development and use of Transition Accountability Plans (TAPs) at four critical points in the offender transition process that succinctly describe for the offender, staff, and community exactly what is expected for offender success. The TAPs, which consist of summaries of the offender's Case Management Plan at critical junctures in the transition process, are prepared with each prisoner at prison intake, at the point of the parole decision, when the offender returns to the community, and when the offender is to be discharged from parole supervision. TAPs are concise guides for the prisoners and staff:

- ***TAP 1*:** The expectations for the prison term that will help prisoners prepare for release.
- ***TAP 2*:** The terms and conditions of offender release to communities.
- ***TAP 3*:** The supervision and services offenders will experience in the community.
- ***TAP 4*:** The elements of the Case Management Plan for eventual discharge from parole.

The Transition Accountability Plan (TAP) integrates offenders' transition from prisons to communities by spanning phases in the transition process and agency boundaries. TAP is a collaborative product involving prison staff, the offender, the releasing authority, community supervision officers, human services providers (public and/or private), victims, and neighborhood and community organizations. TAP describes actions that must occur to prepare individual offenders for release from prison, defines terms and conditions of their release to communities, specifies the supervision and services they will experience in the community, and describes their eventual discharge to aftercare upon successful completion of supervision. The objective of the TAP is to increase both overall community protection by lowering risk to persons and property and by increasing individual offender's prospects for successful return to and self-sufficiency in the community.

The TAP process begins soon after offenders enter prison and continues during their terms of confinement, through their release from prison, and continues after their discharge from supervision as an evolving framework for aftercare provided by human service agencies or other means of self-help and support. **At each step along this continuum TAP is administered by a Transition Team, whose members include prison staff, parole supervision staff, and community agencies and service providers.** The membership of the Transition Management Team and their respective roles and responsibilities will change over time. During the institutional phase prison staff may lead the team. During the reentry and community supervision phase parole officers may lead the team. During the reintegration phase human services agencies or community services providers may lead the team. After offenders have successfully completed community supervision, their TAP may continue and be managed by staff of human services agencies, if the former offender chooses to continue to seek and receive services or support. At each stage in the process Team members will use a case management model to monitor progress in implementing the plan.

TAP reduces uncertainty in terms of release dates and actions (and timing of actions) that need to be taken by prisoners, prison staff, the releasing authority, community supervision staff, and partnering agencies. Increased certainty will motivate prisoners to participate in the TAP process and to become engaged in fulfilling their responsibilities and will ensure that all parties are held accountable for timely performance of their respective responsibilities.

The TAP process is built on the following principles:

1. The TAP process starts during an offender's classification soon after their admission to prison and continues through their ultimate discharge from community supervision.
2. TAPs define programs or interventions to modify individual offender's dynamic risk factors that were identified in a systematic assessment process.
3. TAPs are sensitive to the requirements of public safety, and to the rational timing and availability of services. In an ideal system, every prisoner would have access to programs and services to modify dynamic risk factors. In a system constrained by finite resources, officials need to rationally allocate access to services and resources, using risk management strategies as the basis for that allocation.
4. Appropriate partners should participate in the planning and implementation of individual offender's TAPs. These include the offender, prison staff, releasing authorities, supervision authorities, victims, offenders' families and significant others, human service agencies, and volunteer and faith-based organizations.
5. Individual TAPs delineate the responsibilities of offenders, correctional agencies and system partners in the creation, modification, and effective application of the plans, and hold them accountable for performance of those responsibilities.
6. TAPs provide a long-term road map to achieve continuity in the delivery of treatments and services, and in the sharing of requisite information, both over time and across and between agencies.
7. A case management process is used to arrange, advocate, coordinate, and monitor the delivery of a package of services needed to meet the specific offender's needs. During the prison portion of TAP, prison staff functions as case managers. As offenders prepare for release and adjust to community supervision, their parole officer will become the case manager. When they are successfully discharged from supervision, a staff member from a human service agency may assume case management responsibilities for former offenders who choose to seek services or support.

(The MPRI Model)

Transition Accountability Plan

MPRI Process Flowchart