Drug Court Practitioner
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Six Steps to Improve Your Drug Court Outcomes for Adults with Co-Occurring Disorders

By Henry J. Steadman, Roger H. Peters, Christine Carpenter, Kim T. Mueser, Norma D. Jaeger, Richard B. Gordon
Carol Fisler, Stephen Goss, Eric Olson, Fred C. Osher, Chanson D. Noether, and Carolyn Hardin.

One of the biggest challenges for drug courts is effectively working with participants with co-occurring disorders. By de nition, persons with the dual diagnosis of both substance use disorders and mental illnesses have co-occurring disorders. All mental disorders, such as schizophrenia, bipolar disorder, posttraumatic stress disorder (PTSD), or severe depression, increase the chances of having a drug- or alcohol-use disorder, leading to a co-occurring disorder (Kessler et al., 2005; Grant et al., 2004). While some people with profound impairments related to their mental illnesses will be inappropriately referred to adult drug courts and need other options, these participants will be a small minority of persons with mental illnesses (Kessler et al., 1996). The National Drug Court Institute and Substance Abuse and Mental Health Services Administration's (SAMHSA's) GAINS Center believe that every adult drug court can achieve positive outcomes for persons with co-occurring disorders— if the

Treatment Court Models

Adult treatment courts generally comprise three main types: drug courts, mental health courts, and co-occurring courts. Drug courts are the most abundant and standardized because of federal funding and regulation. Mental health courts and co-occurring courts are alternatives to incarceration and are more varied as a result of evolving independently in their jurisdictions. Table 1 on page 2 highlights some major differences between these treatment courts.

Flexibility

No matter which type of court you have, the key to treating participants with co-occurring disorders is flexibility. People with difficulty thinking, concentrating, or controlling emotions are not able to successfully participate in standard therapeutic groups or 12-step programs (Mueser et al., 2003). However, remaining flexible and using individualized criteria does not mean the participant faces no rules or expectations for change. Courts might need to apply a different paradigm to

participants with co-occurring disorders to achieve best outcomes, revisiting standardized responses to participant failures.

Overlapping Populations

Persons with co-occurring mental illnesses and substance use disorders are in all three types of adult treatment courts. Best estimates are that 30%–40% of current drug court participants have diagnosable mental illnesses, 75%–80% of mental health court enrollees have substance use disorders, and, by de nition, all co-occurring court participants have both disorders (Blenko, 2001; Almquist & Dodd, 2009). All of these courts share the goal of reducing the unnecessary penetration into the criminal justice system of persons with mental illnesses, substance use disorders, or both

substance use disorders, (3) the severity of mental and substance use disorders, including the degree of functional impairment, (4) criminal justice history and risk for criminal recidivism, and (5) prior involvement in behavioral health treatment services. Few persons with co-occurring disorders have received specialized (i.e., integrated) behavioral health services either in the general community (SAMHSA, 2009) or in the criminal justice system (Chandler et al., 2004).

Rates of Co-Occurring Disorders in the Criminal Justice System

Persons in the criminal justice system have rates of mental, substance use, and co-occurring disorders that greatly exceed those found in the general population. For example, a recent study conducted in jails (Steadman et al., 2009) found that 17% of males and 34% of females have either a major depressive disorder, a bipolar disorder, a schizophrenic spectrum disorder, or PTSD. Among prisoners in substance abuse treatment programs, one-third were found to have either a major mood disorder (e.g., bipolar disorder, depression) and 3% were found to have psychotic disorders (Grella et al., 2008). From 70%–74% of persons in the justice system who have mental disorders also have co-occurring substance use disorders (Baillargeon et al., 2010; James & Glaze, 2006). Many others in the criminal justice system have less serious, mental disorders, including approximately 25% who have anxiety disorders (Grella et al., 2008; Zlotnick et al., 2008). Extrapolating from these studies, approximately 12% of males and 24% of females in the criminal justice system have co-occurring disorders.

Trauma and Mental Illness

People with co-occurring disorders are much more likely than the general population to be exposed to a range of traumatic events (such as physical or sexual abuse, the unexpected loss of a loved one, or witnessing violence) both before and after the onset of their disorders. Individuals who have been traumatized as children or adolescents are at increased vulnerability to subsequent retraumatization, which can destabilize both psychiatric and substance use disorders. Therefore courts must have an understanding of the effect of trauma on participants with co-occurring disorders to properly address treatment needs and avoid inadvertent retraumatization.

The most common consequences of exposure to signi cant trauma are acute stress disorders, and adjustment disorders. Another consequence of significant trauma is PTSD, a disorder characterized by symptoms such as reexperiencing the traumatic event (e.g., intense memories, ashbacks, nightmares), avoidance of trauma-related stimuli (e.g., avoidance of people, places, or things that remind them of traumatic events), and physiological overarousal (e.g., exaggerated startle response, increased heart rate and perspiration, anger). PTSD is common in people with a serious mental illness, an addiction, or co-occurring disorders. Most estimates of current PTSD within the co-occurring disorders population range between 20%–40% compared with the lifetime prevalence of PTSD in the general population of 10%. Untreated PTSD can lead to worse outcomes for people with co-occurring disorders, including dropout from treatment, relapse of substance abuse or mental health symptoms, and reoffending.

Despite the high prevalence of PTSD in people with co-occurring disorders, it is not routinely screened for or evaluated in most treatment settings. To make matters worse, people with PTSD usually avoid talking about their traumatic experiences and their PTSD symptoms unless directly asked. Some mental health and addiction specialists have been taught not to inquire about trauma history for fear of opening Pandora's box and retraumatizing the individual. However, research and modern practices show that trauma and PTSD can safely and effectively be evaluated in people with co-occurring disorders without risking destabilizing their mental illness or addiction. Accurate and routine screening for and assessment of trauma exposure and PTSD is important in people with co-occurring disorders to ensure they receive the treatment they need. Cognitive-behavioral treatments for PTSD such as desensitization and cognitive restructuring have been shown to be effective in the general population, and these approaches can be successfully adapted for people with co-occurring disorders in the criminal justice system.

Identifying Appropriate Candidates for Drug Courts

Research clearly indicates that intensive behavioral health treatment services in the criminal justice system should be prioritized for those who are at high risk for criminal recidivism (e.g., new crimes or technical violations;

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will require specialized interventions such as integrated cognitive-behavioral treatment, co-occurring disorders tracks or groups, adaptations to status hearings, and speci cally trained supervision teams (Peters et al., 2012).

Participants with co-occurring disorders may have specialized needs that interfere with their engagement at court. Your drug court might have to address not only the more obvious need for treatment of mental disorders such as PTSD, but also more mundane needs such as better literacy skills, housing, medical care, and transportation.

The court should also consider the criminal history of the participant and the nature and severity of the current charge. A violent history or offense is subject to scrutiny before admission but should not be an automatic disquali er.

Support Groups

Courts that look to the traditional recommendation that their participants join Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) as part of the support network may need to rethink this process. Since participants in co-occurring disorders programs may not be able to handle stress in a group setting or feel comfortable contributing to a group discussion, AA or NA might not be as appropriate for participants with co-occurring disorders as they are for the traditional drug court participants.

The team should identify appropriate support groups, such as Double Trouble in Recovery, that address both the substance abuse and mental illness. Any support group referrals, such as to 12-step programs like AA, should be preceded by some preparation of the participant as to what he or she will encounter. Programs such as Project Match's Twelve-Step Facilitation are a valuable resource for that preparation. Participants with co-occurring disorders should also be reassured that just listening is acceptable participation.

Working with the Family

The family of the participant can be an invaluable asset and support to the court, the team, and the participant. Unfortunately, many individuals with co-occurring

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- Continued engagement and progress in treatment
- Stable home plan
- Establishment of a support network
- Completion of special probation terms such as paying program costs, making restitution, or participating in community service

The goal of adapting expectations within a phase system is to allow ea0 1hogrvice

importance of engaging people with an addiction in long-term substance abuse recovery, people with a serious mental illness bene t most from long-term mental health treatment and rehabilitation addressing the broad range of their needs.

Connecting people with co-occurring disorders to the services they most need is facilitated by knowledge of which treatments research has demonstrated as effective or promising for serious mental illness. Medication is a mainstay in such treatment, but for most people, medication alone is insuf cient. Other services are needed to help them cope more effectively with their illness and to function better in their lives. Table 2 provides a summary of evidence-based and promising treatments for people with serious mental illness, including the focus of each intervention and a summary of how it works. While not every intervention will be available to people in a particular area, many services should be available, and the more needed interventions that an individual can access, the more effective their treatment will be.

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magnitude sanctions for difficult distal behaviors (Marlowe 2012a).

All individuals with a co-occurring substance use and psychiatric disorder should have an individualized relapse prevention plan developed as part of their treatment. Despite developing such a plan, relapses may occur. A relapse is an opportunity to reevaluate and modify the participant's treatment plan, including their relapse prevention plan, based on an understanding of the possible factors that may have contributed to the relapse (e.g., increased levels of stress or exposure to substances). Life improvements, such as working at a new job, resuming an educational program, or developing new relationships, naturally involve change, which can open the door for a mild increase or relapse in symptoms or a relapse of substance use. However, relapses can often be prevented or minimized through collaboration on treatment and by developing or modifying a relapse prevention plan as needed. All efforts by the participant to move forward and improve his or her life should be reinforced. Furthermore, not making efforts to change and improve life has its own hazards, including excessive unstructured time and lack of meaningful roles, which can worsen mental health symptoms and contribute to substance abuse.

In line with the need to individualize treatment plans, the plan for supervision must also be specific to the individual's circumstances and needs. Some participants require closer supervision (e.g., more frequent status hearings, home visits by probation, anklet monitoring, or more frequent drug tests) to ensure they are following through on their co-occurring disorders treatment plans and to identify problems as soon as they appear. Close supervision is especially important in individuals with serious mental illness and co-occurring substance abuse, and it provides more opportunities to help individuals get back on their personal road to recovery.

Intervention	Goals	Additional Information
Medications	• Symptom reduction • Prevention of relapses and hospitalizations	• Medications are provided by psychiatrist, other doctor, or other licensed prescriber, and monitored monthly or more often. • Antipsychotic medications reduce psychotic symptoms and mood swings (mania). • Antidepressants reduce depression and anxiety. • Mood stabilizers reduce mood swings (mania). • Long-acting ('depot') antipsychotic medications are available by injection every 2–4 weeks.

TABLE 2 Evidence-Based & Promising Services for Serious Mental Illness (continued)

Intervention	Goals	Additional Information
Supported Employment	• Competitive jobs paying competitive wages in the community	• Include all participants who want to work in the supported employment program. • Add participants with rapid job search without requiring prevocational training. • Pay attention to individual preferences regarding preferred type of work and disclosure of mental illness. • Provide follow-along supports after job acquisition to facilitate maintenance. • Integrate vocational and clinical services. • Provide counseling on employment bene ts such as SSI, SSDI, and insurance.
Illness Management & Recovery	• Improved capacity for shared decision-making about treatment options • Reduction of symptom severity & distress • Reduction of relapses & hospitalizations	• Provide psychoeducation about mental illness and its treatment. • Teach medication adherence strategies. • Build social support. • Improve self-management of stress and persistent symptoms. • Develop a relapse prevention plan.
Family Psychoeducation	• Improved understanding by family & participant of mental illness • Reduction of stress & tension in family • Improved monitoring of mental illness & prevention of relapses & hospitalizations • Increased support for participant's treatment goals	• Mental health professionals lead single-family or multiple-family group psychoeducation sessions. • Develop a collaborative relationship between family and treatment team. • Provide psychoeducation about mental illness and its treatment. • Teach communication and problem solving skills to reduce family stress. • Develop a relapse prevention plan with the family.
Supported Housing	• Stable, independent housing in community	• Help provide access to independent, stable housing regardless of individual's clinical status. • Set up or work with supports in community to sustain stable housing. • Provide practical help with paying bills, apartment maintenance, and solving everyday problems.

TABLE 2 Evidence-Based & Promising Services for Serious Mental Illness (continued)

Intervention	Goals	Additional Information
Cognitive Behavior Therapy	▪ Reduction of symptom severity or distress related to the following: ¾ Hallucinations or delusions ¾ Depression or suicidal thinking ¾ Anxiety, including PTSD ¾ Urges to use substances ¾ Criminogenic thinking	▪ Conduct 10–25 time-limited individual or group psychotherapy sessions aimed at helping people recognize and change inaccurate thoughts and beliefs that lead to negative feelings and maladaptive behaviors. ▪ Help participant evaluate evidence supporting upsetting thoughts, and change self-defeating thinking (such as catastrophizing) to more helpful thinking. ▪ Teach how to gather more information about upsetting thoughts and beliefs to better evaluate their accuracy. ▪ Problem solve how to handle challenging situations not due to inaccurate, self-defeated thinking.
Social Skills Training	▪ Improved social relationships & independent living skills ▪ Development of healthy & legal leisure & recreational activities ▪ Improved social skills regarding the following: ¾ Refusing offers of alcohol or drugs ¾ Resolving interpersonal con ict ¾ Self-assertion & expression of feelings ¾ Job performance	▪ Conduct group-based training of social skills based on role playing to practice appropriate skills in social situations. ▪ Break down complex skills into smaller steps to facilitate gradual shaping of skills through multiple role plays. ▪ Assign homework for the practice of skills, including trips out into the community. ▪ Elicit natural supports (such as family) who can prompt appropriate use of skills in natural situations.
Case Management	▪ Engagement & retention of individuals in treatment ▪ Identi cation & coordination of treatment & living needs ▪ Address needs relating to other systems, such as criminal justice, medical, & protective services	▪ Individual case manager or team helps the participant perform these goals and the tasks needed to accomplish them. ▪ Meet regularly with the participant. ▪ Evaluate needs, referrals to treatment, and maintenance of outcomes. ▪ Coordinate services between different treatment providers. ▪ Assist with applying for medical and other bene ts. ▪ Set up more intensive community approaches (e.g., assertive community treatment, intensive case management) for people with multiple hospitalizations or homelessness.

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adults who are homeless (or at risk) and have a mental illness or a co-occurring substance use disorder. SOAR-trained case managers can dramatically reduce delays in receiving SSI/SSDI bene ts.

Vocational and Educational Services

One of the most positive contributions of drug courts has been achieving long-term rehabilitation of participants' employment and educational status. For participants with co-occurring disorders, the services of vocational rehabilitation programs have been invaluable. From employability assessment and identi cation of needed job skills to vocational training or job placement and direct assistance in removing barriers, vocational rehabilitation programs are a major resource that should be tapped. Other community resources, such as high school educational programs (e.g., GED), vocational programs at community colleges, and other educational services, are also important resources. Finally some participants may be eligible for mental-health-supported employment. Case management is key to the connection and advocacy that will enable many participants to nd meaningful and economically bene cial work.

Primary Health Care

While attention to both substance use and mental health issues will be the initial and primary focus of the case management plan, health and nutrition should not be overlooked. As recently reported in a Dartmouth study:

> People with serious mental illnesses are at risk of premature death, largely due to cardiovascular and metabolic disorders associated with obesity, sedentary lifestyle, and smoking. Until very recently, mental health services have neglected prevention and health promotion as a core service need for people with serious mental illnesses. (Bartels & Desilets 2012)

Obtaining primary, and in some cases specialist, health care with effective referral and follow-up is a very important long-term recovery strategy for participants with co-occurring disorders. Dental needs should not be neglected since participants with co-occurring disorders frequently have chronic or acute dental pain and related ongoing systemic infections.

Case management can be the critical bridge to the more traditional community health care resources such as the network of federally quali ed health centers across the nation.

Community Supervision

Treatment and supervision needs of participants with co-occurring disorders are beyond those of the general drug court population, but much has been learned in recent years about effective rehabilitation and supervision. Lessons learned include such practices as the following:

- The level of supervision should be dictated according to the assessed risk for recidivism, with more intensive supervision provided to those individuals assessed as being high risk and less intensive supervision for those with lower risk. In addition, supervision of persons with mental illness should emphasize the development of a helping relationship rather than solely a surveillance approach.
- Interventions should target specific criminogenic needs as identi ed through a validated risk and needs assessment. In the case of a participant assessed as having significant antisocial attitudes and values, cognitive restructuring, which addresses criminal thinking, should be included among the interventions used. If procriminal associates are an identi ed risk factor, efforts should be made to redirect the participant to prosocial peer activities and recover support groups. Basic living needs must be addressed such as income assistance, housing, and employment services. Poor problem solving skills or limited self-regulation skills should be addressed through speci c life skills training.
- Supervision should take into consideration the abilities of the participant and function within that framework. (Skeem & Petrila, 2004; Skeem, Encandela, & Louden, 2003).

However, applying these practices within the traditional drug court framework can be challenging. Often there is a one-size- ts-all regimen of supervision. Supervision personnel may lack knowledge of the limitations or cognitive impairments experienced by persons with certain diagnoses. In addition, the agencies delivering the needed services are generally overburdened and underfunded. The result of such factors is that gaining access to needed

Probation of cers or other community supervision agents can be a first line of defense in seeing that this does not happen. As eld agents, they are sometimes the rst to encounter issues that confront participants engaged in the drug court program. Probation of cers are in a position to respond, which can potentially counteract the delays that might adversely affect participants with co-occurring disorders. Therefore it is important for the probation of cer to develop a close working relationship with key treatment providers as a means of assisting participants in accessing treatment as

collaboration is that the efforts of all are directed toward a common goal. This is such an important element of drug courts that it is sixth of the Ten Key Components, which states that “a coordinated strategy governs court response to participant compliance” (Bureau of Justice Assistance & NADCP, 1997). However it is not safe to assume that the goals of each partner to the enterprise are mutually understood and held in common. The individual agencies involved in drug courts frequently see their mission and goals differently. An effective coordinated strategy depends on explicitly clarifying the goals of the drug court. Only from clearly articulated and shared goals and collectively agreed-upon objectives and behavior-changing strategies will true collaboration take place. Court goals and objectives should be codi ed in the initial planning effort when a drug court is established, but it must be revisited as new members join the team. In many courts, mental health professionals will be relatively new team members with knowledge to impart and knowledge to learn in order to help the team understand and address participants’ co-occurring disorders.

Developing a Common Understanding

In working toward shared goals and a coordinated approach, team members must come to a common understanding of fundamental knowledge. Each member of the team contributes a professional knowledge base from which key pieces must become commonly understood. For this reason interdisciplinary training is an important and ongoing team responsibility. In the press of time, this interdisciplinary training is often sacri ced. While mutual respect and common civility may facilitate a super cial level of team work, only real understanding will support true collaboration and lead to establishing court goals and objectives that work well. Each team member must think through and identify the fundamental knowledge that the team nee4m [(inter)20(disciplinarB1d Tf 0.016 j1766eu Tw 10.5 0 0 10.5 54 206.306s93ne6 >>BDC BT /T1_2 1 Tf

Educational Resources

Trainings

- Improving Your Drug Court Outcomes for Individuals with Co-Occurring Disorders: www.ndci.org

Web Sites

For up-to-date information on Co-Occurring disorders

- SAMHSA Co-Occurring Disorders: http://www.samhsa.gov/co-occurring/
- Mental Health America, Co-Occurring Disorders: http://www.mentalhealthamerica.net/go/co-occurring-disorders

For information on finding local support

- Behavioral Health Evolution, Double Trouble in Recovery: http://www.bhevolution.org/public/doubletroubleinrecovery.page
- National Alliance on Mental Illness: www.NAMI.org
- National Association of State Mental Health Program Directors: www.nasmhpd.org

For online articles and publications

- Policy Research Associates, Publications: http://www.prainc.com/projects-services/projects-national-centers/publications/
- SAMHSA's GAINS Center: http://gainscenter.samhsa.gov/topical_resources/cooccurring.asp

Recommended Reading

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Screening

Mental Health

- Brief Jail Mental Health Screen
- GAIN-SS
- SHSF-III
- MINI-Screen

Trauma and PTSD

- Primary Care PTSD Screen (PC-PTSD)
- PTSD Checklist—Civilian Version (PCL-C)
- Stressful Life Events Screening Questionnaire—Revised (SLESQ-R)—This can help identify previous traumatic events, and the PTSD screens (e.g., PC-PTSD, PCL-C) can then be used to examine the current level of impairment related to each of these events.

Cognitive, Intellectual, and Other Areas of Functional Impairment

- Beta-III or the WAIS-Abbreviated Scale of Intelligence (WASI)
- Montreal Cognitive Assessment (MOCA) and the Mini-Mental State Examination, 2nd Edition (MMSE-2)
- Role Functioning Scale—This examines four areas of adult functioning: work productivity, independent living and self-care, immediate social-network relationships, and extended social-network relationships.

Screening for Substance Use Disorders

A number of substance abuse screening instruments are available at nominal cost, free of charge, or are in the public domain. Several evidence-based substance abuse screening instruments are listed below:

- Addiction Severity Index (ASI)—Alcohol and Drug Abuse sections
- GAIN-SS
- Simple Screening Instrument (SSI)
- Texas Christian University Drug Screen—II (TCUDS-2)

Assessment

Diagnosis and Assessment of Mental Disorders

- Millon Clinical Multiaxial Inventory—III (MCMI-III)
- Minnesota Multiphasic Personality Inventory—2 (MMPI-2)
- Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)
- Personality Assessment Inventory (PAI)
- Assessment of Substance Abuse and Related Psychosocial Areas
- Addiction Severity Index—5th Edition (ASI)
- Global Appraisal of Needs (GAIN-Q and GAINI instruments)
- Texas Christian University, Institute of Behavioral Research (Brief Intake Interview, Comprehensive Intake)

Assessment of Criminal Risk

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Improving Drug Court Outcomes for Adults

TABLE 3 Keys to Success (continued)

Target Your Case Management & Supervision

DC Component or Process *	Adaptations & Considerations for Participants with COD †
UCoordination of services UMonitoring UGraduated rewards & sanctions Key Components 1, 2, 5, 6, & 7	1. People with co-occurring disorders have more complex case management needs than typical drug court participants. Elements of a case management plan may include the following: ¾Assisting with access to treatment ¾Medication assessment and management ¾Housing ¾Financial management ¾Vocational & educational services ¾Primary health care 2. Adjust case management structure to maintain lower participant/staff ratios. 3. Functional limitations may interfere with a participant's ability to comply with the court's requirements. 4. A supportive relationship between a participant and the person providing supervision (probation of cer or other court team member) will facilitate compliance with court requirements. Three qualities are especially important: ¾Alliance, or achieving a sense of partnership so that the participant perceives that the supervision of cer is committed to his or her success ¾"Firm but fair" approach, which emphasizes respect and exible consistency ¾Problem-solving, rather than punitive, approach to noncompliance

Expand Mechanisms for Collaboration

DC Component or Process *	Adaptations & Considerations for Participants with COD †
UCourt team UPartnerships Key Components 3, 6, 9, & 10	1. Standard principles of collaboration in drug courts are especially important as new team members and stakeholders join in to support participants with co-occurring disorders. 2. Potential mental health partners include the following: ¾Crisis intervention teams at local law enforcement ¾Mobile crisis teams ¾Hospital emergency departments & behavioral health units ¾Community mental health treatment & psychiatric rehabilitation agencies ¾Assertive community treatment teams ¾Behavioral health agencies that offer integrated mental health and substance abuse treatment or residential behavioral health treatment ¾Supportive housing providers ¾Advocacy and peer/family support organizations

*DC: drug court †COD: co-occurring disorders

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Educate Your Team	
DC Component or Process *	Adaptations & Considerations for Participants with COD †
Interdisciplinary education Key Component 9	1. Interdisciplinary co-occurring disorders education efforts should include personnel who are not members of the court team, especially people who are often the first points of contact with the justice system for individuals with co-occurring disorders: police officers, jail personnel, and first appearance courtroom staff. 2. Team members should understand:

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