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Screening and Assessment of Co-occurring Disorders in the Justice System: A Webinar-Supporting Document

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



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

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



Defining Screening and Assessment

Screening for CODs in the justice system is used to identify problems related to mental health, substance use, trauma/PTSD, criminal risk, other areas that are relevant in determining the need for specialized services (including treatment, case management, and community supervision), and the need for further assessment. Screening also helps to identify acute issues that require immediate attention, such as suicidal thoughts or behaviors, risk for violence,

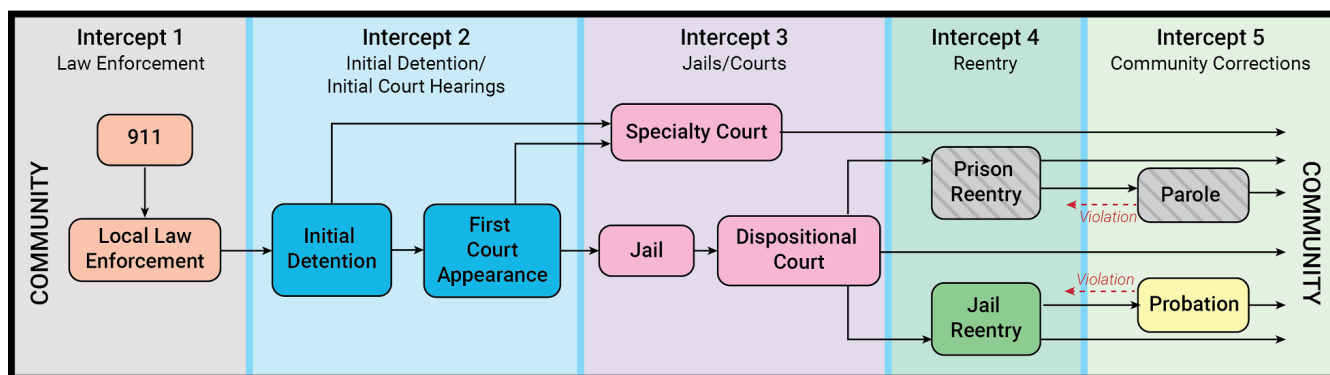
withdrawal symptoms and detoxification needs, and symptoms of serious mental disorders. Often, multiple screenings are used simultaneously to identify problem areas that require referral or additional

assessment. This may be particularly useful at the point of first appearance hearings/pretrial release or at the time of case disposition. Due to the volume of people processed at different points in the justice system, such as booking in larger jails, intake in prison reception centers, and first appearance hearings, it is impractical (and unnecessary) to routinely provide a full psychosocial assessment, and one or more screens will typically provide sufficient information to inform decisions about referral for services and further assessment.

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

Opportunities for Screening and Assessment

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



SAMHSA's GAINS Center. (2013). *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model* (3rd ed.). Delmar, NY: Policy Research Associates, Inc.

Figure 1. The Sequential Intercept Model

Intercept 1: Law Enforcement

In general, opportunities for screening at Intercept 1 are presented to law enforcement; other first responders, such as emergency medical technicians; and to emergency room personnel (see Figure 2). Law enforcement officers have a brief opportunity to flag signs of mental and substance use disorder and hand off individuals experiencing a mental health crisis to appropriate services. Mental health co-response services have expanded in recent years as a specialized response to mental health crises.

With the expansion of Crisis Intervention Teams has come the development of law enforcement-friendly crisis stabilization units as one-stop drop-off sites for people experiencing a mental health crisis.

Law enforcement agencies with limited training in mental health and substance use disorders are at a disadvantage in identifying and appropriately handling people with mental illness or co-occurring disorders. Eight-hour Mental Health First Aid training can provide law enforcement officers with basic skills in identifying and responding to mental illness and substance use disorders. The most comprehensive responses are by Crisis Intervention Teams, which consist of a cadre of officers who have completed 40 hours of training and are responsible for resolving calls involving people experiencing a mental health crisis. These officers often have a dedicated drop-off site, and many use checklists to aid the identification of mental illness and substance use. Tracking forms and databases are used for record-keeping and identification of repeated contacts.

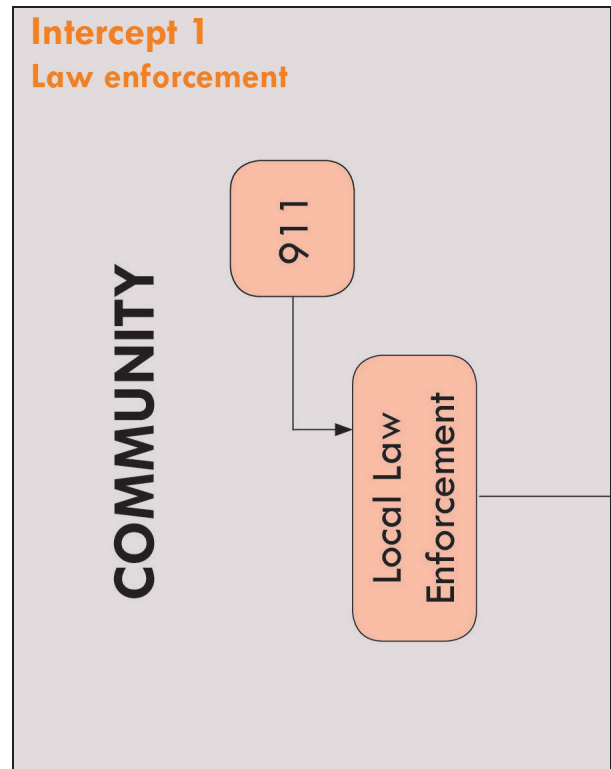


Figure 2. Intercept 1: Law Enforcement

First responders, especially law enforcement officers, are expected to resolve calls in as swift a manner as possible. Opportunities to train responders in the identification of the signs and symptoms of mental and substance use disorders and to more quickly resolve crisis situations, whether through training in de-escalation techniques or in the administration of naloxone to counter a heroin overdose, have more operational value than adding extensive screening procedures. Nevertheless, law enforcement officers should document their observations and ensure that information is provided to emergency room, crisis stabilization unit, or mobile crisis staff. Where a hand off to a health care practitioner is not possible, information should be communicated to jail booking or lockup officers.

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

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

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

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

Intercept 2: Initial Detention/Initial Court Hearings

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

Where available, the second opportunity for screening is by pretrial service staff. Pretrial services may be a function of an independent agency or probation; either way they have an opportunity to briefly screen for co-occurring disorders while developing the pretrial release/detention recommendation. In some communities, arrestees are initially detained in a police or court lockup rather than jail prior to their initial appearance. Pretrial services may be the first opportunity to screen these individuals since their being placed under arrest.

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

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

Intercept 3: Jails/Courts

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

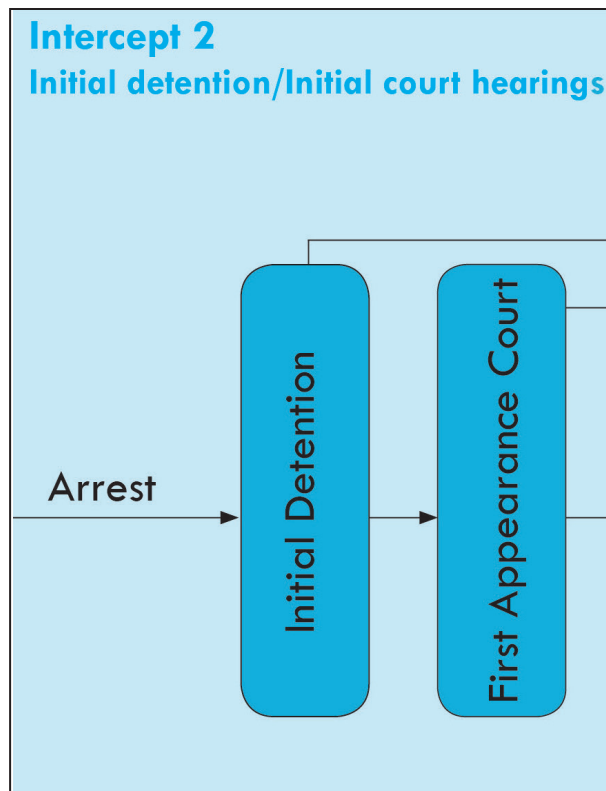


Figure 3. Intercept 2: Initial Detention/Initial Court Hearings

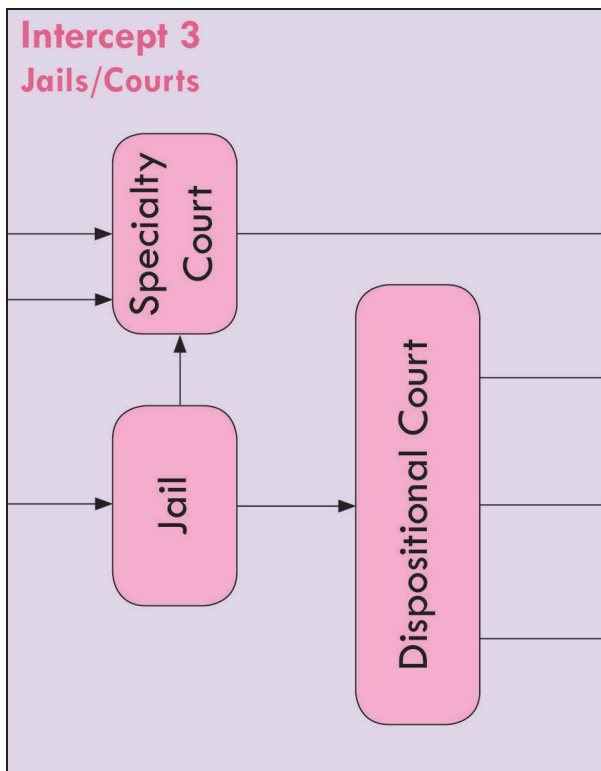


Figure 4. Intercept 3: Jails/Courts

Jail size and resources may impact the practicality of implementing comprehensive assessment procedures. The holding capacity of jails ranges from a handful of cells to space for 15,000 inmates. Small and even mid-size jails may lack the resources to provide basic screening, assessment, and treatment. These jails often rely on reach-in services by community-based providers. However, jails are required to conduct at least basic screening for suicide, mental health, and substance use. Larger jails will have in-house behavioral health professionals to conduct more intensive screening and assessment. The average jail stay is fewer than 7 days; screening and assessment information collected during the jail booking process should be used to refer and link inmates to court-based diversion programs and to community-based services upon release.

At the dispositional court, screening and assessment are important for the purpose of informing the disposition and sentencing decisions. Defense attorneys often gather information on a client's behavioral health history, even if it is not presented

in court. Public defenders in larger jurisdictions may have a staff social worker to help identify clients' treatment needs. Defender-based advocacy programs, operated by a nonprofit or a county agency, may review a client's history (i.e., criminal, familial, educational, occupational, and health) to develop a dispositional recommendation.

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

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

Intercept 4: Reentry

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

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

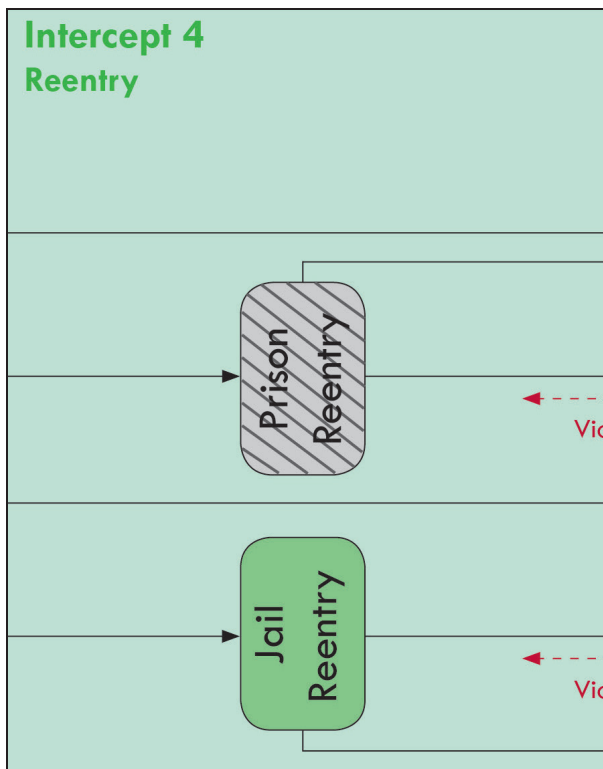


Figure 5. Intercept 4: Reentry

their jail sentence. Transition planners can also work with probation officers on the hand off for inmates being released into the custody of probation.

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

resources often falls on the parole department. Many states and communities have established transitional case management capacity to work with inmates while they are still incarcerated and for a period of time after release. As with probation agencies, prisons and parole departments are implementing risk and need assessment instruments to guide supervision and treatment programming. Information gathered from these instruments should be shared with community practitioners to better inform the treatment process.

Intercept 5: Community Corrections

Probation

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

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

appropriate supervision levels. Probationers who are struggling to comply with the terms of supervision may need to be screened for co-occurring disorders in order to determine if the noncompliance is a result of symptoms or functional impairment.

Parole

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

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

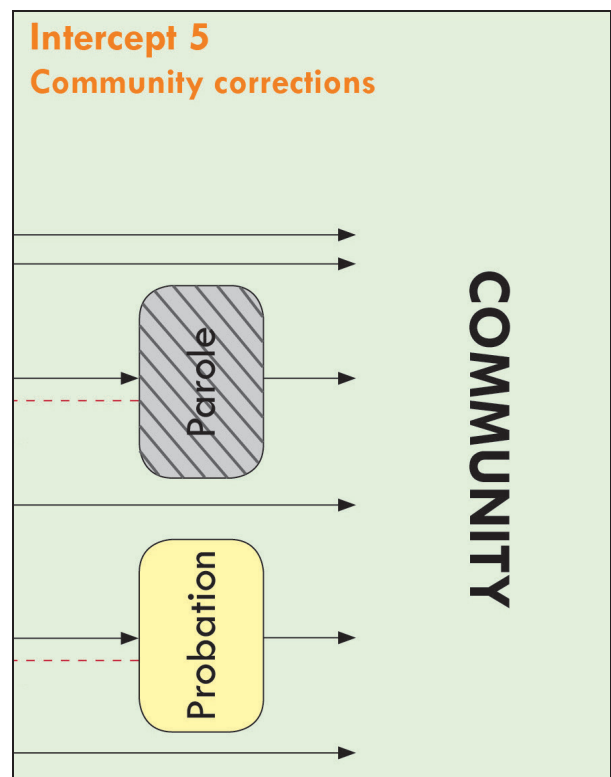


Figure 6. Intercept 5: Community

Developing a Comprehensive Screening and Assessment Approach

Integrated (or blended) screening and assessment approaches should be used to examine CODs in the justice system. In the absence of specialized instruments to address both disorders, an integrated screening approach typically involves use of a combination of mental health and substance use instruments. Integrated screening and assessment approaches are associated with more favorable outcomes among people in the justice system and in the community (Henderson, Young, Farrell, & Taxman, 2009; Hiller et al., 2011; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011) and help to maximize the use of scarce treatment resources.

Instruments for Screening and Assessing Co-occurring Disorders

Screening and assessment of CODs in the justice system should incorporate use of standardized instruments that have been validated with offender populations. Use of standardized instruments will enhance the consistency of information gathered during this process and will promote a shared understanding of important domains to be reviewed in addressing CODs. Standardized instruments that yield summary scores and scores across different domains provide a common vocabulary for staff to communicate needs for treatment, supervision, and monitoring (Fletcher et al., 2009; Taxman, Cropsey et al., 2007) across different justice settings, such as courts, probation, and reentry from custody. However, many criminal justice programs do not administer standardized instruments (Cropsey et al., 2007; Friedmann et al., 2007) and instead use improvised screening and assessment techniques that have questionable validity and that may lead to poor outcomes among offenders who have CODs.

Comparing Screening Instruments

Only a few studies have compared the effectiveness of mental health or substance use screening instruments in detecting the respective disorders (Peters et al., 2000; Sacks et al., 2007b). As part of

the NIDA Criminal Justice–Drug Abuse Treatment Studies (CJ-DATS) network, a multisite study was conducted to identify effective screening instruments for CODs among individuals enrolled in prison-based addiction treatment (Sacks et al., 2007b). The effectiveness of the Global Appraisal of Individual Needs–Short Screener (GAIN-SS), the Mental Health Screening Form-III (MHSF-III), and the Mini International Neuropsychiatric Interview–Modified (MINI-M) were compared by examining results from the SCID, a comprehensive diagnostic interview, which served as the criterion measure. The MHSF-III and the GAIN-SS had somewhat higher overall accuracy than the MINI and had higher sensitivity than the MINI in detecting mental disorders (Sacks et al., 2007b). However, each of the mental health screens performed adequately in detecting severe mental disorders (i.e., bipolar disorder, major depressive disorder, and schizophrenia). These mental health-screening instruments were found to have somewhat higher overall accuracy among male offenders.

One study examined the effectiveness of substance use screening instruments among prisoners (Peters et al., 2000). Three instruments were found to be the most effective in identifying individuals with substance use disorders, as determined by the SCID diagnostic interview: the Simple Screening Instrument (SSI), the Texas Christian University Drug Dependence Screen V (TCUDS V), and a combined measure that consisted of the Alcohol Dependence Scale (ADS) and Addiction Severity Index (ASI)–Drug Use section. These instruments outperformed several other substance use screens, including the Michigan Alcoholism Screening Test (MAST)–Short version, the ASI–Alcohol Use section, the Drug Abuse Screening Test (DAST- 20), and the Substance Abuse Subtle Screening Inventory (SASSI-2) on key measures of positive predictive value, sensitivity, and overall accuracy.

Subsequent sections describe a range of available mental health and substance screening instruments, as well as those examining both mental and substance use disorders.

Recommended Screening Instruments

Specific instruments are recommended for screening of mental disorders, substance use disorders, co-occurring mental and substance use disorders, motivation and readiness for treatment, trauma/PTSD, and suicide risk. These screening instruments can generally be administered by nonclinicians and without extensive specialized training, although staff need to be knowledgeable about how to refer offenders who are positively identified by screens to appropriate services. Recommendations are based on a critical review of the research literature examining each area of screening. In addition to the areas identified in Figure 7, screening of CODs in the justice system should also include examination of criminal risk. A wide variety of criminal risk screening and assessment instruments are available (Desmarais & Singh, 2013).

A set of recommended screening instruments in the justice system is provided below and in Figure 7:

Recommended screening instruments for mental disorders

- Brief Jail Mental Health Screen (BJMHS)
- Correctional Mental Health Screen (CMHS-F/CMHS-M)
- Mental Health Screening Form-III (MHSF-III)

Recommended screening instruments for substance use disorders

- Texas Christian University Drug Screen V (TCUDS V) (Note: To conduct a screening that includes more detail about alcohol use, the AUDIT can be combined with the TCUDS V or the SSI instrument.)
- Simple Screening Instrument (SSI)
- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

Mental Disorders	Substance Use Disorders	Co-occurring Disorders	Motivation & Readiness	Trauma History & PTSD	Suicide Risk
	Brief				
Brief Jail Mental Health Screen (BJMHS) (or) Correctional Mental Health Screen (CMHS-F/CMHS-M) (or) Mental Health Screening Form-III (MHSF-III)	Texas Christian University Drug Screen-V (TCUDS V)* (or) Simple Screening Instrument (SSI)* (or) Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)	Mini International Neuropsychiatric Interview-Screen (MINI-Screen) (or) Brief Jail Mental Health Screen (BJMHS)* and TCU Drug Screen V (TCUDS V)* (or) Correctional Mental Health Screen* (CMHS-F/CMHS-M) and TCU Drug Screen V (TCUDS V)*	Texas Christian University Motivation Form (TCU-MotForm)* (or) University of Rhode Island Change Assessment Scale-M (URICA-M)*	Trauma History Screen (THS)* (or) Life Stressor-Checklist (LSC-R)* (or) Life Events Checklist for DSM-5* (and) Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)*	Interpersonal Needs Questionnaire (INQ) and Acquired Capability Suicide Scale (ACSS)* (or) Beck Scale for Suicide Ideation (BSS) (or) Adult Suicidal Ideation Questionnaire (ASIQ)
	Extended				
	TCU Drug Screen V (TCUDS V)* and Alcohol Use Disorders Identification Test (AUDIT)* (or) Simple Screening Instrument (SSI)* and Alcohol Use Disorders Identification Test (AUDIT)*	TCU Drug Screen V (TCUDS V)*			

* Instrument available at no cost

Figure 7. Recommended Screening Instruments

- TCU Drug Screen V (TCUDS V)
- Alcohol Use Disorders Identification Test (AUDIT)*
- Simple Screening Instrument (SSI)
- Alcohol Use Disorders Identification Test (AUDIT)

Recommended screening instruments for trauma history and PTSD

- The Trauma History Screen (THS), or
- Life Stressor-Checklist (LSC-R), or
- Life Events Checklist for DSM-5 (LEC-5), and
- Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Recommended screening instruments for co-occurring disorders

- Mini International Neuropsychiatric Interview-Screen (MINI-Screen)
- Brief Jail Mental Health Screen (BJMHS) and TCU Drug Screen V (TCUDS V)
- Correctional Mental Health Form (CMHS-F/CMHS-M) and TCU Drug Screen V (TCUDS V)

Recommended screening instruments for motivation and readiness

- Texas Christian University Motivation Form (TCU MOTForm)
- University of Rhode Island Change Assessment Scale-M (URICA-M)

Recommended screening instruments for trauma history and PTSD

- The Trauma History Screen (THS), or
- Life Stressor-Checklist (LSC-R), or
- Life Events Checklist for DSM-5 (LEC-5), and
- Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Recommended screening instruments for suicide risk

- Interpersonal Needs Questionnaire (INQ), combined with the Acquired Capability Suicide Scale (ACSS)
- Beck Scale for Suicide Ideation (BSS)
- Adult Suicidal Ideation Questionnaire (ASIQ)

As per the recommendations in Figure 7 to conduct a comprehensive screening that includes more detail about alcohol use, the AUDIT can be combined with the TCUDS V or the SSI instrument. When screening for trauma/PTSD, the THS, the LSC-R, and the LEC-5 instruments provide checklists for examining traumatic life events, and it is recommended that one of these instruments be used in combination with the PCL-5 screen, which identifies symptoms related to trauma/PTSD. Use of two separate screening instruments to examine mental disorders and substance use disorders would require approximately 10–25 minutes to administer and score. Providing additional screening for trauma/PTSD, suicide risk, and motivation would increase the total amount of time required to approximately 25–35 minutes. Each of the recommended screening instruments in Figure 7 can be administered as repeated measures to examine changes over time. This information can be very useful in identifying the need for changes to treatment/case plans, the level of treatment and supervision services, and for further assessment.

Screening Instruments for Substance Use Disorders

A wide range of substance use screening instruments are available, including both public domain and proprietary products. These instruments vary considerably in their effectiveness, cost, and ease of administration and scoring (Hiller et al., 2011). As with other screening instruments, substance use screens are somewhat vulnerable to manipulation by those seeking to conceal substance use

problems, and concurrent use of drug testing is recommended to generate the most accurate screening information (Richards & Pai, 2003). A range of substance use screening instruments are reviewed in this section that can assist in detecting co-occurring disorders (CODs), with information provided about positive features and concerns related to each instrument.

Issues in Conducting Assessment and Diagnosis

As described previously, assessment of CODs is usually conducted after completing an initial screening and following referral to treatment services. If symptoms of both mental and substance use disorders are detected during screening, the assessment should examine the potential interactive effects of these disorders. Criminal risk factors should also be assessed, particularly the set of “criminogenic needs” or “dynamic” risk factors that can change over time and that should be the targets of justice-system interventions. Assessment provides the basis for developing an individualized treatment/case plan, and depending upon the setting, a community reentry plan. Key elements of CODs assessment include examination of skill deficits, the need for psychotropic medications, and types of treatment and ancillary services that are needed. Sufficient time should be allowed prior to assessment to ensure that an individual is detoxified and to ascertain whether any mental health symptoms exhibited are related to recent substance use (e.g., withdrawal symptoms). Standardized assessment methods should be implemented at early stages of involvement in the justice system and at key transition points during subsequent involvement in the justice system. Use of formal assessment and diagnostic instruments should be supplemented by information from collateral sources (e.g., from family members) and from archival records (e.g., criminal history).

An important component of assessment in the justice system is formal diagnoses of mental and substance use disorders. Among individuals who have CODs, this process often involves differentiating between several types of disorders (e.g., depression, anxiety, PTSD, borderline disorders) that share common symptoms and examining the potential effects of substance use on symptoms of various mental disorders. In addition to providing descriptive and prognostic information, diagnostic classification (e.g., through use of the DSM-IV-TR/DSM-5; APA, 2000, 2013) with justice-involved individuals who have CODs assists in identifying key areas to be addressed during psychosocial assessment and in developing an individualized treatment/case plan (ASAM, 2013; Stallvik, & Nordahl, 2014). Important revisions have been made to the DSM-5 criteria for both mental and substance use disorders, and these should be carefully reviewed before providing diagnoses.

A range of diagnostic instruments are available to examine symptoms of mental and substance use disorders within the DSM-5 classification framework. Instruments may be fully structured (e.g., AUDADIS-IV), thereby requiring minimal training to administer, or may be semistructured (e.g., SCID-IV), requiring training and application of clinical judgment. For a detailed review of available diagnostic instruments for examining CODs in the justice system, refer to the section “Assessment and Diagnostic Instruments for Co-occurring Mental and Substance Use Disorders.”

The following considerations should be reviewed in selecting and administering diagnostic instruments:

Structured interview instruments (e.g., SCID-IV; AUDADIS-IV) are useful in providing reliable and accurate diagnosis of CODs, although these instruments often require considerable time to administer and may not be practical in all justice settings

- Diagnostic instruments should have good interrater reliability and validity
- Diagnosis should be based on observation of mental health and substance use symptoms over time, and diagnostic interviews should be supplemented by review of collateral sources of information and by drug testing, whenever feasible

- Diagnoses of individuals with CODs should be reviewed periodically, given that key symptoms often change over time (e.g., following periods of prolonged abstinence)

Recommended Instruments for Assessment and Diagnosis of Co-occurring Disorders

Few instruments have been validated for use in assessing individuals with CODs. Moreover, few studies have attempted to validate different types of assessment instruments in criminal justice settings. Given the heterogeneity of symptoms presented by individuals with CODs, it is unlikely that a single instrument will be sufficient to assess the full range of co-occurring problems or to distinguish individuals who have CODs from those who have either a mental or a substance use disorder. Therefore, when identifying CODs in the justice system, it is important to combine different types of screening and assessment instruments to gain a comprehensive picture of psychosocial functioning and potential treatment and supervision needs (Steadman et al., 2013).

An integrated approach for assessing CODs in the justice system should include a comprehensive review of mental and substance use disorders, an examination of criminal justice history and status, and assessment of criminal risk (Steadman et al., 2013; Kubiak et al., 2011). Assessment should also review the interactive effects of mental and substance use disorders. Several previously described screening instruments may be used as part of an assessment battery to examine specialized areas (e.g., trauma history/PTSD) related to CODs. The Suicide Risk Decision Tree should be administered if suicide risk is indicated by one of the screening tools described in Figure 7. The PSS-I or PDS should also be administered if an individual endorses “high risk” on screens used to identify trauma/PTSD. These instruments can assist in differential diagnosis of PTSD and other mental disorders.

Recommendations assessment instruments are provided below and in Figure 8:

Recommended instruments for mental disorders

- Personality Assessment Inventory (PAI)

Recommended instruments for substance use disorders and treatment matching

- TCU Drug Screen V (TCUDS V)
- TCU Client Evaluation of Self and Treatment (TCU CEST)
- TCU Mental Trauma and PTSD Screen (TCU TRMA)
- TCU Physical and Mental Health Status Screen (TCU HLTH)
- TCU Criminal Justice Comprehensive Intake (TCU CJ CI)

Recommended assessment and diagnostic instruments for co-occurring disorders

- Alcohol Use Disorders and Associated Disabilities Interview Schedule-IV (AUDADIS-IV)
- Mini International Neuropsychiatric Interview (MINI)
- Structured Clinical Interview for DSM

Recommended assessment instruments for trauma history and PTSD

- The Posttraumatic Symptom Scale (PSS-I)
- The Posttraumatic Diagnostic Scale (PDS)
- Clinician Assisted PTSD Scale for DSM-5 (CAPS-5)

Recommended assessment and diagnostic instruments for suicide risk

- Suicide Risk Decision Tree

Mental Disorders	Substance Use Disorders and Treatment Matching	Co-occurring Disorders	Trauma History and PTSD	Suicide Risk
Personality Assessment Inventory (PAI)	TCU Drug Screen V (TCUDS V)*, TCU Client Evaluation of Self and Treatment (TCU CEST)*, TCU Mental Trauma and PTSD Screen (TCU TRMA)*, and TCU Physical and Mental Health Status Screen (TCU HLTH)* (and/or) TCU Criminal Justice Comprehensive Intake (TCU CJ CI)*	Alcohol Use Disorders and Associated Disabilities Interview (AUDADIS-IV)* (or) Mini International Neuropsychiatric Interview (MINI) (or) Structured Clinical Interview for DSM (SCID)	Posttraumatic Symptom Scale (PSS-I)* (or) Posttraumatic Diagnostic Scale (PDS) (or) Clinician Assisted PTSD Scale for DSM-5 (CAPS-5)*	Suicide Risk Decision Tree (SRDT)*

*Instrument available at no cost

Figure 8. Recommended Assessment Instruments

These instruments are based on a critical review of the research literature examining both assessment and diagnostic instruments for use with CODs. Assessment instruments differ significantly in their coverage of areas related to mental and substance use disorders, validation for use in community and criminal justice settings, cost, scoring procedures, and training required for administration.

Assessment instruments generally require from 45–90 minutes to administer. Depending on the individual symptom presentation, administration of diagnostic instruments can require up to two hours. Selection of assessment and diagnostic instruments should consider the level of staff training, certification, and expertise required.

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