Co-occurring Serious Mental Illness and Substance Use Disorders Within a Countywide System: Who Interfaces With the Jail and Who Does Not?

SHERYL PIMLOTT KUBIAK
School of Social Work, Michigan State University, East Lansing, Michigan, USA

LYNETTE ESSENMACHER and JULIE HANNA
School of Medicine, Wayne State University, Detroit, Michigan, USA

APRIL ZEOLI
School of Criminal Justice, Michigan State University, East Lansing, Michigan, USA

The presence of a co-occurring substance use disorder increases the risk of incarceration for those with a serious mental illness. To examine the interface between jail and mental health systems, a sample of 1,440 individuals diagnosed with both disorders was followed for 48 months using administrative data. The majority (63%) experienced incarceration with a median length of stay of 14 days. Predictors of incarceration were a more severe substance use diagnosis and younger age. These findings inform community-wide discussions aimed at enhancing coordination and collaboration between systems with the specific goal of decreasing the high prevalence of jail interface for this population.

KEYWORDS administrative data, jail, longitudinal, mental health, system collaboration

INTRODUCTION

One unintended consequence of deinstitutionalization—coupled with a lack of access to adequate treatment within the community—may be a greater number of individuals with serious mental illness (SMI) confined in criminal
justice facilities (Morrissey et al., 2006; Solomon, Draine, & Marcus, 2002). Over 1 million individuals with SMI are criminally detained each year (James & Glaze, 2006). In addition to causing treatment and/or custody dilemmas for the community mental health (CMH) and criminal justice systems (Morrissey et al.; Drake, Morrissey, & Mueser, 2006), this trend is frequently incongruous with the tenet of treatment being offered in the “least restrictive environment.”

The presence of a substance use disorder (SUD) is a major risk factor associated with incarceration for those with, as well as without, SMI (Andrews & Dowden, 2006; Lamberti, 2007). However, those with SMI are much more likely than those without an SMI to have a SUD (Drake et al., 2001). Nearly half of those with SMI have a co-occurring SUD, which has unique and often more severe consequences for this population (Regier et al., 1990).

Best practice standard for individuals with COD is an integrated approach in which mental health and substance abuse treatment is administered through one provider (Drake et al., 2001; Mueser, Noordsy, Drake, & Fox, 2003). More than a specific intervention technique, integrated treatment is a “rubric for sensible structural arrangements to ensure access” (Drake et al., 2006, p. 430) to services for those experiencing both types of disorders. However, these “sensible structural arrangements” often focus on the integration of mental health and substance abuse treatment systems, bypassing a key relationship with the criminal justice system.

Through this study, we illustrate one aspect of a community’s assessment of care for individuals with COD. The assessment was conducted to identify barriers to treatment and/or services across systems (including the jail) that may impede the implementation of best practices. Our goals are to determine the prevalence of COD within the CMH system, to highlight the likelihood of incarceration over time for those with COD, and to compare characteristics of individuals with COD who were incarcerated with those who were not.

BACKGROUND

Community epidemiologic estimates show that approximately 26% of the U.S. population has experienced symptoms that are sufficient for diagnosing a mental disorder during the past 12 months (Kessler, Chiu, Demler, & Walters, 2005). Although many of these cases are mild and will be resolved without any formal interventions, this is not the case for the 6% of those with SMI, defined by Kessler and colleagues (2005) as one that involves a substantial limitation in daily activities or work disability, a suicide attempt with serious lethal intent, or psychosis. Individuals experiencing one disorder are at a high risk for also having a second disorder. Nearly half (45%) of those with
one mental disorder met criteria for two or more disorders (Kessler et al., 2005). In many instances, that second disorder is an SUD.

Individuals with COD are at higher risk for a variety of factors that may indirectly or directly contribute to criminal involvement, such as suicide, homelessness, psychiatric hospitalizations, HIV infection, hepatitis C, job interference, violence, abuse, and poverty; higher costs to health care systems; and lower rates of treatment and medication adherence when compared with individuals with a single disorder (Dickey, Normand, Weiss, Drake, & Azeni, 2002; Elbogen, Swanson, Swartz, & Van Dorn, 2005; Mueser, Drake, & Wallach, 1998; Substance Abuse and Mental Health Services Administration, [SAMHSA], 2002). Most salient to this study is the higher incidence of criminal involvement and recidivism among individuals with COD (R. K. Chandler, Peters, Field, & Juliano-Bult, 2004; Messina, Burdon, Hagopian & Prendergast, 2004; Swartz & Lurigio, 2007).

The interaction of individual and system level risk factors often accounts for the arrests and incarceration of those with SMI (Lamberti, 2007). For example, if an individual with SMI uses alcohol or other drugs and stops taking the medication prescribed for his/her thought or mood disorder (i.e., individual-level risk), psychiatric symptoms will return and the individual may engage in inappropriate or illegal behavior, prompting law enforcement intervention. A lack of officer training and/or the absence of a crisis service or psychiatric bed (i.e., system-level risk) can lead to an arrest and confinement in the local jail. Numerous studies (Teplin, 1990; Teplin, 1983; Teplin, Abram, & McClelland, 1994, 1997) have shown that arrest was often a last resort and the result of limited resources.

Although 76% of those in jails have symptoms that suggest a mental health disorder, estimates indicate that between 10% and 25% of those in local jails have serious mental illnesses such as bipolar disorder, major depression, or schizophrenia (James & Glaze, 2006). Nearly 17% of jail inmates were prescribed psychiatric medication in the year prior to incarceration and 14.8% were using them while in the jail (James & Glaze, 2006). Jail inmates have higher rates of mental health disorder symptoms (60.5%) compared to state (49.2%) and federal (39.8%) prisoners (James & Glaze, 2006). Of those confined to criminal justice institutions, it is estimated that between 3% and 23% of individuals have both SMI and SUD (Abram & Teplin, 1991; Teplin, 1990; Steadman, Fabisiak, Dvoskin, & Holohan, 1987; Swartz & Lurigio, 1999).

Among individuals with COD, criminal justice involvement is associated with poorer treatment outcomes and lower retention rates (Lang & Belenko, 2000; Brady, Krebs, & Laird, 2004). They are difficult to engage and retain in community treatment and often cycle in and out of jail; therefore, treatment of this population has critical implications for providers in correctional, mental health, and substance abuse treatment settings. This is particularly salient considering that criminal justice detention can compound the psychological
issues for individuals with mental illness (Lurigio, Fallon, & Dincin, 2000) since routines may be upset or medication types and/or schedules interrupted, making it critical to link individuals with post-incarceration services.

CURRENT STUDY

As part of a plan to increase the use of integrated treatment for individuals eligible for community mental health services, administrators from the county CMH system enlisted the services of university researchers to conduct a system-wide assessment and to work with provider agencies to implement and evaluate integrated models of care. In their initial assessment, researchers engaged in both qualitative and quantitative inquiry including interviews with community members from several sectors and an initial review of the CMH administrative database to assess the prevalence of COD (see Kubiak, Sobeck, & Rose, 2005). In this phase of this longitudinal assessment, we sought to answer the following questions: (a) How many individuals within the county CMH system were identified as having a COD?; (b) Of those identified as having COD, how many interfaced with the county jail during a four-year period?; (c) What are the characteristics of those who interfaced with the jail versus those who did not?; and (d) What individual characteristics predicted multiple incarcerations?

METHOD

Sample

A large urban midwestern county under review encompasses over 2 million people and 825,000 households (U.S. Census Bureau, 2000). The publicly funded mental health system is under the county authority and provides services to those with severe and persistent mental illness (including developmental disabilities). Similar to the publicly funded substance abuse system, it is considered the provider of last resort. This particular regional mental health system is comprised of multiple managed care networks with several direct service providers. The local jail encompasses a mental health unit with 120 beds and capacity to treat individuals within the general population. Jail-based mental health services are funded through a carve-out from the countywide CMH system budget. In fiscal year 2003, the year of initial data procurement, approximately 55,000 people (48,000 with SMI) were enrolled with an annual budget of approximately $90 million.

Individuals meeting diagnostic criteria for both SMI and SUD within the CMH database were selected. Those under 18 years of age and those with a diagnosis that included a developmental disability were removed from analysis due to Institutional Review Board constraints. Furthermore, we
limited our analysis to those individuals with diagnostic categories eligible for CMH services and the most common SMIs in our database, namely schizophrenia, bipolar disorder, major depressive disorder, and depressive disorder not otherwise specified (NOS) in an effort to maintain sufficient group size for analyses. For example, of the 260 individuals who had a diagnosis that did not fit into these four categories, anxiety related disorders was the largest group with 36 members.

As a way of tracking clients’ transitions and treatment engagement over time, data extraction from the countywide CMH database (administrative data) was conducted. Information was extracted over 4 years through a continual review and assessment of the “encounter” data, which is completed for every episode of care and required for billing purposes. The following information was collected from every encounter involving each of the clients identified as having a COD: (a) provider name, (b) service provided, and (c) dates of service.

During data extraction, we noted several episodes of care in which the provider was the mental health unit within the jail. Therefore, a request for data sharing was made to the jail administrator so we could review jail-related data for the same 48-month time frame on the entire sample.

The primary unique identifier for matching data was the social security number, followed by congruence on birth date, name, and race. Information obtained from the county jail data included: (a) dates of admission and discharge, (b) type of offense, and (c) the location to which the individual was released. Per institutional review board and HIPAA criteria, the information provided to the jail for matching purposes was later stripped to provide a de-identified dataset. Case-wise files that merged the two datasets were produced, containing dates of incarceration (if applicable), dates of mental health service, type of service received, and service provider.

ANALYSES

Descriptive and inferential statistics were used to illuminate sample characteristics as well as similarities and differences between groups. To determine if any of these characteristics were associated with jail interface, a logistic regression was conducted. Independent variables included were the dummy variables indicating COD diagnosis group, the binary indicator of gender and the continuous age variable.

Additional analyses were performed on the subsample of individuals who had experienced incarceration to determine whether the factors under study predicted multiple incarcerations. The ordered logistic regression assumption of proportional odds was tested by comparing the log likelihoods obtained in the ordered logistic regression (using three groups) with those obtained with the model run as a multinomial logistic regression. This
is only an approximate test, as the models are not nested; however, the results indicated that the ordered model was appropriate.

RESULTS

To illustrate the data procurement, as well as individuals' location within and between systems, we utilize Figure 1 as a heuristic throughout this section. Less than 5% of the county’s CMH clients of at least 18 years of age were identified as having COD (N=1,440; Figure 1, Text Box A). The sample was largely composed of males and almost half of those in the sample were identified as Black; however, race identifiers were missing on nearly a quarter of the sample (23.5%; see Tables 1 and 2). Mean age of the sample was 39 years (M = 38.6; SD = 10.0), with a range of 18 to 68 at the first episode of care in 2002. The most common mental health diagnosis was schizophrenia (37.4%), followed by depressive disorder not otherwise specified (NOS; 32.9%), bipolar disorder (18.5%), and major depressive disorder (11.2%). In relation to substance use disorders, we began by differentiating between abuse from the more severe diagnosis of dependence, as well as drug of choice (alcohol or drugs) in Table 2. Most of the individuals were diagnosed with drug dependence (50.5%), and the least common substance use disorder was drug abuse (11.7%). For the sake of parsimony, subsequent analyses only differentiate between abuse and dependence diagnosis, eliminating attention to drug of choice. The most common COD combination was

![Figure 1](https://example.com/f1.png)

**FIGURE 1** Illustration of sample selection through merging of jail and mental health data.
depressive disorder NOS with drug dependence (16.9%), followed closely by schizophrenia with drug dependence (16.7%). Interestingly, the majority of those who had substance abuse had a mental health diagnosis of schizophrenia, while the majority of those with substance dependence had a mental health diagnosis of depressive disorder NOS.

A total of 63% \((n = 910; \text{Figure 1, Text Box B})\) of the 1,440 individuals identified within the CMH database as having COD in fiscal year 2002/2003 received mental health services within the county jail’s mental health unit on at least one occasion over the 48 months of the study, as indicated by the CMH records. Of these 910, 45% received their only mental health service in the county jail. We found that we could only partially cross validate the CMH data with the jail’s admission database due to the absence of social security numbers within the jail data for 233 individuals. Therefore, only 677 individuals (Figure 1, Text Box B1) could be verified in both data sources. This is not to say that the discrepant group of 233 individuals (Figure 1, Text Box B2) were not in the jail (i.e., encounter or service data indeed list the jail as the site of service), but the lack of corresponding jail data diminished

### TABLE 2 Co-occurring Disorder Diagnoses for Community Mental Health Sample in a Large, Urban County \((N = 1,440)\)

<table>
<thead>
<tr>
<th>Co-occurring disorders</th>
<th>Alcohol dependency (%)</th>
<th>Drug dependency (%)</th>
<th>Alcohol abuse (%)</th>
<th>Drug abuse (%)</th>
<th>Totals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>73 (5.1)</td>
<td>241 (16.7)</td>
<td>126 (8.8)</td>
<td>99 (6.9)</td>
<td>539 (37.4)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>59 (4.1)</td>
<td>160 (11.1)</td>
<td>28 (1.9)</td>
<td>19 (1.3)</td>
<td>266 (18.5)</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>32 (2.2)</td>
<td>83 (5.8)</td>
<td>25 (1.7)</td>
<td>21 (1.5)</td>
<td>161 (11.2)</td>
</tr>
<tr>
<td>Depressive disorder NOS</td>
<td>164 (11.4)</td>
<td>243 (16.9)</td>
<td>38 (2.6)</td>
<td>29 (2.0)</td>
<td>474 (32.9)</td>
</tr>
<tr>
<td>Totals</td>
<td>328 (22.8)</td>
<td>727 (50.5)</td>
<td>217 (15.1)</td>
<td>168 (11.7)</td>
<td>1,440</td>
</tr>
</tbody>
</table>

*Note. NOS = not otherwise specified.*

*Percentages represent percent of the total sample of 1,440, and not percent of column or row sample only.*
our ability to report any criminal justice related characteristics (e.g., time served; type of offense) for this group.

A logistic regression analysis was conducted to determine if those found in both databases differed significantly from those only found in the CMH database. The estimates showed no differences in age or gender between those found in both data systems and those only in the CMH database. Those with substance dependence and either bipolar disorder (OR: 0.57, 95% CI: 0.35 to 0.94) or depressive disorder NOS (OR: 0.56, 95% CI: 0.37 to 0.85) were significantly less likely than those with substance dependence and schizophrenia to be found only in the CMH database. Indeed, individuals found solely in the CMH database appeared to underrepresent those with bipolar disorder and depressive disorder NOS and overrepresent those with schizophrenia, when compared with those found in both databases. The racial composition of the two groups also revealed a statistically significant difference: Individuals found in both databases were less likely to be Black and more likely to be White than the sample found only in the CMH database. While this is an important limitation to bear in mind, given that providing race information on the jail data forms was optional, we do not believe this to be a critical flaw in the data. Therefore, despite these differences, in subsequent analysis we confine our definition of the “jail group” to the 677 individuals found in both databases.

CMH records indicated that a smaller group of 547 individuals (Figure 1, Text Box C) did not receive any mental health services within the jail. Of these 547 individuals, we verified the absence of incarceration through cross validation with jail records for 496 (Figure 1, Text Box C2). Interestingly, the remaining 51 individuals (3.5% of the sample; Figure 1, Text Box C1) were not found in the CMH database to have received mental health services in jail, but were present in the jail database. This suggests that they spent time within the jail, but did not receive any mental health treatment while confined. Subsequent analyses of the “no jail” group are restricted to the 496 that we verified through both data sources.

Jail Versus No Jail

Statistically significant differences in diagnoses were present between those who went to jail and those who never went to jail during the 48-month study period (Table 3). The reference group used for these and other analyses throughout the article were individuals with schizophrenia and substance dependence because the severity of their diagnoses would presumably warrant the greatest need for CMH services. Those who had substance dependence in combination with bipolar disorder (OR: 2.63, 95% CI: 1.67 to 4.14) or depressive disorder NOS (OR: 6.37, 95% CI: 4.15 to 9.80) were significantly more likely to interface with jail. On the other hand, those with substance abuse in combination with schizophrenia, major depression
TABLE 3 Differences in Co-occurring Disorder Diagnoses Between Those Who Interfaced With Jail \((n = 677)\) and Those Who Did Not \((n = 496)\) Among a Community Mental Health Sample in a Large, Urban County

<table>
<thead>
<tr>
<th>Co-occurring disorder</th>
<th>Jail (N)</th>
<th>(OR) (95%) confidence interval (p) value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abuse Dependence</td>
<td>131</td>
<td>114 ref</td>
</tr>
<tr>
<td>Abuse Abuse</td>
<td>35</td>
<td>163 0.19 0.12–0.29 &lt;.001</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependence Abuse</td>
<td>138</td>
<td>38 2.63 1.67–4.14 &lt;.001</td>
</tr>
<tr>
<td>Abuse</td>
<td>15</td>
<td>21 0.49 0.23–1.03 .059</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependence Abuse</td>
<td>49</td>
<td>46 0.88 0.54–1.43 .603</td>
</tr>
<tr>
<td>Abuse</td>
<td>4</td>
<td>35 0.08 0.03–0.23 &lt;.001</td>
</tr>
<tr>
<td>Depressive disorder NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependence Abuse</td>
<td>290</td>
<td>38 6.37 4.15–9.80 &lt;.001</td>
</tr>
<tr>
<td>Abuse</td>
<td>15</td>
<td>41 0.26 0.13–0.51 &lt;.001</td>
</tr>
<tr>
<td>Control variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>—</td>
<td>— 0.79 0.58 to 1.07 .129</td>
</tr>
<tr>
<td>Age</td>
<td>—</td>
<td>— 0.95 0.93 to 0.96 &lt;.001</td>
</tr>
</tbody>
</table>

\(\text{Note. } \text{NOS} = \text{not otherwise specified.}\)

(OR: 0.08, 95% CI: 0.03 to 0.23), or depressive disorder NOS (OR: 0.26, 95% CI: 0.13 to 0.51) were significantly less likely to go to jail.

Jailed Group

There were 1,774 episodes of incarceration, with an average of 2.6 \((SD = 2.2)\) and a range of 1 to 14 episodes per person. The average number of days in jail was 37.2 \((SD = 50.5)\) with nearly half (46.3%) of the episodes lasting 14 days or less. The results of the ordered logistic regression performed to determine if COD was related to increasing numbers of jail stays suggested that it was not (results not shown). The only covariate estimated to significantly affect number of jail stays was age: For each year of age a person gained, the adjusted probability of going from one jail stay to two to three jail stays was 0.37, and the adjusted probability of moving into the category of four or more jail stays was 0.21.

DISCUSSION

In this countywide assessment, we found a lower than expected number of individuals diagnosed with COD within the CMH database. Similar to other reviews of administrative data across the country, the prevalence of COD within the county is underidentified. The reasons for this underidentification include the lack of a systematic process of screening and assessment and/or
the use of instruments that do not possess adequate reliability and validity. In addition, there are often system barriers that providers must overcome in relation to identifying substance use in clients receiving community mental health treatment. These barriers include regulatory issues related to eligibility criteria and procedural and policy issues with documentation and payment (see Kubiak et al., 2005). CMH and jail administrators within this county are currently working on improving identification through appropriate screening and assessment, and through changing policies, procedures, and public perceptions regarding eligibility and documentation of COD.

In contrast, it is possible that some individuals identified as having COD were “overidentified” in our sample. Individuals that received their only mental health treatment within the jail (28% of all individuals with a COD in the CMH database) were more likely to have a diagnosis of major depression or depression NOS. A more thorough review of clinical files may suggest that the depression NOS was situational—secondary to incarceration or detoxification from drugs and alcohol—and not a chronic or persistent mental health issue. If this is so, symptoms may not meet the necessary eligibility criteria of “severely and persistently mentally ill” for inclusion in the CMH system. Moreover, these may be clients that would otherwise meet criteria for a primary substance use disorder and be more appropriately served within the substance abuse treatment system.

Despite the low number of individuals identified as having COD, a majority interfaced with the county jail at some point—and often multiple points—during the 48 months under investigation. The high number of individuals with SMI found in prisons and jails around the country indicates that this is not a local phenomenon. However, jail-based prevalence studies frequently do not differentiate between individuals with COD and individuals with a single disorder, nor do they examine jail interface longitudinally. Although our study focused exclusively on individuals identified as having COD, issues of underidentification within the CMH system and possible over-identification of those with SMI who were only treated within the jail may limit the generalizability of our results. However, it is remarkable that many of the individuals identified as having a COD were assessed within the jail mental health unit and were not otherwise known to community-based CMH, as demonstrated by the lack of services within the CMH system either before or after their confinement.

We found that those who were jailed were more likely to be younger and have psychiatric diagnoses along with substance dependence (vs. abuse). In fact, Table 3 illustrates that in every mental health diagnostic grouping, over half of the individuals with a co-occurring dependence experienced incarceration (i.e., 53% of those with schizophrenia and dependence, 78% of those with bipolar, 51% of those with major depression, and 88% of those with depression NOS), which was dissimilar to individuals with a co-occurring abuse disorder. In other words, regardless of mental health
diagnosis, those with a more serious substance use diagnosis (dependence) were more likely to be jailed than those with a less severe substance use diagnosis (abuse). This is similar to Swartz and Lurigio’s (2007) finding that substance dependence, rather than psychiatric disorder or crime, was the strongest predictor of arrest.

Individuals experiencing confinement averaged 2.6 episodes during the 48 months, with approximately one third experiencing a single confinement. Perhaps one of the most pertinent issues to collaboration and coordination between the jail and CMH, as well as transition planning for the individual, is the relatively brief period of time in the jail (46% confined for 14 days or less). Brief periods of incarceration are likely to be very disruptive to community treatment regimens, particularly when someone is on medication, as incarceration may also disrupt Medicaid eligibility (Morrissey et al., 2006). The brief lengths of stay also indicate low levels of threat to public safety as the majority of offenses were nonviolent (i.e., 29% property offenses, 20% drug or alcohol related, 20% misdemeanor or ordinance violations, and 9% violations of probation or bench warrants). Many of these nonviolent offenses, in combination with the mental health and/or substance use diagnoses, may have evoked eligibility in the county’s mental health diversion program or drug court; however, there was no indicator in either database about this type of involvement, so we were unable to assess such assignment or participation. However, not all offenses were nonviolent and, similar to other studies (Lamb, Weinberger, Marsh, & Gross, 2007), we agree that confinement in jail or prison may be the appropriate placement for violent or assaultive offenders—with or without a serious mental illness or COD.

Treatment Integration and Systems Coordination

Although structural barriers between mental health treatment and substance use treatment systems can be formidable, barriers between treatment and criminal justice systems may be even greater due to differing missions and philosophies that can often obstruct rather than encourage collaboration (Taxman, Perdoni, & Harrison, 2007). In other words, “cultural” differences among systems may impede collaborative efforts and contribute to system-wide risks associated with higher levels of incarceration and recidivism among those with SMI (Lamberti, 2007).

Konrad’s (1996) proposed hierarchical service integration framework describes various levels of integration ranging from informal and less structured activities (i.e., information sharing, cooperation, coordination) to more formal and structured arrangements (i.e., consolidation, integration). The efforts underway nationally to integrate mental health and substance abuse treatment are more formal and appropriately defined as integration since they involve a seamless approach to service delivery that fully blends activities and funding (SAMHSA, 2002). However, the philosophy and mission of
jails versus mental health treatment systems are not as congruent. Jails are focused primarily around the concerns for public safety, whereas mental health treatment systems are focused on public health, recovery, and tenets of self-determination. The differences between these systems preclude more formal integration efforts, requiring them to rely on cooperation, coordination, and collaboration. These less formal activities allow criminal justice and mental health or substance abuse treatment agencies to work together to make each more successful by creating referral and follow-up systems for offender clients and holding mutual agreements for case processing and outcome monitoring.

To be able to coordinate and collaborate more effectively, accurate diagnosis of SUD is necessary and should be included in the screening and assessment processes within CMH and jail systems. Screening and assessment of SUD and/or COD within mental health systems has been a longstanding problem (SAMHSA, 2002). Many mental health clinicians have little experience assessing SUD, and cross training of professional staff is needed (Institute of Medicine, 2005). Similarly, many jails lack appropriate screening mechanisms for mental illness, SUD, or both, resulting in difficulty establishing diagnosis or appropriate care (Kubiak, Beeble, & Bybee, 2010; Morris & Steadman, 1994; Peters, Bartoi, & Sherman, 2008; Spaite, 2001; Steadman, Morris, & Dennis, 1995; Swartz & Lurgio, 2005). Moreover, as this study confirms, confinement in local jails is often brief, necessitating relationships with community providers and procedures that support community coordination of care. The mechanisms to implement and support this interface have to be initiated and maintained at an administrative or structural level to ensure their viability.

For individuals with COD, best practice standards dictate an integrated approach. Integrated Treatment for Co-occurring Disorders (Mueser et al., 2003; SAMHSA, 2009) is an evidence-based practice (Drake et al., 2001; Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998) that emphasizes change at systems, organizational, and clinical levels in the treatment of those with COD. In this model, services are based on an integrated treatment plan and are provided by a multidisciplinary team of individuals who are cross-trained in mental health and substance use. Integrated treatment is associated with fewer arrests, improvement of mental health symptoms, lower rates of substance use, decreased hospitalizations, and increased housing stability (Drake et al., 2001). Research shows that integrated treatment leads to recovery at reduced costs compared to traditional parallel treatment, which has proven to be “costly, inefficient, and ineffective” (SAMHSA, 2009, p. 8).

A recent study of individuals who received treatment for COD within the jail found that they were more likely to be engaged in community treatment upon jail release than those who were not involved in jail-based treatment (D. W. Chandler & Spicer, 2006). However, upon release the treatment group was assigned to two different conditions: Integrated Dual Diagnosis Treatment (IDDT, the precursor to Integrated Treatment for Co-occurring
Disorders) or treatment as usual. The group receiving IDDT had better mental health outcomes (i.e., less hospitalizations and use of crisis centers), but there was no difference on criminal justice outcomes (i.e., time to first arrest or number of arrests; D. W. Chandler & Spicer, 2006). Drake et al. (2006) argue that these results illustrate the need not only for integrated treatment, but for it also to be tailored to the specific population to which it is being delivered—in this case, to individuals interfacing with the criminal justice system who may require more cognitive-behavioral restructuring around “criminal thinking.” As our data demonstrates, it may be the more serious substance abuse issues that need to be addressed in order to reduce recidivism for those individuals with a mental health disorder. Programs within these community mental health and substance abuse treatment systems need to structure program services that account for this unique need, perhaps providing more residential services for those with COD.

Limitations

There are some limitations of the study and caveats about the system that need to be addressed. First, our review of treatment interface was limited to the mental health providers within the county, excluding the substance abuse treatment providers. This initial exclusion was deliberate for two reasons: (a) CMH administrators enlisted us to help improve service delivery within the mental health system, and (b) statewide policies require that the CMH system provide outreach, systems collaboration, jail diversion, and person-centered planning in the treatment of individuals with COD—specifically those identified as severely and persistently mentally ill. Although individuals with COD may be referred to substance abuse treatment programs, if substance abuse treatment providers do not receive extensive training in mental health treatment, a referral would be inappropriate for an individual with COD in a case in which the mental illness is serious and may contribute to higher utilization of intensive mental health services and/or incarceration. Another important limitation is the use of administrative data that generally is not structured for research or longitudinal studies. The primary use for this data is fiscal and state or county level record-keeping; therefore, some problems (e.g., missing data and inability to confirm criteria used for diagnosis) are aspects that we could not control. However, the ability to track service utilization and match that with jail admission records is a powerful tool for assessing community level interventions in this area.

CONCLUSION

Although the goals of criminal justice institutions center on public safety rather than on public health, these institutions are a vital part of the “continuum of care” in which individuals with COD may find themselves. As communities
work toward integration of mental health and substance abuse treatment systems, collaborating with local jails to avoid or minimize disruptions in care will benefit the individuals as well as promote cost savings across systems. Working with the local jails may not reach a highly formalized and structured integrative model, but should meet standards for collaboration in which two agencies work together for a common goal (Konrad, 1996; Fletcher et al., 2009). SAMHSA (2009) has presented an evidence-based integrated treatment model that requires collaboration between systems. To provide a seamless approach to service delivery, an integrated model must include the jail so that individuals confined in the jail receive COD-specific services within the jail and immediate access to similar services within the community upon release. Failure of an integrated treatment model is evidenced by a lack of service continuity between the jail and the community before or after release.

Although the importance of transition planning and services for individuals with SMI has been demonstrated (Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999; Wexler, Melnick, Lowe, & Peters, 1999), these individuals are often viewed as outside both the criminal justice and mental health systems. Often, funding is unavailable and consequently linkages to community systems of care are not made or assertively monitored. Coordination, planning, and policy-making needs to occur at a systems level in order to ensure that transition services are in place. Leadership in all systems must advocate for in-jail and transition-to-community treatment services. Moreover, outcome data must be collected to demonstrate effectiveness of such services.

Involving criminal justice personnel in multilevel planning for individuals with COD may decrease their recidivism and save local funds by providing the best treatment in the least restrictive environment. Because much of our knowledge of effective treatment for individuals with COD comes from studies with nonincarcerated populations, additional research is needed to identify, develop, and test treatment strategies for incarcerated individuals with COD. A large proportion of those with SMI and a co-occurring SUD are spending time confined within criminal justice institutions, which are certainly a most, not least, restrictive environment.

REFERENCES


