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## Interventions for drug-using offenders with co-occurring mental health problems (Review)

Perry AE, Martyn-St James M, Burns L, Hewitt C, Glanville JM, Aboaja A, Thakkar P, Santosh Kumar KM, Pearson C, Wright K, Swami S

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**Interventions for drug-using offenders with co-occurring mental health problems (Review)**

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## [Intervention Review]

# Interventions for drug-using offenders with co-occurring mental health problems

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## ABSTRACT

### Background

This review represents one from a family of three reviews focusing on interventions for drug-using offenders. Many people under the care of the criminal justice system have co-occurring mental health problems and drug misuse problems; it is important to identify the most effective treatments for this vulnerable population.

### Objectives

To assess the effectiveness of interventions for drug-using offenders with co-occurring mental health problems in reducing criminal activity or drug use, or both.

This review addresses the following questions.

- Does any treatment for drug-using offenders with co-occurring mental health problems reduce drug use?
- Does any treatment for drug-using offenders with co-occurring mental health problems reduce criminal activity?
- Does the treatment setting (court, community, prison/secure establishment) affect intervention outcome(s)?
- Does the type of treatment affect treatment outcome(s)?

### Search methods

We searched 12 databases up to February 2019 and checked the reference lists of included studies. We contacted experts in the field for further information.

### Selection criteria

We included randomised controlled trials designed to prevent relapse of drug use and/or criminal activity among drug-using offenders with co-occurring mental health problems.

## Data collection and analysis

We used standard methodological procedures as expected by Cochrane .

## Main results

We included 13 studies with a total of 2606 participants. Interventions were delivered in prison (eight studies; 61%), in court (two studies; 15%), in the community (two studies; 15%), or at a medium secure hospital (one study; 8%). Main sources of bias were unclear risk of selection bias and high risk of detection bias.

Four studies compared a therapeutic community intervention versus (1) treatment as usual (two studies; 266 participants), providing moderate-certainty evidence that participants who received the intervention were less likely to be involved in subsequent criminal activity (risk ratio (RR) 0.67, 95% confidence interval (CI) 0.53 to 0.84) or returned to prison (RR 0.40, 95% CI 0.24 to 0.67); (2) a cognitive-behavioural therapy (one study; 314 participants), reporting no significant reduction in self-reported drug use (RR 0.78, 95% CI 0.46 to 1.32), re-arrest for any type of crime (RR 0.69, 95% CI 0.44 to 1.09), criminal activity (RR 0.74, 95% CI 0.52 to 1.05), or drug-related crime (RR 0.87, 95% CI 0.56 to 1.36), yielding low-certainty evidence; and (3) a waiting list control (one study; 478 participants), showing a significant reduction in return to prison for those people engaging in the therapeutic community (RR 0.60, 95% CI 0.46 to 0.79), providing moderate-certainty evidence.

One study (235 participants) compared a mental health treatment court with an assertive case management model versus treatment as usual, showing no significant reduction at 12 months' follow-up on an Addictive Severity Index (ASI) self-report of drug use (mean difference (MD) 0.00, 95% CI -0.03 to 0.03), conviction for a new crime (RR 1.05, 95% CI 0.90 to 1.22), or re-incarceration to jail (RR 0.79, 95% CI 0.62 to 1.01), providing low-certainty evidence.

Four studies compared motivational interviewing/mindfulness and cognitive skills with relaxation therapy (one study), a waiting list control (one study), or treatment as usual (two studies). In comparison to relaxation training, one study reported narrative information on marijuana use at three-month follow-up assessment. Researchers reported a main effect  $< .007$  with participants in the motivational interviewing group, showing fewer problems than participants in the relaxation training group, with moderate-certainty evidence. In comparison to a waiting list control, one study reported no significant reduction in self-reported drug use based on the ASI (MD -0.04, 95% CI -0.37 to 0.29) and on abstinence from drug use (RR 2.89, 95% CI 0.73 to 11.43), presenting low-certainty evidence at six months (31 participants). In comparison to treatment as usual, two studies (with 40 participants) found no significant reduction in frequency of marijuana use at three months post release (MD -1.05, 95% CI -2.39 to 0.29) nor time to first arrest (MD 0.87, 95% CI -0.12 to 1.86), along with a small reduction in frequency of re-arrest (MD -0.66, 95% CI -1.31 to -0.01) up to 36 months, yielding low-certainty evidence; the other study with 80 participants found no significant reduction in positive drug screens at 12 months (MD -0.7, 95% CI -3.5 to 2.1), providing very low-certainty evidence.

Two studies reported on the use of multi-systemic therapy involving juveniles and families versus treatment as usual and adolescent substance abuse therapy. In comparing treatment as usual, researchers found no significant reduction up to seven months in drug dependence on the Drug Use Disorders Identification Test (DUDIT) score (MD -0.22, 95% CI -2.51 to 2.07) nor in arrests (RR 0.97, 95% CI 0.70 to 1.36), providing low-certainty evidence (156 participants). In comparison to an adolescent substance abuse therapy, one study (112 participants) found significant reduction in re-arrests up to 24 months (MD 0.24, 95% CI 0.76 to 0.28), based on low-certainty evidence.

One study (38 participants) reported on the use of interpersonal psychotherapy in comparison to a psychoeducational intervention. Investigators found no significant reduction in self-reported drug use at three months (RR 0.67, 95% CI 0.30 to 1.50), providing very low-certainty evidence. The final study (29 participants) compared legal defence service and wrap-around social work services versus legal defence service only and found no significant reductions in the number of new offences committed at 12 months (RR 0.64, 95% CI 0.07 to 6.01), yielding very low-certainty evidence.

## Authors' conclusions

Therapeutic community interventions and mental health treatment courts may help people to reduce subsequent drug use and/or criminal activity. For other interventions such as interpersonal psychotherapy, multi-systemic therapy, legal defence wrap-around services, and motivational interviewing, the evidence is more uncertain. Studies showed a high degree of variation, warranting a degree of caution in interpreting the magnitude of effect and the direction of benefit for treatment outcomes.

## PLAIN LANGUAGE SUMMARY

### Interventions for drug-using offenders with co-occurring mental health problems

#### What is the aim?

To identify therapies to reduce drug use and/or criminal activity among criminal justice involved people with mental health problems.

#### What is the key message?

Therapeutic community interventions and mental health treatment courts may help people to reduce subsequent drug use and/or criminal activity.

### Interventions for drug-using offenders with co-occurring mental health problems (Review)

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## What was studied?

Therapies identified to support criminal justice involved people with mental health and drug misuse problems.

## What are the results?

- When men engage with a therapeutic community intervention compared to treatment as usual, they are probably less likely to be re-arrested or return to prison (moderate-certainty).
- When women engage with a therapeutic community intervention compared to a cognitive-behavioural course, they may not be more likely to reduce drug use, or become involved in criminal activity/drug-related crimes (low-certainty).
- When men engage with a therapeutic community compared to no intervention, they are probably less likely to return to prison (moderate-certainty).
- When juveniles engage with a mental health court compared to treatment as usual, they may be less likely to commit a new crime, return to prison, or take drugs (low-certainty).
- When juveniles engage with motivational interviewing/mindfulness and cognitive skills, they are probably less likely to show fewer problems than receiving relaxation training (moderate-certainty).
- When people engage with motivational interviewing/mindfulness and cognitive skills, they may not be more likely to report a reduction/abstinence from drug use when compared to a waiting list control (low-certainty).
- We are uncertain whether people engaged in motivational interviewing/mindfulness and cognitive skills are not more likely to report a reduction in marijuana use, a positive drug test, or to be re-arrested when compared to treatment as usual (very low-certainty).
- When families and juveniles engage in multi-systemic therapy, they may be more likely to report a reduction in drug dependence or to be re-arrested in comparison to treatment as usual or group substance abuse therapy (low-certainty).
- We are uncertain whether people involved in interpersonal psychotherapy are not more likely to use drugs again in comparison to a psychoeducational intervention (very low-certainty).
- We are uncertain whether people involved in legal defence service and wrap-around services are not more likely to commit new offences in comparison to a legal defence service only (very low-certainty).

Sources of funding included government institutes, research bodies, or charities.

## How up-to-date is this review?

February 2019.

## SUMMARY OF FINDINGS

**Summary of findings for the main comparison. Therapeutic community compared to treatment as usual for drug-using offenders with co-occurring mental illness**

### Therapeutic community compared to treatment as usual for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** prison

**Intervention:** therapeutic community

**Comparison:** treatment as usual

Outcomes	Nº of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with treatment as usual	Risk difference with therapeutic community
Re-arrests assessed with official records Follow-up: 12 months	266 (2 RCTs)	⊕⊕⊕⊖ MODERATE <sup>a</sup>	RR 0.67 (0.53 to 0.84)	Study population 98 per 100	32 fewer per 100 (46 fewer to 16 fewer)
Re-incarceration assessed with official records Follow-up: 12 months	266 (2 RCTs)	⊕⊕⊕⊖ MODERATE <sup>a</sup>	RR 0.40 (0.24 to 0.67)	Study population 59 per 100	36 fewer per 100 (45 fewer to 20 fewer)

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by one for risk of bias (blinding and selective reporting).



## Summary of findings 2. Therapeutic community and aftercare compared to cognitive behavioural skills for drug using women offenders with co-occurring mental illness

### Therapeutic community and aftercare compared to cognitive-behavioural skills for drug-using women offenders with co-occurring mental health problems

**Patient or population:** drug-using women offenders with co-occurring mental health problems

**Setting:** prison

**Intervention:** therapeutic community and aftercare

**Comparison:** cognitive-behavioural skills

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with cognitive-behavioural skills	Risk difference with therapeutic community and aftercare
Self-reported drug use Follow-up: 6 months	314 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a,b</sup>	RR 0.78 (0.46 to 1.32)	Study population  17 per 100	  4 fewer per 100 (9 fewer to 6 more)
Re-arrest for any type of crime assessed with Colorado Department of Corrections Record Information System (CDOC-RIS) Follow-up: 6 months	314 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a,b</sup>	RR 0.69 (0.44 to 1.09)	Study population  33 per 100	  10 fewer per 100 (19 fewer to 3 more)
Criminal Activity assessed with Colorado Department of Corrections Record Information System (CDOC-RIS) Follow-up: 6 months	314 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a,b</sup>	RR 0.74 (0.52 to 1.05)	Study population  33 per 100	  9 fewer per 100 (16 fewer to 2 more)
Drug-related crime assessed with Colorado Department of Corrections Record Information System (CDOC-RIS) Follow-up: 6 months	314 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a,b</sup>	RR 0.87 (0.56 to 1.36)	Study population  21 per 100	  3 fewer per 100 (9 fewer to 8 more)

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

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**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.  
**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Unclear reporting in the paper raises concerns about the potential high risk of bias with regards to blinding and methods used in the randomisation procedure; we downgraded by one.

<sup>b</sup>One study with 95% confidence intervals through the line of no effect.

### Summary of findings 3. Therapeutic community compared to waiting list control for drug-using offenders with co-occurring mental illness

#### Therapeutic community compared to waiting list control for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** prison

**Intervention:** therapeutic community

**Comparison:** waiting list control

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with waiting list control	Risk difference with therapeutic community
Return to prison (recidivism) post parole assessed with California Department of Correction's computerised Offender Based Information System Follow-up: 36 months	478 (1 RCT)	⊕⊕⊕⊖ MODERATE <sup>a</sup>	RR 0.60 (0.46 to 0.79)	Study population 40 per 100	16 fewer per 100 (21 fewer to 8 fewer)

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

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**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by one for risk of bias (randomisation process, concealment, and selective reporting).

## Summary of findings 4. Mental health treatment court with assertive case management model compared to treatment as usual for drug-using offenders with co-occurring mental illness

### Mental health treatment court with assertive case management model compared to treatment as usual for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** court

**Intervention:** mental health treatment court with assertive case management model

**Comparison:** treatment as usual

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with treatment as usual	Risk difference with mental health treatment court with assertive case management model
Conviction for a new crime assessed with data from probation office Follow-up: 12 months	235 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a</sup>	RR 1.05 (0.90 to 1.22)	Study population 72 per 100	4 more per 100 (7 fewer to 16 more)
Re-incarceration to jail assessed with data from probation office Follow-up: 12 months	235 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a</sup>	RR 0.79 (0.62 to 1.01)	Study population 71 per 100	15 fewer per 100 (27 fewer to 1 more)
Self-reported drug use assessed with Addiction Severity Index (ASI) Follow-up: 12 months	235 (1 RCT)	⊕⊕⊕⊕ LOW <sup>a</sup>	-	Mean self-reported drug use was 0.08	MD 0.00 (-0.03 lower to 0.03 higher)

\*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by one for risk of bias (allocation concealment and blinding of assessors) and by one for imprecision.

## Summary of findings 5. Motivational interviewing/mindfulness and cognitive skills compared to relaxation training for drug-using offenders with co-occurring mental illness

### Motivational interviewing/mindfulness and cognitive skills compared to relaxation training for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** prison

**Intervention:** motivational interviewing and cognitive skills

**Comparison:** relaxation training

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Impact
Self-reported marijuana use continuous	181 (1 RCT)	MODERATE <sup>a</sup>	This study compared cognitive skills to a relaxation training intervention for adolescents in prison with depressed mood. Researchers measured marijuana use at 3-months follow-up assessment using the Risks and Consequences Questionnaire (RCQ). They report a main effect < .007, with participants in the motivational interviewing group showing fewer problems than participants in the relaxation training group.

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by one for unclear risk of bias (random allocation and blinding).

## Summary of findings 6. Motivational interviewing/mindfulness and cognitive skills compared to waiting list control for drug-using offenders with co-occurring mental illness

### Motivational interviewing/mindfulness and cognitive skills compared to waiting list control for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** prison

**Intervention:** motivational interviewing and cognitive skills  
**Comparison:** waiting list control

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with waiting list control	Risk difference with motivational interviewing and cognitive skills
Self-reported drug use assessed with Addiction Severity Index (ASI) composite drug score across 13 items of drug use in the last 30 days Follow-up: 6 months	31 (1 RCT)	⊕⊕⊕⊖ LOW <sup>a</sup>	-	Mean self-reported drug use was 0.44	MD -0.04 lower (-0.37 lower to 0.29 higher)
Abstinence from drug use Follow-up: 6 months	31 (1 RCT)	⊕⊕⊕⊖ LOW <sup>a</sup>	RR 2.89 (0.73 to 11.43)	Study population	
				15 per 100	29 more per 100 (4 fewer to 160 more)

\*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; MD: mean difference; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by two for optimal information size not met.

### Summary of findings 7. Motivational interviewing/mindfulness and cognitive skills compared to treatment as usual for drug-using offenders with co-occurring mental illness

#### Motivational interviewing/mindfulness and cognitive skills compared to treatment as usual for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** medium secure hospital and jail

**Intervention:** motivational interviewing and cognitive skills

**Comparison:** treatment as usual

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with treatment as usual	Risk difference with motivational interviewing and cognitive skills
Self-reported frequency of marijuana use assessed with TCU-CRTF (Texas Christian University: Correctional Residential Treatment Form) Scale from 0 to 32 Follow-up: 3 months	40 (1 RCT)	⊕⊕⊕⊕ VERY LOW <sup>a,b</sup>	-	Mean self-reported frequency of marijuana use was 1.50	MD -1.05 lower (-2.39 lower to 0.29 higher)
Arrest frequency post release assessed with official police records Follow-up: 36 months	40 (1 RCT)	⊕⊕⊕⊕ VERY LOW <sup>a,b</sup>	-	Mean arrest frequency post release was 1.47	MD -0.66 lower (-1.31 lower to -0.01 lower)
Time to first arrest or offence assessed with official police records Follow-up: 36 months	40 (1 RCT)	⊕⊕⊕⊕ VERY LOW <sup>a,b</sup>	-	Mean time to first arrest or offence was 1.6	MD 0.87 higher (-0.12 lower to 1.86 higher)
Positive drug screen or refusal to provide a urine sample assessed with urine sample Scale from negative to positive Follow-up: 12 months	84 (1 RCT)	⊕⊕⊕⊕ VERY LOW <sup>a,b</sup>	-	Mean positive drug screen or refusal to provide a urine sample was 3.25	MD -0.7 lower (-3.5 lower to 2.1 higher)

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; MD: mean difference; RCT: randomised controlled trial.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by two for optimal size not met.

<sup>b</sup>Downgraded by one for risk of bias (incomplete outcome measures).

## Summary of findings 8. Multi-systemic therapy involving family and juveniles compared to treatment as usual for drug-using offenders with co-occurring mental illness

### Multi-systemic therapy involving family compared to treatment as usual for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** community

**Intervention:** multi-systemic therapy involving family

**Comparison:** treatment as usual

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with treatment as usual	Risk difference with multi-systemic therapy involving family
Drug dependence assessed with DUDIT questionnaire Scale from 0 to 44 Follow-up: 7 months	156 (1 RCT)	⊕⊕⊕⊖ LOW <sup>a</sup>	-	Mean drug dependence was 3.55	MD -0.22 lower (-2.51 lower to 2.07 higher)
Arrested assessed by corroborating with police data Follow-up: 7 months	158 (1 RCT)	⊕⊕⊕⊖ LOW <sup>a</sup>	RR 0.97 (0.70 to 1.36)	Study population  47 per 100	  1 fewer per 100 (14 fewer to 17 more)

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; MD: mean difference; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by one for risk of bias (blinding measures) and downgraded by one for imprecision.

## Summary of findings 9. Multi-systemic therapy involving family compared to group substance abuse therapy for drug-using adolescents with co-occurring mental illness

### Multi-systemic therapy involving family compared to group substance abuse therapy for drug-using adolescents with co-occurring mental health problems

**Patient or population:** drug-using adolescents with co-occurring mental health problems

**Setting:** court

**Intervention:** multi-systemic therapy involving family

**Comparison:** group substance abuse therapy

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with group substance abuse therapy	Risk difference with multi-systemic therapy involving family
Arrests Follow-up: range 6 months to 24 months	112 (1 RCT)	⊕⊕⊕⊖ LOW <sup>a</sup>	-	Mean arrests were 1.19 SD	MD -0.24 SD lower (-0.76 lower to 0.28 higher)

\*The risk in the intervention group (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; MD: mean difference; RCT: randomised controlled trial; SD: standard deviation.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by one for risk of bias (selective reporting of outcomes) and by one for imprecision.

## Summary of findings 10. Interpersonal psychotherapy compared to a psychoeducational intervention for drug-using offenders with co-occurring mental illness

### Interpersonal psychotherapy compared to a psychoeducational intervention for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** prison

**Intervention:** interpersonal psychotherapy

**Comparison:** psychoeducational intervention



Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with a psychoeducation-intervention	Risk difference with interpersonal psychotherapy
Substance abuse relapse post release Follow-up: 3 months	38 (1 RCT)	⊕⊕⊕⊕ VERY LOW <sup>a,b</sup>	RR 0.67 (0.30 to 1.50)	Study population  47 per 100	  16 fewer per 100 (33 fewer to 24 more)

\***The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by two for optimal size not met.

<sup>b</sup>Downgraded by one for risk of bias (selective reporting outcomes).

### Summary of findings 11. Legal defence service and wrap-around social work services compared to legal defence service only for drug-using offenders with co-occurring mental illness

#### Legal defence service and wrap-around social work services compared to legal defence service only for drug-using offenders with co-occurring mental health problems

**Patient or population:** drug-using offenders with co-occurring mental health problems

**Setting:** court

**Intervention:** legal defence service and wrap-around social work services

**Comparison:** legal defence service only

Outcomes	Nº of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with legal defence services only	Risk difference with legal defence services and wrap-around social work services
Committing new offences	29 (1 RCT)	⊕⊕⊕⊕ VERY LOW <sup>a,b</sup>	RR 0.64 (0.07 to 6.01)	Study population	

Follow-up: 12 months		1 per 100	2 fewer per 100 (0 fewer to 2 fewer)
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**\*The risk in the intervention group** (and its 95% confidence interval) is based on the assumed risk in the comparison group and the **relative effect** of the intervention (and its 95% CI).

CI: confidence interval; RCT: randomised controlled trial; RR: risk ratio.

#### GRADE Working Group grades of evidence.

**High certainty:** we are very confident that the true effect lies close to that of the estimate of the effect.

**Moderate certainty:** we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

**Low certainty:** our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

**Very low certainty:** we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

<sup>a</sup>Downgraded by two for optimal size not met.

<sup>b</sup>Downgraded for risk of bias (incomplete outcome data).

## BACKGROUND

This review is part of a family of three reviews providing a close examination of what works in reducing drug use and criminal activity among drug-using offenders. These three reviews report on trials generating several publications and numerous comparisons (Perry forthcoming; Perryforthcoming). Two of the three reviews represent a specific interest in pharmacological interventions and interventions for female offenders. All three reviews stem from a previous Cochrane systematic review (Perry 2006). We consider the effectiveness of interventions based on two key outcomes - drug use and criminal activity. We have presented here the revised method for this individual review, focusing on the impact of interventions for drug-using offenders with co-occurring mental health problems.

### Description of the condition

People involved in the criminal justice system are more likely to experience mental health problems. Many studies report different prevalence figures dependent upon the methods used to estimate prevalence (Fazel 2016). Some studies report generic figures that represent all serious mental health problems - e.g. over half (64%) of jail inmates in the United States reporting serious mental health problems (Glase 2006) - and others attempt to break down different types of mental health diagnoses (e.g. psychosis vs major depression). In a systematic review of 33,000 prisoners, one in seven prisoners had major depression or psychosis, with little change in rates of diagnoses over the past three decades (Fazel 2012).

Differences in the prevalence of mental health problems differentiate between males and females and by age. One study of mental health problems in jails found that more women than men (31% and 14.5%, respectively) have a serious mental health problem (Steadman 2009), and one estimate suggests that two-thirds of juveniles in detention custody have a mental health disorder severe enough to limit their ability to function (Shufelt 2006). Moreover, violent female offenders were found to be five times more likely than male offenders to present with anxiety disorders (Waserman 2005). Other studies have reported that a greater proportion of people who have mental health problems are more likely to be arrested compared with the general population (Lamb 1998).

We also know that rates of comorbidity between mental health problems and substance misuse are high (Butler 2011). Such comorbidity worsens the prognosis of the individual psychiatric disorder and increases the likelihood of repeat offending and premature mortality after release (Chang 2015). Despite these difficulties, it is unknown how well interventions devised to deal with this comorbidity address these problems (Fazel 2002).

### Description of the intervention

Many different treatments for substance misuse (e.g. detoxification, therapeutic communities) have been adopted for use in the criminal justice system. This review includes any intervention that was designed to reduce, eliminate, or prevent relapse to drug use or criminal activity, or both. This goal has resulted in the inclusion of a wide range of treatments, including mental health treatment courts with an assertive case management model, therapeutic communities, motivational interviewing (MI) with cognitive skills, use of multi-systemic/multi-dimensional therapy involving

families and mindfulness training, legal defence service with wrap-around social services, and interpersonal psychotherapy.

Case management evolved traditionally to address the needs of prisoner re-entry programmes covering employment, education, health, housing, and family support via assessment and connection of clients with appropriate services (Austin 1994). Case management in the United States has been applied in Treatment Accountability for Safer Communities programmes (Marlowe 2003b); it has shown initial effectiveness but *without* systematic evidence in support of the process. In the United Kingdom, similar wrap-around service provision was developed in the 1980s in an attempt to provide services that were more comprehensive by using a 'joined up' approach (Synder 2012). Wrap-around service provision requires a team-based approach that includes the young person, the family, and service providers in developing, implementing, and evaluating each part of any support plan (Wilson 2008).

Mental health treatment courts help to link offenders who would ordinarily be prison-bound to long-term community-based treatment. They rely on mental health assessments, individualised treatment plans, and ongoing judicial monitoring to address both the mental health needs of offenders and the public safety concerns of communities. Like other problem-solving courts such as drug courts, domestic violence courts, and community courts, mental health courts seek to address the underlying problems that contribute to criminal behaviour. Mental health courts share characteristics with crisis intervention teams, jail diversion programmes, specialised probation and parole caseloads, and a host of other collaborative initiatives intended to address the significant overrepresentation of people with mental illness in the criminal justice system.

Since the 1960s, therapeutic community interventions have been used in the United States in combination with work release programmes to rehabilitate offenders via a supportive environment over a relatively long period. Therapeutic community interventions specifically providing aftercare have modest effects on the reduction of recidivism and drug use (Mitchell 2012a; Pearson 1999), but less is known about the impact of using such schemes with people who have mental health and drug misuse problems that co-occur (e.g. Sacks 2008).

Cognitive-behavioural approaches, including self-monitoring, goal-setting, self-control training, interpersonal skills training, relapse prevention, group work, and lifestyle modification, have shown signs of success (Lipsey 2007). Previous research based on systematic reviews has excluded evaluations focusing specifically on the needs of drug-using offenders and/or mentally disordered offenders, but not for people with co-occurring mental health and drug misuse problems. Motivational interviewing techniques are often employed to promote retention in treatment and are aimed at enhancing motivational change and reducing subsequent re-offending (McMurran 2009; Smedslund 2011).

Multi-systemic/multi-dimensional therapy (MST/MDST) consists of intensive family- and community-based treatment provided to adolescents with serious clinical, social, and emotional difficulties. Research on the effectiveness of MST has failed to produce findings that MST is more effective than other services in preventing restrictive out-of-home living arrangements, reducing arrests or convictions, or improving life and family functioning (Littell 2005). The transferability of such schemes has been questioned with variable

findings when employed in different countries and contexts (Bogt 2006). MDST has also been employed via the juvenile drug court model, which is designed to address the link between substance abuse and criminal activity; it is compared in current work to manualised group-based substance abuse treatment (adolescent group treatment (AGT)) (Dakof 2015).

Despite growing knowledge about the effectiveness of treatment programmes for offenders, it appears that no recent systematic review evidence has focused on the effectiveness of treatment for offenders with drug misuse and co-occurring mental health problems.

## How the intervention might work

Interventions delivered to drug-using offenders under the care of the criminal justice system have varied over time. Case management is used to describe what amounts to a range of diverse practices and supervision models spanning several different services, including probation. Examples of case management have been used to co-ordinate and integrate all aspects of community supervision, from initial offender needs assessment through to programme delivery and intended completion of the order or sentencing requirement (Partridge 2004). Similarly, wrap-around care has several strengths in its approach, including the family-centred and culturally sensitive tailoring of each service plan to needs, values, and talents of the individual person (Synder 2012).

Mental health treatment courts aim to identify clients early on in the criminal process, either at the jail or by court staff such as pretrial service officers or social workers in the public defender's office. Most courts have criteria related to what types of charges, criminal histories, and diagnoses will be accepted. For example, a court may accept only defendants charged with misdemeanours who have no history of violent crimes, and who have an Axis I diagnosis based on recognised diagnostic criteria. Defendants who fit the criteria based on the initial screening are usually given a more comprehensive assessment to determine their interest in participating and their community treatment needs. Defendants who agree to participate receive a treatment plan and other community supervision conditions. Cases are dismissed or the sentence is greatly reduced for those who adhere to their treatment plan for the agreed upon time, usually between six months and two years.

Since the 1960s, therapeutic community interventions have been used in the United States in combination with work release programmes to rehabilitate offenders via a supportive environment over a relatively long period. This usually encompasses the transition between being in prison and working within the community (Prendergast 2011). The ethos of a therapeutic community intervention is to focus on treatment for the whole self (not on the drug abuse per se) and underlying symptomatic problems, with residents instrumental in running the therapeutic community (Mitchell 2012a). These interventions are usually based on group activities provided to address long-term mental illness, personality disorders, and drug addiction. The approach is usually residential, with clients and therapists living together.

Cognitive-behavioural therapy (CBT) approaches using programmes based on psychological theory have been employed to try to help people address their offending behaviour and generally have received good support from the literature in their reduction of recidivism. This therapy is often described as a psychoso-

cial intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions (e.g. thoughts, beliefs, attitudes) and behaviours, improving emotional regulation, and developing personal coping strategies that target solving current problems. Originally, it was designed to treat depression, but its uses have been expanded to include treatment of various mental health conditions, including anxiety.

Interpersonal psychotherapy (IPT) is a brief, attachment-focused psychotherapy that centres on resolving interpersonal problems and achieving symptomatic recovery. It is an empirically supported treatment (EST) that follows a highly structured and time-limited approach and is intended to be completed within 12 to 16 weeks. IPT is based on the principle that relationships and life events impact mood, and that the reverse is also true.

Miller and Rollnick developed motivational interviewing as a process to motivate change in substance abusers (Miller 1991). This technique uses different strategies such as expressing empathy, avoiding arguing for change, and working on ambivalence to strengthen commitment to change. Meta-analyses support the use of motivational interviewing as a stand-alone treatment and in combination with more intensive programmes (Vasilaki 2006). Linked to this idea of commitment to change is the idea of self-control, which has established links between substance use and antisocial behaviour (Malouf 2014). The theory suggests that use of mindfulness involves greater self-awareness, which may promote thoughtful rather than reactive responding and might help to improve mood and problem behaviour (Shonin 2013).

## Why it is important to do this review

Many people who are under the care of the criminal justice system have co-occurring mental health problems and drug misuse problems. Although previous research has broadly evaluated treatment programmes for offenders, we know little about the challenges, treatments, and rehabilitation opportunities for offenders with co-occurring mental health and drug misuse problems. We therefore believe that an evaluation of existing evidence on the impact of interventions for drug-using offenders with co-occurring mental health problems might be helpful in identifying treatments for reducing drug use and criminal activity in this vulnerable population.

## OBJECTIVES

To assess the effectiveness of interventions for drug-using offenders with co-occurring mental health problems in reducing criminal activity or drug use, or both.

This review addresses the following questions.

- Does any treatment for drug-using offenders with co-occurring mental health problems reduce drug use?
- Does any treatment for drug-using offenders with co-occurring mental health problems reduce criminal activity?
- Does the treatment setting (court, community, prison/secure establishment) affect intervention outcome(s)?
- Does the type of treatment affect treatment outcome(s)?

## METHODS

### Criteria for considering studies for this review

#### Types of studies

Randomised controlled trials (RCTs).

#### Types of participants

We included people involved in the criminal justice system with co-occurring mental health problems and drug misuse problems regardless of gender, age, or ethnicity. Drug misuse included any study that referred to participants who used occasionally, were dependent, or were known to abuse drugs. We defined offenders as people who were involved in the criminal justice system. Individuals could reside in special hospitals, prisons, or the community or were diverted from court or placed on arrest referral schemes for treatment. The study setting could change throughout the process of the study. For example, people involved in the criminal justice system could begin in prison but progress through a work release project into a community setting. We judged offenders to have co-occurring mental health problems when the paper explicitly stated this. We used several different mechanisms to identify study samples with mental health problems, including:

- diagnostic gold standard tests such as criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, or the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)*;
- the nature of the intervention (e.g. mental health court); and/or
- study authors' descriptions of participants as having a "history of psychiatric health problems" or a "serious mental disorder" with co-occurring substance misuse.

#### Types of interventions

Included interventions were designed, wholly or in part, to eliminate or prevent relapse to drug use or criminal activity, or both, among participants. We included a range of interventions in the review.

#### Experimental interventions included in the review

- Any pharmacological intervention (e.g. buprenorphine, methadone)
- Any psychosocial intervention (e.g. therapeutic community, case management, cognitive-behavioural therapy, interpersonal psychotherapy, motivational interviewing)

#### Control interventions included in the review

- No treatment or waiting list control
- Minimal and/or alternative treatment (e.g. reporting use of a similar but less intense intervention, using a different theoretical approach with the same components and/or a different alternative intervention)
- Treatment as usual (included any study that reported a combination and/or component of (1) a psychologically based intervention (e.g. anger management, motivational interviewing, counselling, aggression replacement, family therapy), (2) an educational programme (e.g. health, substance abuse education on risky behaviour), and/or (3) life skills (e.g. financial planning, employment skills, computer skills, interpersonal skills in interviews)

### Types of outcome measures

#### Primary outcomes

When papers reported several different follow-up periods, we reported the longest period, as we believe this measure provides the most conservative estimate of effectiveness. We provided:

- drug use measures reported as:
  - \* self-reported drug use (unspecified drug, specific drug use not including alcohol, Addiction Severity Index composite scores); or
  - \* biological drug use (measured by drugs testing urine or analysing hair); and
- criminal activity as measured by:
  - \* self-reported or officially reported criminal activity (including arrest for any offence, drug offences, and/or re-incarceration).

### Search methods for identification of studies

#### Electronic searches

Updated searches identified records from 2014 to 6 February 2019.

- Cochrane Central Register of Controlled Trials (CENTRAL; issues to February 2019).
- MEDLINE (1966 to February 2019).
- Embase (1980 to February 2019).
- PsycINFO (1978 to February 2019).
- SciSearch (Science Citation Index) (1974 to February 2019).
- Social SciSearch (Social Science Citation Index) (1972 to February 2019).
- Applied Social Sciences Index and Abstracts (ASSIA; 1987 to February 2019).
- National Technical Information Service (NTIS; 1964 to March 2014).<sup>a</sup>
- Sociological Abstracts (1963 to March 2014).<sup>b</sup>
- Healthcare Management Information Consortium (HMIC; to February 2019).
- Public Affairs Information Service (PAIS; 1972 to February 2019).
- Criminal Justice Abstracts (1968 to February 2019).
- Latin American Caribbean Health Sciences Literature (LILACS; 2004 to February 2019).
- Current Controlled Trials (December 2009).<sup>c</sup>
- SPECTR (March 2004).<sup>d</sup>
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)plus (up until February 2019).

<sup>a</sup>Paid access only - insufficient resources to search.

<sup>b</sup>Not available to search through York University.

<sup>c</sup>No longer available to search.

<sup>d</sup>No public access through Campbell Collaboration website, which previously hosted the database.

To update the review, we restricted the search to studies that were published since the end date of the previous search (May 2014). We did not search several original databases indicated by the key at the end of the database list. One database (NTIS) was fee charged.



ing, and the other three databases (Sociological Abstracts, Current Controlled Trials, and SPECTR) were not available for searching due to changes in the provision of databases through the University of York.

We developed search strategies for each database to exploit the search engine most effectively and to make use of any controlled vocabulary. We included methodological search filters designed to identify RCTs. Whenever possible, we used filters retrieved from the InterTASC Information Specialists' Sub-Group (ISSG) Search Filter Resource site ([www.york.ac.uk/inst/crd/intertasc/](http://www.york.ac.uk/inst/crd/intertasc/)). If filters were unavailable from this site, we substituted search terms based on existing versions. We did not place any language restrictions on identification and inclusion of studies in the review.

We have listed details of the update search strategies and results and the websites searched in [Appendix 1](#), [Appendix 2](#), [Appendix 3](#), [Appendix 4](#), [Appendix 5](#), [Appendix 6](#), [Appendix 7](#), [Appendix 8](#), [Appendix 9](#), [Appendix 10](#), and [Appendix 11](#).

## Searching other resources

### Reference checking

We scrutinised the reference lists of all retrieved articles for additional references and searched the catalogues of relevant organisations.

### Personal communication

We sought out experts for their knowledge of other published or unpublished studies relevant to the review.

## Data collection and analysis

### Selection of studies

A team of review authors independently inspected the search hits by reading the titles and abstracts. Each potentially relevant study was obtained as a full-text article. Each article was independently assessed for inclusion. In the case of discordance, a third independent review author arbitrated. One review author undertook translation of articles not written in the English language.

We divided the screening process into two key phases. Phase one used eight key questions as reported in the original review.

#### Prescreening criteria: phase one

- Is the document an empirical study? If not, exclude the document
- Does the study evaluate an intervention, a component of which is designed to reduce, eliminate, or prevent relapse with drug-using offenders?
- Are participants referred by the criminal justice system at baseline?
- Does the study report pre- and post-programme measures of drug use?
- Does the study report pre- and post-programme measures of criminal behaviour?
- Is the study an RCT?
- Do the outcome measures refer to the same length of follow-up for the two groups?

Papers included after phase one screening were then scrutinised for further assessment.

#### Prescreening criteria: phase two

- Does the study population comprise wholly participants with diagnosed mental health problems using DSM-IV or ICD-10 diagnostic criteria? if yes, include the document
- Does the study population comprise wholly participants identified on screening to have a mental health problem(s) based on intervention eligibility (e.g. mental health court)? if yes, include the document
- When the full study population does not comprise offenders with diagnosed or presumed mental health problems, are separate results given for those participants with mental health problems? if no, exclude the document

## Data extraction and management

We used data extraction forms to standardise the reporting of data from all studies obtained as potentially relevant. Two review authors independently extracted data and subsequently checked them for agreement. The narrative tables presented study details (e.g. author, year of publication, country of study origin), study methods (e.g. random assignment), participants (e.g. number in sample, age, gender, ethnicity, age, mental health status), interventions (e.g. description, duration, intensity, setting), outcomes (e.g. description, follow-up period, reporting mechanism), and notes (e.g. country, funding).

## Assessment of risk of bias in included studies

The team of review authors independently assessed risk of bias of all included studies using the 'Risk of bias' assessment criteria recommended in the *Cochrane Handbook for Systematic Reviews of Interventions* ([Higgins 2011](#)).

The recommended approach for assessing risk of bias in studies included in Cochrane Reviews involves a two-part tool that addresses four specific domains, namely, sequence generation and allocation concealment (selection bias), blinding of outcome assessors (detection bias), incomplete outcome data (attrition bias), and selective outcome reporting (reporting bias). The first portion of the tool involves describing what was reported to have happened in the study. The second portion of the tool involves assigning a judgement related to the risk of bias for that entry, in terms of low, high, or unclear risk. To make these judgements, we used the criteria indicated by the *Cochrane Handbook for Systematic Reviews of Interventions*, as adapted to the addiction field. See [Appendix 12](#) for details.

The domains of sequence generation and allocation concealment (avoidance of selection bias) were addressed in the tool by a single entry for each study.

Participants and personnel cannot be blinded to the type of intervention; moreover, we think that being aware of receiving a psychosocial treatment is in itself part of the therapeutic effect; for these reasons, we did not assess risk of performance bias.

Detection bias was considered separately for objective outcomes (e.g. dropout, use of substance of abuse measured by urine analysis, participants relapsed at end of follow-up, participants engaged in further treatments) and subjective outcomes (e.g. duration and

severity of signs and symptoms of withdrawal, participant self-reported use of substance, side effects, social functioning as integration at school or at work, family relationship).

Incomplete outcome data (avoidance of attrition bias) was considered for all outcomes except for dropout from treatment, which is very often the primary outcome measure in trials on addiction.

For studies identified in the search, the review authors attempted to contact study authors to establish whether a study protocol was available.

### Measures of treatment effect

The mean differences (MD) with 95% confidence intervals (CIs) was used for continuous outcomes measured on the same scale, and the standardised mean difference (SMD) was used for continuous outcomes measured on different scales. Higher scores for continuous measures are representative of greater harm. We presented dichotomous outcomes as risk ratios (RRs), with 95% CIs.

### Unit of analysis issues

To avoid double-counting of outcome measures (e.g. arrest, parole violation) and follow-up periods (e.g. 12 months, 18 months), we checked all trials to ensure that multiple studies reporting the same evaluation did not contribute towards multiple estimates of programme effectiveness. We followed Cochrane guidance, and where appropriate, we combined intervention and control groups to create a single pair-wise comparison. When this was not appropriate, we selected one treatment arm and excluded the others.

### Dealing with missing data

We attempted to contact study authors via email when we noted missing data in the original publication.

### Assessment of heterogeneity

We assessed heterogeneity using the  $I^2$  statistic and the Chi<sup>2</sup> statistic (Higgins 2011). We regarded heterogeneity as substantial if  $I^2$  was greater than 50% or if the P value was lower than 0.10 for the Chi<sup>2</sup> test for heterogeneity (Deeks 2017). In keeping with the guidance provided in the *Cochrane Handbook for Systematic Reviews of Interventions* (Deeks 2017), we distinguished the following values to denote no important heterogeneity and moderate, substantial, and considerable heterogeneity, respectively: 0% to 40%, 30% to 60%, 50% to 90%, and 75% to 100%.

### Data synthesis

We used the RevMan software package to perform a series of meta-analyses for continuous and dichotomous outcome measures (RevMan 2012). We used a random-effects model to account for the fact that participants did not come from a single underlying population. We combined two studies of the therapeutic community and aftercare in comparison to treatment as usual.

### Subgroup analysis and investigation of heterogeneity

We had planned to conduct sensitivity analyses to assess the impact of studies at high risk of bias compared with those at low or unclear risk of bias. Because of the overall high risk of bias of the included studies, this analysis was not possible.

### Grading of evidence and 'Summary of findings' tables

We assessed the overall quality of the evidence for the following primary outcomes using the GRADE system: relapse, frequency of use, extent of use, any adverse events, and dropout from treatment. The GRADE Working Group developed a system for grading the quality of evidence (Schunemann 2013); this system takes into account issues related not only to internal validity but also to external validity, such as directness of results.

We have presented the main findings of the review in a 'Summary of findings' table. This transparent and simple tabular format provides key information concerning quality of evidence, magnitude of effect of the interventions examined, and sums of available data for the main outcomes.

The GRADE system uses the following criteria for assigning grades of evidence.

- High: we are very confident that the true effect lies close to that of the estimate of the effect.
- Moderate: we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
- Low: our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
- Very low: we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Grading is decreased for the following reasons.

- Serious (-1) or very serious (-2) study limitations for risk of bias.
- Serious (-1) or very serious (-2) inconsistency between study results.
- Some (-1) or major (-2) uncertainty about directness (correspondence between the population, the intervention, or the outcomes measured in the studies actually found and those under consideration in our systematic review).
- Serious (-1) or very serious (-2) imprecision of the pooled estimate.
- Publication bias strongly suspected (-1).

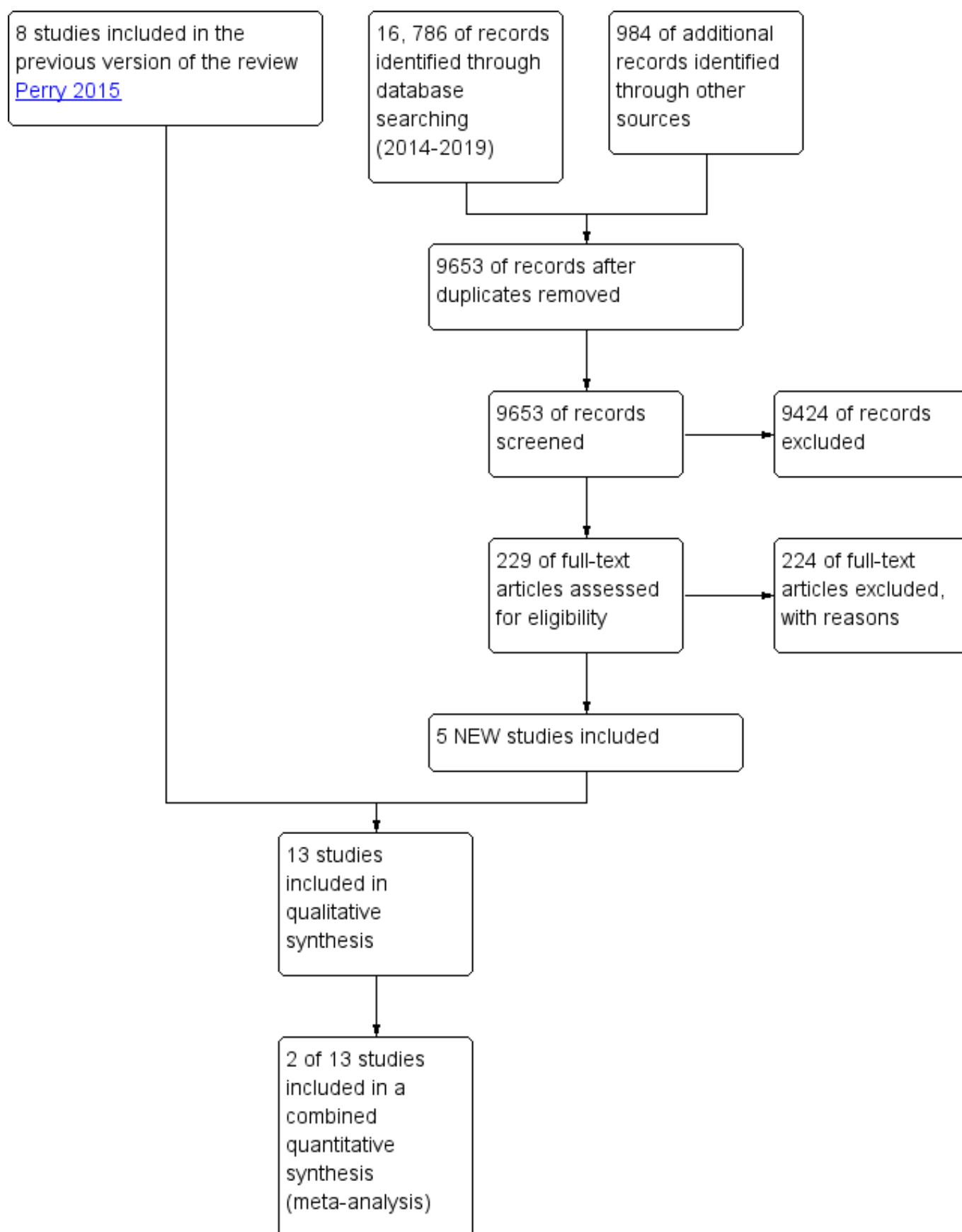
## RESULTS

### Description of studies

#### Results of the search

As shown in Figure 1, our update searches identified 9653 records. We screened out 9424 references based on titles and abstracts. We examined the remaining 229 records in full text and excluded 224 of them (see *Characteristics of excluded studies*). We included five new trials (Cullen 2012; Dakof 2015; Malouf 2017; McCarter 2016; Sundell 2008), along with one follow-up study to an existing trial within the review (Lanza 2014), and we included three ongoing trials (Baldus 2011; Tinland 2013; VanDorn 2017), along with eight studies from the previous review. The total number of included studies is 13 (see *Characteristics of included studies*).

**Figure 1. Study flow diagram.**





## Included studies

### Population

The 13 included trials randomised a total of 2606 participants and were published between 1999 and 2017. Seven of the 13 trials included adult drug-using offenders. Three studies investigated the impact on interventions with adolescents and/or youth (Dakof 2015; McCarter 2016; Stein 2011). Two studies included females only (Johnson 2012; Sacks 2008). Three studies reported on juveniles or youth involved in the criminal justice system (Dakof 2015; McCarter 2016; Stein 2011). Adult male offenders were the focus of study populations in the remaining studies, with a mean age of 30 years. In all but two studies (Cullen 2012; McCarter 2016), most participants were of white ethnic origin.

Mental health diagnoses varied across studies (see Table 1).

### Settings

Eight studies were conducted in a secure setting (Johnson 2012; Lanza 2014; Malouf 2017; Sacks 2004; Sacks 2008; Sacks 2011; Stein 2011; Wexler 1999), two studies were conducted in community settings (Cosden 2003; Sundell 2008), and two studies were conducted in court settings (Dakof 2015; McCarter 2016). One study was conducted with a medium forensic secure hospital population in the United Kingdom (Cullen 2012). Studies were published in the United States ( $n = 10/13$ ; 76%), Spain ( $n = 1/13$ ; 7.6%), the United Kingdom ( $n = 1/13$ ; 7.6%), and Sweden ( $n = 1/13$ ; 7.6%).

### Duration of trials

Trial duration varied between three-month follow-up in Johnson 2012, Lanza 2014, Stein 2011, and Sundell 2008, and five-year follow-up in Wexler 1999. Six-month follow-up was reported in Cosden 2003, Dakof 2015, and Sacks 2008. The remaining studies reported on outcomes at 12, 24, and 36 months (Cosden 2003; Cullen 2012; Dakof 2015; Malouf 2017; McCarter 2016; Sacks 2011; Sacks 2004). Treatment duration was most intensive (e.g. lasting between three and seven days per week) when a therapeutic community model was employed for periods of up to 12, 18, and 24 months (e.g. Sacks 2004; Sacks 2008; Sacks 2011); typically all other treatment interventions lasted between four and six months (e.g. Cullen 2012; Lanza 2014). The shortest treatment intervention was delivered in a 90-minute session followed by a 60-minute booster session upon release (Stein 2011).

### Outcome measures

A total of 5 of 13 (38%) trials reported drug outcomes (Cullen 2012; Johnson 2012; Lanza 2014; Stein 2011; Sundell 2008), 5 of 13 (38%) reported crime outcomes (Dakof 2015; McCarter 2016; Sacks 2004; Sacks 2011; Wexler 1999), and 3 of 13 (23%) reported both drug and crime outcomes (Cosden 2003; Malouf 2017; Sacks 2008).

### Interventions

#### Therapeutic interventions and aftercare

Four studies compared a therapeutic community (TC) intervention with aftercare versus treatment as usual (Sacks 2004; Sacks 2011), another intervention (Sacks 2008), or no intervention (Wexler 1999). Sacks 2004 compared a modified TC residential treatment programme using a cognitive-behavioural curriculum to change attitudes and lifestyles versus a programme of intensive psy-

chiatric services with medication, weekly individual therapy and counselling, and specialised groups of cognitive-behavioural work, anger management, therapy and education, domestic violence, parenting, and weekly drug/alcohol therapy sessions.

Sacks 2008 evaluated a modified TC group with programme activities supplemented by peer-led activities on weekends in comparison to an intensive outpatient programme that consisted of an educational programme on substance abuse treatment.

Sacks 2011 consisted of a re-entry residential TC programme where participants worked in the community and saved money for independent living. This was compared to participants who were released to a community corrections facility during the day; they left the facility to go to work, receive treatment, and report to parole officers. This group engaged with brokering community-based services and directly received support and counselling services. A weekly relapse prevention group and daily medication monitoring were provided. Psychiatric and substance abuse services were provided by outside agencies (community parole officers helped clients choose). The Wexler study compared a TC treatment programme with aftercare in the community versus a waiting list control.

#### Mental health court

One study compared use of a mental health court and case management to treatment as usual (Cosden 2003). The mental health treatment court (MHTC) consisted of case management and assertive community treatment (ACT) provided via a case management model. This model included weekly or bi-weekly court supervision and frequent contact with case managers, followed by treatment as usual (if required), and compared this to treatment as usual, which included traditional court proceedings and county mental health services (Cosden 2003).

#### Motivational interviewing, mindfulness, and cognitive skills

Four studies compared motivational interviewing, mindfulness, and cognitive skills to no intervention (Lanza 2014), another intervention (Stein 2011), or treatment as usual (Cullen 2012; Malouf 2017). Stein 2011 was a manualised motivational intervention focused on empathy - not arguing and developing discrepancy; self-efficacy; and personal choice, and compared this approach to a relaxation intervention that included progressive muscle relaxation, use of guided imagery, and feedback on use of techniques.

Malouf 2017 used a manualised group intervention for jail inmates nearing release into the community. The intervention incorporated and adapted elements from several mindfulness-based interventions (MBIs), including acceptance and commitment therapy, mindfulness-based relapse prevention (MBRP), and dialectical behavioural therapy (DBT), and was compared to programmes that were normally available within the prison (e.g. anger management financial planning, health education).

Lanza 2014 used cognitive-behavioural therapy (CBT) to change behaviour through cognitive restructuring and compared to ACT, which aimed to construct an alternative context in which behaviour aligned with one's values is more likely to occur.

## Multi-systemic therapy including families

Two studies compared multi-systemic therapy including families versus treatment as usual (in [Sundell 2008](#)) and another intervention (in [Dakof 2015](#)). [Sundell 2008](#) compared an intensive family- and community-based treatment to support prosocial development versus individual counselling, family therapy, addiction treatment, and special education services.

[Dakof 2015](#) compared an intervention that involved therapists who worked individually with each family in four areas of treatment (adolescent, parent, family, and community) versus adolescent group therapy based on cognitive-behavioural therapy and motivational interviewing.

## Legal defence and social work

One study compared legal defence and wrap-around social work to legal defence service only ([McCarter 2016](#)). The wrap-around approach provides a collaborative and co-ordinated response of service providers that organises and streamlines service delivery. This includes attending any team meeting with or on behalf of youth, providing service referrals, and connecting families and guardians to local providers for appropriate mental health, substance abuse, and educational services and support. This was compared to provision of only legal defence service.

## Interpersonal psychotherapy

One study compared interpersonal psychotherapy versus another intervention ([Johnson 2012](#)). Study participants in the intervention group received manualised group and individual sessions in prison for treatment of substance misuse and mental health problems. These approaches were compared to an attention-matched manualised in-prison and post-release psychoeducation course on mental health and drug problems.

## Excluded studies

We excluded 224 full-text studies. (See [Characteristics of excluded studies](#) for further details.) Reasons for exclusion were lack of criminal justice involvement in referral to the intervention; lack of reporting of relevant drug or crime outcome measures, or both, at pre- and post-intervention periods; and allocation of participants to study groups that were not strictly randomised or did not contain original trial data.

## Risk of bias in included studies

### Allocation

#### Randomisation

All 13 studies were described as randomised. Nine of the included studies reported on how the randomisation sequence was generat-

ed and were judged as having low risk of bias ([Cosden 2003](#); [Dakof 2015](#); [Johnson 2012](#); [Lanza 2014](#); [Malouf 2017](#); [McCarter 2016](#); [Sacks 2011](#); [Stein 2011](#); [Sundell 2008](#)). The remaining four studies did not report how the randomisation sequence of participants was generated ([Cullen 2012](#); [Sacks 2004](#); [Sacks 2008](#); [Wexler 1999](#)).

### Characteristics at baseline

Eight of the 13 studies were similar in terms of drug use at baseline ([Cullen 2012](#); [Dakof 2015](#); [Johnson 2012](#); [McCarter 2016](#); [Sacks 2008](#); [Sacks 2011](#); [Stein 2011](#); [Wexler 1999](#)); four studies were rated unclear ([Cosden 2003](#); [Lanza 2014](#); [Malouf 2017](#); [Sundell 2008](#)); and one study showed comparable baseline differences ([Sacks 2004](#)). For similarity on criminal justice measures, nine studies were rated as similar ([Cosden 2003](#); [Cullen 2012](#); [Dakof 2015](#); [Johnson 2012](#); [McCarter 2016](#); [Sacks 2008](#); [Sacks 2011](#); [Sacks 2004](#); [Wexler 1999](#)), and four were rated as unclear ([Lanza 2014](#); [Malouf 2017](#); [Stein 2011](#); [Sundell 2008](#)).

### Allocation concealment

Of the 13 studies, only two adequately reported that the allocation process was concealed ([Johnson 2012](#); [Sundell 2008](#)). The remaining 11 (85%) studies were rated as unclear.

### Blinding

We assessed risk of detection bias across subjective and objective measures (see [Appendix 12](#)). We rated eight studies as having unclear risk ([Cosden 2003](#); [McCarter 2016](#); [Sacks 2004](#); [Sacks 2008](#); [Sacks 2011](#); [Stein 2011](#); [Sundell 2008](#); [Wexler 1999](#)); two studies as having low risk ([Cullen 2012](#); [Lanza 2014](#)); and the remaining three studies as having high risk of bias.

### Incomplete outcome data

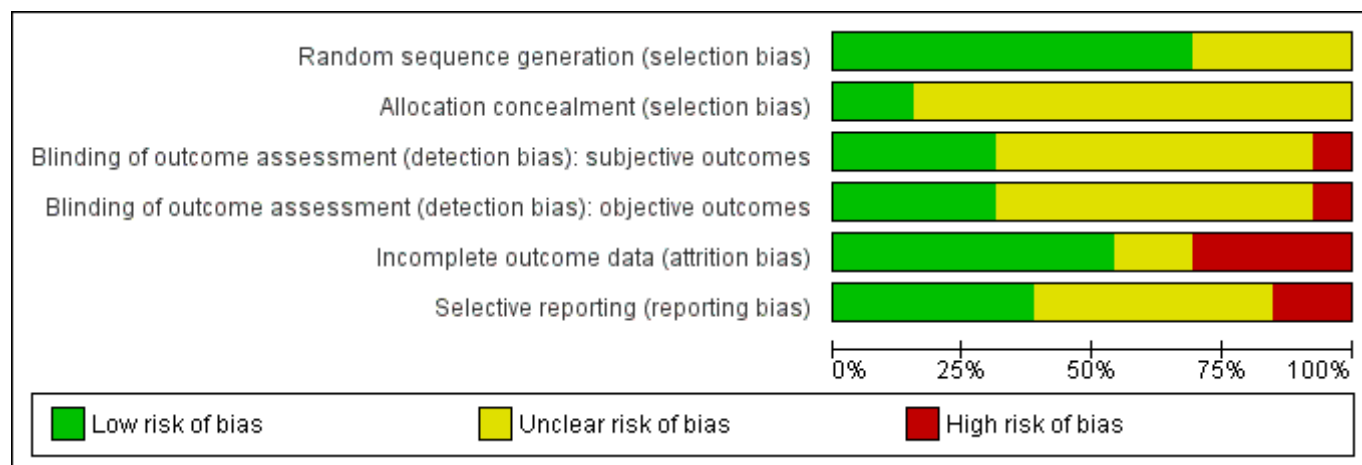
Loss to follow-up was reported to a differing extent in the included studies. We rated six studies as having low risk with limited attrition noted ([Johnson 2012](#); [Lanza 2014](#); [Sacks 2004](#); [Stein 2011](#); [Sundell 2008](#); [Wexler 1999](#)); three studies as having unclear risk ([Dakof 2015](#); [Sacks 2008](#); [Sacks 2011](#)); and four studies as having high risk of bias ([Cosden 2003](#); [Cullen 2012](#); [Malouf 2017](#); [McCarter 2016](#)).

### Selective reporting

We rated five of the thirteen trials as having unclear risk of bias ([McCarter 2016](#); [Sacks 2004](#); [Stein 2011](#); [Sundell 2008](#); [Wexler 1999](#)); six studies as having low risk ([Cosden 2003](#); [Cullen 2012](#); [Lanza 2014](#); [Malouf 2017](#); [Sacks 2008](#); [Sacks 2011](#)), and two studies as having high risk of bias ([Dakof 2015](#); [Johnson 2012](#)).

See [Figure 2](#) and [Figure 3](#) for details.

**Figure 2. Risk of bias graph: review authors' judgements about each risk of bias item presented as percentages across all included studies.**



**Figure 3. Risk of bias summary: review authors' judgements about each risk of bias item for each included study.**

	Random sequence generation (selection bias)	Allocation concealment (selection bias)	Blinding of outcome assessment (detection bias): subjective outcomes	Blinding of outcome assessment (detection bias): objective outcomes	Incomplete outcome data (attrition bias)	Selective reporting (reporting bias)
Cosden 2003	+	?	?	?	-	+
Cullen 2012	?	?	-	-	-	+
Dakof 2015	+	?	+	+	?	-
Johnson 2012	+	+	+	+	+	-

Figure 3. (Continued)

Johnson 2012	+	+	+	+	+	-
Lanza 2014	+	?	+	+	+	+
Malouf 2017	+	?	+	+	-	+
McCarter 2016	+	?	?	?	-	?
Sacks 2004	?	?	?	?	+	?
Sacks 2008	?	?	?	?	?	+
Sacks 2011	+	?	?	?	+	?
Stein 2011	+	?	?	?	+	?
Sundell 2008	+	+	?	?	+	?
Wexler 1999	?	?	?	?	+	?

## Effects of interventions

See: [Summary of findings for the main comparison](#) Therapeutic community compared to treatment as usual for drug-using offenders with co-occurring mental illness; [Summary of findings 2](#) Therapeutic community and aftercare compared to cognitive behavioural skills for drug using women offenders with co-occurring mental illness; [Summary of findings 3](#) Therapeutic community compared to waiting list control for drug-using offenders with co-occurring mental illness; [Summary of findings 4](#) Mental health treatment court with assertive case management model compared to treatment as usual for drug-using offenders with co-occurring mental illness; [Summary of findings 5](#) Motivational interviewing/mindfulness and cognitive skills compared to relaxation training for drug-using offenders with co-occurring mental illness; [Summary of findings 6](#) Motivational interviewing/mindfulness and cognitive skills compared to waiting list control for drug-using offenders with co-occurring mental illness; [Summary of findings 7](#) Motivational interviewing/mindfulness and cognitive skills compared to treatment as usual for drug-using offenders with co-occurring mental illness; [Summary of findings 8](#) Multi-systemic therapy involving family and juveniles compared to treatment as usual for drug-using offenders with co-occurring mental illness; [Summary of findings 9](#) Multi-systemic therapy involving family compared to group substance abuse therapy for drug-using adolescents with co-occurring mental illness; [Summary of findings 10](#) Interpersonal psychotherapy compared to a psychoeducational intervention for drug-using offenders with co-occurring mental illness; [Summary of findings 11](#) Legal defence service and wrap-around social work services compared to legal defence service only for drug-using offenders with co-occurring mental illness

### 1. Therapeutic community and aftercare versus treatment as usual

See [Summary of findings for the main comparison](#).

#### Impact on self-reported drug use

This was not reported.

#### Impact on self-reported criminal activity

[Sacks 2011](#) and [Sacks 2004](#) were combined to show a significant reduction in the number of re-arrests (risk ratio (RR) 0.67, 95% confidence interval (CI) 0.53 to 0.84) and re-incarcerations (RR 0.40, 95% CI 0.24 to 0.67), with moderate-certainty evidence at 12-month follow-up (266 participants; see [Analysis 1.1](#)).

### 2. Therapeutic community and aftercare versus cognitive-behavioural skills for drug-using women

See [Summary of findings 2](#).

#### Impact on self-reported drug use

[Sacks 2008](#) showed no significant reduction in self-reported drug use (RR 0.78, 95% CI 0.46 to 1.32), with low-certainty evidence at six-month follow-up (314 participants; see [Analysis 2.1](#)).

#### Impact on self-reported criminal activity

[Sacks 2008](#) showed no significant reduction in re-arrest for any type of crime (RR 0.69, 95% CI 0.44 to 1.09), criminal activity (RR 0.74, 95% CI 0.52 to 1.05), or drug-related crime (RR 0.87, 95% CI 0.56 to

1.36), with low-certainty evidence at six-month follow-up (314 participants; see [Analysis 2.2](#), [Analysis 2.3](#), and [Analysis 2.4](#)).

### 3. Therapeutic community versus waiting list control

See [Summary of findings 3](#).

#### Impact on self-reported drug use

This was not reported.

#### Impact on self-reported criminal activity

[Wexler 1999](#) showed a significant reduction (but a trend towards favouring) return to prison in favour of the therapeutic community intervention (RR 0.60, 95% CI 0.46 to 0.79), with moderate-certainty evidence at 36-month follow-up (478 participants; see [Analysis 3.1](#)).

### 4. Mental health treatment court with assertive case management model versus treatment as usual

See [Summary of findings 4](#).

#### Impact on self-reported drug use

[Cosden 2003](#) showed no significant reduction in Addiction Severity Index (ASI)-self-reported drug use (mean difference (MD) 0.00, 95% CI -0.03 to 0.03), with low-certainty evidence at 12-month follow-up (235 participants; see [Analysis 4.3](#)).

#### Impact on self-reported criminal activity

[Cosden 2003](#) showed no significant reduction in conviction for a new crime (RR 1.05, 95% CI 0.90 to 1.22) or re-incarceration to jail (RR 0.79, 95% CI 0.62 to 1.01), with low-certainty evidence at 12-month follow-up (235 participants; see [Analysis 4.1](#) and [Analysis 4.2](#)).

### 5. Motivational interviewing/mindfulness and cognitive skills versus relaxation therapy

See [Summary of findings 5](#).

#### Impact on self-reported drug use

[Stein 2011](#) compared cognitive skills to a relaxation training intervention for adolescents in prison with depressed mood. This study measured marijuana use at three-month follow-up assessment using the Risks and Consequences Questionnaire (RCQ). Researchers reported a main effect  $< .007$ , with participants in the motivational interviewing group showing fewer problems than participants in the relaxation training group. No further numerical information is available (moderate-certainty of evidence; 181 participants).

#### Impact on self-reported criminal activity

This was not reported.

### 6. Motivational interviewing/mindfulness and cognitive skills versus waiting list control

See [Summary of findings 6](#).

#### Impact on self-reported drug use

[Lanza 2014](#) reported no significant reduction in self-reported drug use based on the ASI (MD -0.04, 95% CI -0.37 to 0.29) and abstinence from drug use (RR 2.89, 95% CI 0.73 to 11.43), with low-certainty ev-

idence at six months (31 participants; see [Analysis 5.1](#) and [Analysis 5.2](#)).

### **Impact on self-reported criminal activity**

Studies did not assess this outcome.

## **7. Motivational interviewing/mindfulness and cognitive skills versus treatment as usual**

See [Summary of findings 7](#).

### **Impact on self-reported drug use**

[Malouf 2017](#) found no significant reduction in frequency of marijuana use (MD -1.05, 95% CI -2.39 to 0.29), with very low-certainty evidence at three months post release (40 participants; see [Analysis 6.1](#)).

[Cullen 2012](#) found no significant reduction in positive drug screens (MD -0.7, 95% CI -3.5 to 2.1), with very low-certainty evidence at 12 months (84 participants; see [Analysis 6.4](#)).

### **Impact on self-reported criminal activity**

[Malouf 2017](#) found a significant reduction in frequency of re-arrest (MD -0.66, 95% CI -1.31 to -0.01) but not in time to first arrest (MD 0.87, 95% CI -0.12 to 1.86), with very low-certainty evidence up to 36 months (40 participants; see [Analysis 6.2](#) and [Analysis 6.3](#)).

## **8. Multi-systemic therapy (involving family) and juveniles versus treatment as usual**

See [Summary of findings 8](#).

### **Impact on self-reported drug use**

[Sundell 2008](#) found no significant reduction in drug dependence on the Drug Use Disorders Identification Test (DUDIT) score (MD -0.22, 95% CI -2.51 to 2.07), with low-certainty evidence up to seven months (156 participants; see [Analysis 7.2](#)).

### **Impact on self-reported criminal activity**

[Sundell 2008](#) found no significant reduction in arrests (RR 0.97, 95% CI 0.70 to 1.36), with low-certainty evidence up to seven months (158 participants; see [Analysis 7.1](#)).

## **9. Multi-systemic therapy (involving family) versus adolescent group substance abuse therapy**

See [Summary of findings 9](#).

### **Impact on self-reported drug use**

This was not reported.

### **Impact on self-reported criminal activity**

[Dakof 2015](#) reported no significant reduction in re-arrests (MD -0.24, 95% CI -0.76 to 0.28), with low-certainty evidence up to 24 months (112 participants; see [Analysis 8.1](#)).

## **10. Interpersonal psychotherapy versus a psychoeducational intervention**

See [Summary of findings 10](#).

### **Impact on self-reported drug use**

[Johnson 2012](#) reported no significant reduction in self-reported drug use (RR 0.67, 95% CI 0.30 to 1.50), with very low-certainty evidence up to three months (38 participants; see [Analysis 9.1](#)).

### **Impact on self-reported criminal activity**

This was not reported.

## **11. Legal defence service and wrap-around social work services versus legal defence service only**

See [Summary of findings 11](#).

### **Impact on self-reported drug use**

This was not reported.

### **Impact on self-reported criminal activity**

[McCarter 2016](#) reported no significant reduction in the number of new offences committed (RR 0.64, 95% CI 0.07 to 6.01), with very low-certainty evidence up to 12 months (29 participants; [Analysis 10.1](#)).

## **DISCUSSION**

### **Summary of main results**

This systematic review provides evidence from 13 trials involving 2606 participants and evaluating 11 different comparisons; one pooled analysis was possible. Certainty of evidence was generally low. Most interventions were delivered in prison-based (eight studies; 61%), court (two studies; 15%), community (two studies; 15%), or medium secure hospital (one study; 8%) settings. Most studies compared an intervention versus treatment as usual or another intervention (11/13 studies; 84%).

The 11 different treatment comparisons were divided into:

- therapeutic community and aftercare versus treatment as usual ([Sacks 2004](#); [Sacks 2011](#));
- therapeutic community and aftercare versus a cognitive-behavioural skills course ([Sacks 2008](#)); and
- therapeutic community and aftercare versus a waiting list control ([Wexler 1999](#)).

Two studies comparing therapeutic community interventions reported a significant reduction in subsequent re-incarceration and criminal activity compared to treatment as usual ([Sacks 2004](#); [Sacks 2011](#)), with moderate-certainty evidence. [Sacks 2008](#) adapted a therapeutic community treatment for women offenders compared to a cognitive-behavioural skills course. This study compared women assigned to therapeutic community treatment or standard treatment versus a cognitive-behavioural recovery and relapse prevention curriculum, referred to in the system as the 'intensive outpatient programme' ([Sacks 2008](#)), with low-certainty evidence. At six months, researchers found that *both* groups improved significantly on variables of mental health, substance use, criminal behaviour, and HIV risk. Study authors noted that further exploration of each model for different offender groups is required to permit more precise utility of each model. They concluded that these preliminary findings suggest the importance of providing gender-specific sensitive and comprehensive approaches within the correctional system to respond to the complex substance abuse needs of



female offenders (Sacks 2008). Therapeutic community treatment was found to be more beneficial than cognitive-behavioural therapy, lengthening time spent in the community before subsequent re-incarceration (Sacks 2008). This finding partially supports previous research suggesting that the combination of therapeutic community treatment and aftercare release seems to produce the most consistent and successful results among offenders who do not have co-occurring mental health problems (Mitchell 2012a). Although this is not addressed within this review, clients who remained in treatment for the longest period appeared to benefit the most (Sacks 2004). These differences seem to be borne out for up to 36 months when compared to people who received nothing, suggesting that over time, the impact of the intervention eventually became dissipated (Wexler 1999), with moderate-certainty evidence. Only one of the four studies reported on outcomes of drug use (in women) and found no reductions following the intervention in comparison to attending a cognitive skills course (Sacks 2008). We do not know whether drug use is reduced in men with co-occurring mental health problems.

### **Mental health treatment court (MHTC) and use of an assertive case management model versus treatment as usual**

People under the care of the criminal justice system in *both* groups showed improvement across a range of outcomes in life satisfaction, a decrease in distress levels, and improvement in independent living. Overall, the pattern of criminal activity suggested that both groups spent time in jail but for different reasons. The individual under the care of the MHTC was more likely to be 'booked' for a crime and not convicted and to have more convictions due to probation violation in comparison to individuals who had received only treatment as usual. Those people receiving treatment as usual were more likely to be convicted of a new offence (Cosden 2003), with low-certainty evidence.

### **Motivational interviewing/mindfulness and cognitive skills versus a waiting list control; motivational interviewing/mindfulness and cognitive skills versus relaxation training; motivational interviewing/mindfulness and cognitive skills versus treatment as usual**

See Cullen 2012, Lanza 2014, Malouf 2017, and Stein 2011.

Four studies of motivational interviewing/mindfulness and cognitive skills compared to a waiting list control, relaxation training, and treatment as usual reported moderate- to very low-certainty evidence. No significant differences were noted across these studies, suggesting that use of such skills may not reduce subsequent drug use and/or criminal activity in comparison to any of the alternatives. In addition, one of the four studies was a pilot randomised controlled trial (RCT) of motivational interviewing versus treatment as usual, which suggests that larger studies are required to support any future findings. Use of self-reported measures often contaminated by social desirability bias means that confidence in these results may be limited (moderate-certainty evidence; Malouf 2017).

### **Multi-systemic therapy (MST) involving families versus treatment as usual; MST involving families versus group-based substance abuse therapy**

Two studies of multi-systemic therapy for juveniles included families and compared treatment as usual or an alternative group-based substance abuse therapy (Dakof 2015; Sundell 2008). Findings show that MST did not support short-term effectiveness rela-

tive to services usually available for conduct disordered youths in Sweden (Sundell 2008). This outcome is contrary to other work conducted in the United States and Norway but similar to work performed in Canada (Cunningham 2002). Sundell 2008 highlighted the importance of measuring and monitoring fidelity during transportation and delivery of interventions to other settings and different countries worldwide; the importance of the impact of social context should not be underestimated (low-certainty evidence).

### **Interpersonal psychotherapy versus psychoeducational intervention**

One pilot study of interpersonal psychotherapy in comparison to a psychoeducational intervention showed no significant reduction in subsequent drug use. However, these results should be interpreted with caution, given the small sample and the short follow-up period (very low-certainty evidence; Johnson 2012).

### **Legal defence work and wrap-around social services versus legal defence work only**

One pilot study of legal defence work and wrap-around social services in comparison to legal defence work with juveniles did not reveal any significant reduction in subsequent return to prison in the 12-month follow-up period. Study authors argue that holistic representation services can help to provide protective factors that might strengthen underlying risks and needs of young people, which might contribute to additional court involvement and/or re-offending in the future (very low-certainty evidence; McCarter 2016).

### **Successful treatment elements and dealing with complex co-occurring problems**

In terms of addressing some of the complex issues of individuals with mental health problems and co-occurring substance abuse, the evidence from this systematic review provides sparse information.

Several successful treatment elements were reported throughout these trials, and several key themes can be identified.

First, we noted that the issue of treatment engagement was important. In the mental health court trial, informal support from family and friends encouraged the engagement of clients within the community to longer-term gain, but more research is required to assess whether interventions that empower families can enhance and sustain outcomes longer than non-family-based interventions (Cosden 2003; Dakof 2015).

Second, programmes that were specifically adapted to the needs of mental health clients tended to include a cognitive-behavioural curriculum that emphasised criminal thinking and behaviour alongside psychoeducational classes. The purpose of combining these two types of mechanisms is to enhance an individual's ability to recognise and understand his/her substance misuse and mental health problems in greater detail (Sacks 2004).

Third, the longer an individual is engaged in treatment, the better is the outcome(s) (Wexler 1999).



## Overall completeness and applicability of evidence

### General applicability

Applicability of the evidence is hindered in general by the range of trials covering various different treatment options, making it inappropriate to pool study results. Most trials were conducted within the US judicial system; therefore, they are limited in their generalisability to criminal justice systems outside the United States. Three trials conducted in Spain (Lanza 2014), the United Kingdom (Cullen 2012), and Sweden provide a European perspective but with moderate-certainty evidence (Sundell 2008). As a result, study findings must be interpreted with caution.

### Mental health information

Although this review specifically sought to identify studies including participants with co-occurring mental health problems, study descriptions of mental ill health varied (see Table 1). Cosden 2003 used a psychiatrist or a psychologist to conduct a clinical interview to determine a mental health diagnosis alongside substance misuse. This resulted in a mental health court sample of individuals diagnosed with various mental health problems, including mood disorder, schizophrenia, bipolar disorder, and dual diagnosis. Other papers referred to use of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* diagnostic criteria, akin to the Youth Self-Report measure (Dakof 2015; McCarter 2016; Sacks 2011; Sundell 2008), but subsequently provided little information with regards to individual mental health needs. Demographic information in Sacks 2004 revealed other aspects of mental health prognosis, including lifetime mental health treatment, lifetime patient care, and prescribed medication.

The Wexler 1999 series of studies reported a range of diagnoses, including antisocial personality disorder, phobias, post-traumatic stress disorder, depression, dysthymia, and attention deficit disorder, but did not describe how these diagnoses were confirmed or assessed within the population.

Six of the 13 trials reported on change in mental health well-being. Three trials reported on use of the Beck Depression Inventory, the Global Severity Index, and the Posttraumatic Diagnostic Scale (Sacks 2004; Sacks 2008; Sacks 2011). Another study reported on depression but used the Hamilton Rating Scale for Depression (Johnson 2012). Four studies reported the presence of mood disorder alongside schizophrenia, general anxiety disorder, and/or antisocial personality disorder (Cosden 2003; Cullen 2012; Lanza 2014; Malouf 2017). Four studies discussed differential effects of treatment on the severity of depression (Cosden 2003; Johnson 2012; McCarter 2016; Stein 2011). Cosden 2003 noted that further understanding of how to help clients with serious mental health problems through different levels of treatment is needed. Johnson 2012 noted that participants undergoing interpersonal psychotherapy had significantly reduced levels of depression and substance misuse over attention-matched controls. Study authors noted that the intensity of treatment delivered once the individual is released into the community is key to maintaining good outcomes. However, they go on to state that people under the care of the criminal justice system often experience delays in treatment and service provision on release, and they suggest that alternative services such as phone treatment might be helpful in providing more intensive and useful post-release treatment in times of crisis.

## Quality of the evidence

We rated eight of 13 (62%) studies as having unclear risk of bias in more than four of eight domains. The main limiting factor was lack of reporting evidence, which prevented review authors from making a clear judgement on bias. Given that the imprecision of reporting lowers the quality of evidence, further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate. In addition, several specific limitations related to study design (and leading to problems of selection bias) were described, and sample sizes were small. Stein 2011 and Cullen 2012 were noted as being relatively underpowered. Replication of these studies is required to enhance the generalisability and external validity of study findings.

Similar modest sample sizes were reported, with some trials referred to as pilot studies (e.g. Malouf 2017; McCarter 2016). Sacks 2011 and Cosden 2003 suggest that larger samples should be used to provide a more precise estimate of effect. Small sample sizes limit the generalisability of the sample population to other settings, and few studies collected longitudinal data sufficient to support the ongoing use of such schemes without additional larger trials commissioned (Cullen 2012; Dakof 2015; McCarter 2016). Cosden 2003 also reported on the possibility of outcome bias, as the interviewer was not blind to the outcome condition of the participant nor to loss to follow-up (25% of the study sample were lost to follow-up) at 12 months.

Another possible selection bias concern in the series of Wexler studies was that participants were randomly assigned to prison therapeutic community treatment and regular prison conditions but not to aftercare (Prendergast 2003; Prendergast 2004; Wexler 1999). Study authors noted that possible differences in personal motivation may account for some of the positive outcomes associated with participants' continued support for aftercare services. Subsequently, these participants were noted as having the highest 'readiness scores', which suggests that motivation creates an important consideration for client selection (Wexler 1999). Cullen 2012 reported on the use of randomisation within sites, which may have led to contamination across treatment groups, and the likelihood that further selection bias might have arisen from the fact that declining patients were more unwell and/or antisocial, and that these factors might influence treatment outcomes (Cullen 2012).

Overall we judged the certainty of evidence as moderate to very low for all included interventions.

### Potential biases in the review process

Besides the limitations already discussed, the search method was limited to databases that could be accessed via the University of York, and extensive website searches were not conducted. We did not search specific trial registers. As a result, some literature may have been omitted from this updated version.

## AUTHORS' CONCLUSIONS

### Implications for practice

This review provides moderate- to very low-certainty evidence suggesting that use of therapeutic interventions might reduce subsequent criminal activity compared to control interventions such as treatment as usual, an alternative intervention, or nothing. Mental health treatment courts may reduce the number of subsequent

new crimes committed in comparison to treatment as usual. We do not have sufficient evidence to support whether these interventions are effective for both men and women involved in the criminal justice system, and evidence is insufficient to permit any judgements about differential effectiveness among different ethnic groups. Longer or more intensive interventions appear to have some effect on improving outcomes but perhaps only up until a particular time point. A further challenge in this field is the very wide range of outcome measures, which are reported over greatly varying periods of time. We identified too few trials reporting many of these outcome measures to provide sufficient statistical power to detect potentially small effects.

### Implications for research

We have identified several research implications.

- Good quality research is required to evaluate the effectiveness of interventions for offenders with substance misuse problems and co-occurring mental health problems. Of particular interest are the extended long-term effects of aftercare and the level of contact required with services in the community. Further research to explore the intensity of different community treatment alternatives following release may help to unravel this process.
- Better descriptions of participants' mental health problems and more detailed information about mental health diagnoses are

required to enable the transferability of information to clinical practice. Such information could also facilitate the use of mental health diagnoses as a moderator within analysis of these outcomes.

- Trial interventions specifically focusing on females and adolescents are required. In the current review, two studies focused only on females, and three studies reported on outcomes with youth involved in the criminal justice system.
- Little is known about the interaction between mental health problems, individual personal characteristics, and positive outcomes related to treatment success. In terms of depression, [Stein 2011](#) attempted to explore some of the differences between participants with few and with many depressive symptoms. Future studies should consider an analysis of existing data sets that might reveal which individuals with which mental health diagnoses fare better than others. This would reveal who might potentially benefit most from treatment and would enable appropriate targeting of resources.

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\* Indicates the major publication for the study

## CHARACTERISTICS OF STUDIES

### Characteristics of included studies [ordered by study ID]

#### Cosden 2003

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	235 adults Age not reported 50.2% male 70.6% European American Drug use not reported Alcohol use not reported 100% psychiatric history <b>Eligibility criteria:</b> adults charged with a crime or misdemeanour who were booked into county jail, had at least 1 prior booking, were diagnosed with a serious and pervasive mental illness, and were residents of the county involved. Pre-plea participants were required to have no previous offences involving violence; post-adjudication participants with prior violence were eligible if they were considered to no longer pose a threat
Interventions	Court-based sentencing and case management intervention vs treatment as usual <b>Experimental intervention</b>  Psychosocial intervention: mental health treatment court (MHTC) consisting of case management and assertive community treatment (ACT) based on a case management model: weekly or bi-weekly court supervision and frequent contact with case managers, duration 18 months, followed by treatment as usual if required (n = 137)  <b>Setting:</b> community  <b>Length of treatment:</b> 18 months  <b>Length of follow-up:</b> 6 months and 12 months

#### Interventions for drug-using offenders with co-occurring mental health problems (Review)

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**Cosden 2003** (Continued)

**Control:** treatment as usual: traditional court proceedings and county mental health services as usual for at least 18 months, which was less intensive than the intervention (n = 98)

**Setting:** community

**Length of treatment:** 18 months

**Length of follow-up:** 6 months and 12 months

Outcomes	Drug use (Addiction Severity Index, self-report) during the last month at 12 months' follow-up Re-arrests
Notes	<b>Funding:</b> this research was sponsored by a grant from the California State Board of Corrections, the Mentally Ill Offender Crime Reduction Grant Program <b>Contract/grant sponsor:</b> California State Board of Corrections  <b>Conflict of interest:</b> no declaration of interest reported by study authors  <b>Country:</b> USA

**Risk of bias**

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random numbers table
Allocation concealment (selection bias)	Unclear risk	Not reported
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	Insufficient information to permit judgement
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	Insufficient information to permit judgement
Incomplete outcome data (attrition bias) All outcomes	High risk	25% of the initial population could not be located at the end of 12 months
Selective reporting (reporting bias)	Low risk	All study outcomes listed and reported in the paper; no evidence of a trial protocol

**Cullen 2012**

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	84 adults  <b>Average age:</b> 35 years (SD 11.4)  100% male  52% African American

**Cullen 2012** (Continued)

100% psychiatric history

**Eligibility criteria:** (a) a primary clinical diagnosis of psychotic disorder (schizophrenia, schizoaffective disorder, bipolar disorder, or other psychotic disorder); (b) history of violence; (c) not having participated in R&R or a similar programme previously; (d) not actively psychotic (score of 4 on each of the Positive and Negative Symptom Scale P items (PANSS; Kay, Opler, & Fiszbein, 2000)); (e) absence of significant cognitive impairments (i.e. IQ70 or impairments likely to lead to inability to cope with the demands of the group); and (f) proficiency in English language sufficient to allow participation in the programme as judged by the treating team. Patients with comorbid personality or substance use disorders were not excluded

**Interventions**

Reasoning and rehabilitation vs treatment as usual

**Experimental intervention:** psychosocial intervention: Reasoning and Rehabilitation (R&R) is a highly structured, manualised programme targeting social problem-solving skills and thinking styles. This programme is delivered over a minimum of 36 two-hour sessions and includes 8 core modules: problem-solving, assertiveness skills, social skills, negotiation skills, creative thinking, emotion management, values reasoning, and critical reasoning. The programme was delivered by experienced staff who had received training during intensive 5-day workshops provided by the programme authors. Sessions were held twice or three times weekly (5 to 8 patients per group). Unit staff were given the flexibility to deliver the original R&R programme or the revised programme (n = 44)

**Setting:** medium secure forensic hospital

**Length of treatment:** 36 two-hour sessions, 2 to 3 times per week. Participants attending a minimum of 30 sessions were considered 'completers'

**Length of follow-up:** 12 months post intervention

**Control:** treatment as usual; none of the sites provided any other interventions that were aimed at reducing violent or antisocial behavior throughout the trial (n = 40)

**Setting:** medium secure forensic hospital

**Length of treatment:** not reported

**Length of follow-up:** 12 months post intervention

**Outcomes**

Urine drug screen for substance abuse

**Notes**

**Funding:** financial support provided by the NHS National Research and Development Programme on Forensic Mental Health Science, United Kingdom

**Conflict of interest:** not reported

**Country:** UK

**Risk of bias**

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method used for random sequence generation not reported
Allocation concealment (selection bias)	Unclear risk	Method used for concealed allocation not reported
Blinding of outcome assessment (detection bias) subjective outcomes	High risk	"Researchers who conducted assessments were not blinded to allocation status, as this information was often revealed in clinical notes or by patients themselves"

## Cullen 2012 (Continued)

Blinding of outcome assessment (detection bias) objective outcomes	High risk	"Researchers who conducted assessments were not blinded to allocation status, as this information was often revealed in clinical notes or by patients themselves"
Incomplete outcome data (attrition bias) All outcomes	High risk	Although > 10% had missing data in both groups, 50% of the R&R group did not complete treatment
Selective reporting (reporting bias)	Low risk	Outcomes were represented in the paper; study authors specified primary and secondary outcomes and listed all outcomes in the analyses

## Dakof 2015

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	112 juveniles  100 (89%) male  Mean age (SD): not reported (age range reported as between 13 and 18 years)  <b>Eligibility criteria:</b> participants were (a) between the ages of 13 and 18; (b) diagnosed with substance abuse or dependence based on a structured interview; (c) not actively suicidal, demonstrating psychotic symptoms, or diagnosed with pervasive developmental disorder or mental retardation; (d) not currently charged for sale of drugs, weapons, or violent offences, or sexual battery; and (e) after consultation with their attorney, voluntarily enrolled in drug court
Interventions	Multi-dimensional family therapy (MDFT) vs adolescent group-based treatment (AGT)  <b>Experimental Intervention:</b> MDFT family-based treatment: therapists work individually with each family. Therapists work simultaneously in 4 interdependent treatment domains - adolescent, parent, family, and community. At various points throughout treatment, therapists meet alone with the adolescent, alone with the parent(s), or conjointly with the adolescent and parent(s), depending on the treatment domain and the specific problem being addressed (n = 55)  <b>Setting:</b> juvenile drug court (JDC) sessions conducted in clinic and at home  <b>Length of treatment:</b> 4 to 6 months - with 2 sessions per week (average of 9.4 hours per month)  <b>Length of follow-up:</b> 6, 12, 18, and up to 24 months after baseline  <b>Control:</b> AGT was a manual-guided intervention based on cognitive-behavioural therapy and motivational interviewing. Features and format were guided by research-supported principles and procedures and combine education, skills training, and social support (Center for Substance Abuse Treatment (CSAT)). Each session was structured, beginning with goal-setting/self-monitoring of goal attainment, and followed by didactic/experiential activities, group processing/reflection, and closure. One therapist led each session, with between 4 and 6 male and female adolescents participating. Groups were "open" (vs "closed") in that new members were admitted on a rolling basis (n = 57)  <b>Setting:</b> juvenile drug court (JDC) sessions conducted in clinic  <b>Length of treatment:</b> 4 to 6 months - with 3 sessions per week (average of 10.56 hours per month)  <b>Length of follow-up:</b> 6, 12, 18, and up to 24 months after baseline
Outcomes	Drug consumption

## Dakof 2015 (Continued)

Number of arrests

### Notes

**Funding:** the work reported was supported by the National Institute on Drug Abuse, Grant R01 DA 017478

**Conflict of Interest:** 2 study authors received financial compensation for their role as consultants and members of the Board of Directors of MDFT International. One study author received financial compensation for his role of Director on the MDFT Board

**Country:** USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Urn randomisation procedure to ensure equivalence
Allocation concealment (selection bias)	Unclear risk	Method used for allocating randomised participants to treatment groups not reported
Blinding of outcome assessment (detection bias) subjective outcomes	Low risk	Efforts were made to keep assessors unaware of study hypotheses and treatment assignments
Blinding of outcome assessment (detection bias) objective outcomes	Low risk	Efforts were made to keep assessors unaware of study hypotheses and treatment assignments
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	Study authors report that an intent-to-treat analysis was used and provide numbers withdrawing by group in a flow chart. However, statistical methods used for handling missing data are not reported
Selective reporting (reporting bias)	High risk	Not all outcomes are reported in the results. Two outcomes are reported in the methods section of the paper: graduation from drug court, and length of time on treatment; these are not included in the protocol

## Johnson 2012

### Methods

**Study design:** RCT

**Study grouping:** parallel-group

### Participants

38 adults

Average age: 35 years (SD 9.2)

100% female

18% Hispanic, 18% African American

58% cocaine dependence, 24% opiate dependence, 21% marijuana dependence, 21% sedative/hypnotic dependence

58% alcohol dependence

100% psychiatric history

**Johnson 2012** (Continued)

Criteria used for mental health diagnoses: "MDD as determined by the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First et al., 1996a) after at least 4 weeks of abstinence and prison substance use treatment"

Description of mental health problem: major depressive disorder

**Eligibility criteria:** primary major depressive disorder as determined by the Structured Clinical Interview for DSM-IV Axis I Disorders after at least 4 weeks of abstinence and prison substance use treatment, minimum 17-item Hamilton Depression Scale score of 18, substance use disorder 1 month before incarceration as determined by the SCID, 10 to 24 weeks away from prison release. Women with bipolar disorder and psychotic disorder were excluded

**Interventions**

Interpersonal psychotherapy vs psychoeducation attention-matched control

**Experimental Intervention**

Participants received manualised group and individual sessions in prison for treatment of substance misuse and mental health problems. Participants in both conditions also received 6 weekly post-release individual sessions to help maintain gains and address crises as they transitioned to the community. Session length varied between 60 and 75 minutes because of time taken to assemble women within the facilities, occasional early prison counts, and other facility logistics. In-prison treatment was condensed into 2 months because many incarcerated women serve short sentences (30, 60, 90, 180 days) (n = 19)

**Setting:** prison

**Length of treatment:** 60 to 75 minutes, 3 times a week for 8 weeks, plus pre/mid and post-group individual sessions and 6 weekly post-release individual sessions to support transition into the community

**Length of follow-up:** end of treatment at 8 weeks

**Control:** participants received attention-matched manualised in-prison and post-release psychoeducation, which is described as co-occurring mental health and substance use disorders (PSYCHOED). The psychoeducation condition was adapted from a class on co-occurring disorders for prisoners that had been used at the women's facilities in the past but was not being used at the time of the study. It was designed to be credible and engaging without focusing on the theorised active ingredients of interpersonal psychotherapy (e.g. focus on social support, relationships, life changes, analysis of communication, exploration of emotions). The stated purpose of PSYCHOED was to help women become informed and to empower consumers of mental health treatment services. The 24 in-prison sessions focused on the meaning of dual diagnosis, women's experience with dual diagnosis, major depression, bipolar disorder, each of the anxiety disorders, post-traumatic stress disorder, personality disorders, psychotic disorders, eating disorders, and self-care. Sessions for each disorder described symptoms (including relevant self-report tests), interactions between the disorder and substance use, effects of the disorder on women in prison (including film clips and written stories), and disorder-specific medication and psychosocial treatment options. When a woman in the group had symptoms of a disorder, the group discussed her treatment options and preferences.

The 6 post-release sessions focused on women's symptoms and connection with various mental health and substance use treatment options in the community. Study treatments took place in addition to prison treatment as usual. Treatment as usual consisted of prison residential or day treatment for substance use disorder (typically 16 to 30 hours per week) for all participants and prison mental health treatment as usual for most participants (n = 19)

**Setting:** prison

**Length of treatment:** 60 to 75 minutes, 3 times a week for 8 weeks, plus pre/mid and post-group individual sessions and 6 weekly post-release individual sessions to support transition into the community

**Length of follow-up:** end of treatment at 8 weeks

**Outcomes**

Relapse defined as using drugs on at least 10% of non-incarcerated days or any positive breath test/urine drug screen



## Johnson 2012 (Continued)

Notes

**Funding:** work supported by US National Institute of Drug Abuse

**Conflicts of interest:** no declarations of interest were noted by study authors

**Country:** USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Wave randomisation used with at least 8 weeks between allocations to avoid contamination across prison wings
Allocation concealment (selection bias)	Low risk	Random sequence generated by person independent of rest of study. Allocation adequately concealed from principal investigator and research assistants. An independent individual concealed the assignment of each wave before the study started. After the intake assessment was complete, the principal investigator unsealed the waves treatment assignment
Blinding of outcome assessment (detection bias) subjective outcomes	Low risk	Adequate blinding throughout study. Research assistants who conducted follow-up assessment at 3 months after prison release were kept blind to the condition
Blinding of outcome assessment (detection bias) objective outcomes	Low risk	Adequate blinding throughout the study. Research assistants who conducted follow-up assessment at 3 months after prison release were kept blind to the condition
Incomplete outcome data (attrition bias) All outcomes	Low risk	No loss to follow-up; intention-to-treat analysis
Selective reporting (reporting bias)	High risk	Did not report on SCID-I/SCID-II, Trauma History Questionnaire, or Timeline Followback

## Lanza 2014

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	50 adults  Average age: overall mean 33.2 (SD 7.2) (range 21 to 49)  CBT 35.2 (mean); ACT 31.1 (mean); control 33.1 (mean)  100% female  NR % white  % drug users: CBT 100%, ACT 83.3%, control 100%  % alcohol users: CBT 0%, ACT 16.7%, control 100%  % psychiatric history: 86% had at least 1 mental disorder  <b>Eligibility criteria:</b> met diagnostic criteria for current substance use disorder; serving sentence longer than 6 months

**Lanza 2014** (Continued)

## Interventions

**Cognitive-behavioural therapy vs acceptance commitment therapy**

**Experimental Intervention one:** cognitive-behavioural therapy (CBT) was used to change behaviour through cognitive restructuring, whereby therapist works with offender to identify thoughts that cause distress and uses cognitive and behavioural therapy to alter resulting behaviour. The main outcome of the CBT intervention was increased abstinence from drug use; this was measured and corroborated by urine analysis testing (n = 19)

**Setting:** prison

**Length of treatment:** 16 weekly group sessions lasting 90 minutes each

**Length of follow-up:** 6, 12, 18 months

**Experimental Intervention two:** acceptance commitment therapy (ACT) seeks to undermine the grip of the literal verbal content of cognition that provokes avoidance behaviour and constructs an alternative context in which behaviour aligned with one's values is more likely to occur. Sessions involve both experiential and didactic learning to enable clients to experience and understand the size key ACT processes. ACT helps offenders to respond to previously avoided events in new ways and uses validation and empowerment. ACT was aimed at increasing substance use abstinence within the prison population. After treatment offenders were assessed by the therapist, follow-up was conducted at 6 months (n = 18)

**Setting:** prison

**Length of treatment:** 16 weekly group sessions lasting 90 minutes each

**Length of follow-up:** 6, 12, 18 months

**Control:** received a mental health assessment at the same time as experimental groups. After 6-month follow-up, they received treatment. Offenders received a re-educational programme for inmates during incarceration (n = 13)

**Setting:** prison

**Length of treatment:** 16 weekly group sessions lasting 90 minutes each

**Length of follow-up:** 6, 12, 18 months

## Outcomes

Abstinence from drug use, corroborated by urinalysis

Percentage of abstinence

## Notes

**Funding:** work supported by Trust for the Promotion of Scientific Applied Research and Technology, in Asturias, Spain

**Conflict of Interest:** no conflict of interest reported by study authors

**Country:** Spain

**Risk of bias**

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Use of random numbers table noted
Allocation concealment (selection bias)	Unclear risk	No information reported
Blinding of outcome assessment (detection bias)	Low risk	Urinalysis was used to corroborate self-reported abstinence

## Lanza 2014 (Continued)

subjective outcomes

Blinding of outcome assessment (detection bias) objective outcomes	Low risk	The clinician who conducted baseline assessments was also in charge of administering the measures
Incomplete outcome data (attrition bias) All outcomes	Low risk	Similar loss to follow-up across all 3 groups; a total of 9/50 lost (n = 4 for ACT, n = 3 for CBT, n = 2 for control)
Selective reporting (reporting bias)	Low risk	Protocol measures and information reported in the methods section of the paper were comparable

## Malouf 2017

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group	
Participants	40 adults  Average age: overall mean 37.2 (15.7)  Ethnicity not reported  % drug users: not reported  % alcohol users: not reported  % psychiatric history: REVAMP group 10.8% and TAU group 16.4% diagnosed at time one  <b>Eligibility criteria:</b> participants were 40 adult males incarcerated at a suburban jail in the mid-Atlantic region of the USA. Inclusion criteria were assignment to the jail's general population (i.e. not solitary confinement), language proficiency in English, post-sentencing status, and a release date that would allow adequate time for study participation. The group does contain those with a borderline personality disorder. No details are provided about how the sample was diagnosed	
Interventions	The Re-entry Values and Mindfulness Program (REVAMP) vs treatment as usual  <b>Experimental intervention:</b> the Re-entry Values and Mindfulness Program (REVAMP) is a manualised group intervention for jail inmates nearing release into the community. It incorporates and adapts elements from several mindfulness-based interventions (MBIs), including acceptance and commitment therapy, mindfulness-based relapse prevention (MBRP), and dialectical behavioural therapy (DBT). REVAMP begins with a focus on personal values identification to reduce defensiveness and increase motivation for treatment. Next, it uses a variety of exercises to reduce experiential avoidance and thereby alleviate psychological suffering. These exercises include metaphors from ACT, distress tolerance skills from DBT, and mindfulness meditation practices from MBRP. Treatment closes with return to a focus on valued living, and participants are engaged in values clarification and goal identification exercises. Throughout REVAMP, mindfulness meditation practice is encouraged through centring exercises at the beginning and end of sessions, in addition to mindfulness meditation homework assignments (n = 21)  <b>Setting:</b> jail  <b>Length of treatment:</b> 2 times per week for 90 minutes for a total of 4 weeks  <b>Length of follow-up:</b> up to 3 years post release  <b>Control:</b> treatment as usual: included programmes that were normally available within the prison such as anger management, financial planning, health education, GED preparation, religious services, substance abuse treatment, employability skills, and computer skills (n = 19)	

## Malouf 2017 (Continued)

**Setting:** jail

**Length of treatment:** not reported

**Length of follow-up:** up to 3 years post release

Outcomes	Arrest frequency 3 years post release Time to first arrest/offence 3 years post release Frequency of marijuana use 3 months post release
Notes	<b>Funding:</b> grant from the Center for Consciousness and Transformation (CCT) at George Mason University; 2 grants from the National Institute on Drug Abuse (NIDA) (#R01 DA14694 and #F31DA029397) <b>Conflict of interest:</b> not reported <b>Country:</b> USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Using a computerised random number generator
Allocation concealment (selection bias)	Unclear risk	Not specified
Blinding of outcome assessment (detection bias) subjective outcomes	Low risk	All data were collected by trained research assistants who were blind to treatment conditions
Blinding of outcome assessment (detection bias) objective outcomes	Low risk	All data were collected by trained research assistants who were blind to treatment conditions
Incomplete outcome data (attrition bias) All outcomes	High risk	At follow-up, over 50% of the group had been lost to follow-up in the intervention and treatment as usual arms. Reduction from n = 21 to n = 11 in the intervention arm. Less loss to follow-up was shown in the treatment as usual group, which was reduced from n = 19 to n = 13. Study authors do not mention how they treated missing data in their analysis plan
Selective reporting (reporting bias)	Low risk	Measures listed in the methods section of the paper

## McCarter 2016

Methods	<b>Study design:</b> RCT <b>Study grouping:</b> parallel-group
Participants	51 juveniles Average age: overall mean 14.5 years Ethnicity: 70% African American % drug users: not reported

## McCarter 2016 (Continued)

% alcohol users: not reported

% psychiatric history: not reported

**Eligibility criteria:** first-time offenders, ages 11 to 16, with assignment to an agency attorney. Exclusion criteria were prior offences or a diversion contract, current mental health commitments, undisciplined designation, or limited English proficiency

### Interventions

Family wrap-around forensic social work services and existing legal defence service vs treatment as usual comparison group

**Experimental intervention:** the wrap-around approach provides a collaborative and co-ordinated response of service providers who organise and streamline service delivery. This includes attending any team meeting with or on behalf of youth, providing service referrals, and connecting families and guardians to local providers for appropriate mental health, substance abuse, and educational services and support. When needed, they also arrange for physical health services at the local clinic that served the adolescents' medical home (n = 22)

**Setting:** court and community

**Length of treatment:** not reported

**Length of follow-up:** 6 months after baseline and up to 12 months during the study

**Control:** received only legal defence service (n = 25)

**Setting:** court and community

**Length of treatment:** not reported

**Length of follow-up:** 6 months after baseline and up to 12 months during the study

### Outcomes

Recidivism

### Notes

**Funding:** supported in part by a Faculty Research Grant at the University of North Carolina Charlotte

**Conflict of interest:** not reported

**Country:** USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Individuals were assigned case numbers via a random number generator
Allocation concealment (selection bias)	Unclear risk	Insufficient information was provided
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	Not reported
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	Not reported
Incomplete outcome data (attrition bias) All outcomes	High risk	Study authors describe intention-to-treat analysis. However, there is a significant imbalance between missing data in the intervention and control groups, with attrition rates of less than 10% and greater than 70%, respectively. Out-

## McCarter 2016 (Continued)

		come data were reported for completers only, and 18/25 (72%) withdrew from the control group
Selective reporting (reporting bias)	Unclear risk	A study protocol is not reported to check for selective reporting. Prespecified outcomes are reported, although without much detail. It is not clear where "number of new offences" was stated beforehand

## Sacks 2004

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	236 adults Mean age 34.3 years (SD 8.8) 100% male 49% white 100% drug-using 32% alcohol-using 100% psychiatric history  <b>Eligibility criteria:</b> prisoners who had both a serious mental disorder and a substance use disorder
Interventions	Secure establishment-based therapeutic community vs treatment as usual  <b>Experimental intervention:</b> the Personal Reflections initiative is a modified TC residential treatment programme that uses a cognitive-behavioural curriculum within a foundation of TC principles to change attitudes and lifestyles in 3 critical areas: substance abuse, mental illness, and criminal thinking and behaviour. The intervention group received a mixture of psychoeducational classes, cognitive-behavioural methods, medication, and group therapy. Aftercare included mental health counselling, medication and psychiatric services, and basic skills (n = 142)  <b>Setting:</b> prison  <b>Length of treatment:</b> 5 days per week for 4 to 5 hours per day for up to 12 months. Voluntary aftercare following the TC intervention included attendance for between 3 and 7 days per week for 3 to 5 hours per day for up to 6 months  <b>Length of follow-up:</b> 12 months post prison release  <b>Control:</b> received intensive psychiatric services with medication, weekly individual therapy and counselling, and specialised groups of cognitive-behavioural work, anger management, therapy and education, domestic violence, parenting, and weekly drug/alcohol therapy, with a 72-hour course on substance abuse education and relapse prevention over 12 months (n = 94)  <b>Setting:</b> prison  <b>Length of treatment:</b> a variety of activities including a 72-hour course up to 12 months  <b>Length of follow-up:</b> 12 months post prison release
Outcomes	Criminal activity regarding a new offence (official records) Incarceration for a new offence (official records)  Drug use (self-report)
Notes	<b>Funding:</b> contract/grant sponsor: National Institute on Drug Abuse (NIDA); contract/grant number: P50 DA7700.0003  <b>Conflict of interest:</b> no declaration of interest reported by study authors

**Sacks 2004** (Continued)

Country: USA

**Risk of bias**

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Methods used for random sequence generation not reported
Allocation concealment (selection bias)	Unclear risk	Method used for concealment not reported
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	No information on blinding reported
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	No information on blinding reported
Incomplete outcome data (attrition bias) All outcomes	Low risk	Some differences between groups: at follow-up, 82% for the (I) group and 69% for the (C) group. ITT was performed and missing data were added to the data set
Selective reporting (reporting bias)	Unclear risk	Protocol for trial not identified. Measures reported in the methods of the paper provide some information and concur with the outcomes reported in the results section of the paper

**Sacks 2008**

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	573 adult women Mean age 35.6 (SD 7.5) 100% female 47.8% white 99% drug-using  <b>Eligibility criteria:</b> female inmates with at least 6 months remaining until parole with serious substance abuse problems requiring treatment and presenting a minimum/medium security risk
Interventions	Therapeutic community programme vs cognitive-behavioural intervention  <b>Experimental intervention:</b> the therapeutic community group received a modified intervention for male inmates with co-occurring serious mental and substance use disorders. The intervention involved a 6-month tenure in a separate residential building, with programme activities supplemented by peer-led activities on weekends, and a further 4 hours per day. The programme followed therapeutic community principles, with additional gender-specific aspects (n = 257)  <b>Setting:</b> prison  <b>Length of treatment:</b> 5 days per week for 4 hours per day (and supplemented on the weekend with additional 4 hours per day); average time spent was 6.5 months  <b>Length of follow-up:</b> 6, 12, and 18 months post prison release



## Sacks 2008 (Continued)

**Control:** the Intensive Outpatient Program is the standard treatment that the Colorado Department of Corrections offers to all female offenders who have been classified as substance abusers. This intervention is designed to address substance abuse and criminality, with focus on prevention of relapse and recidivism. The Intensive Outpatient Program substance abuse treatment curriculum consists of a 90-hour course, presented in an educational format (Strategies for Self-Improvement and Change, Wanburg & Milkman, 1998), utilising a cognitive-behavioural format to address underlying issues of substance use/abuse and criminal behaviour. Women in the programme can participate in multiple other services facility-wide, including mental health assessments (n = 211)

**Setting:** prison

**Length of treatment:** 2 days per week for 2 hours per day. Duration was approximately between 6 and 9 months

**Length of follow-up:** 6, 12, and 18 months post prison release

Outcomes	Criminal activity, arrest, and drug-related activity (self-reported)  Criminal record data (% incarcerated, mean days to incarceration)  Self-reported illegal drug use
Notes	<b>Funding:</b> work supported by US Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse  <b>Conflict of interest:</b> no declarations of interest are noted by study authors  <b>Country:</b> USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	No information other than "were randomly assigned"
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	No information about whether assessors were blind
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	No information about whether assessors were blind
Incomplete outcome data (attrition bias) All outcomes	Unclear risk	No loss to follow-up for re-incarceration outcome, but loss to follow-up for other outcomes unclear  Differences noted between data collected via self-report and official records. Intention-to-treat analysis used to analyse outcome measures
Selective reporting (reporting bias)	Low risk	No evidence of selective reporting

## Sacks 2011

Methods	<b>Study design:</b> RCT
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### Interventions for drug-using offenders with co-occurring mental health problems (Review)

**Sacks 2011** (Continued)

**Study grouping:** parallel-group

Participants	<p>127 adults</p> <p>Mean age 38.2 years (SD 9.9)</p> <p>100% male</p> <p>56% white</p> <p>100% co-occurring substance use and mental health problems</p> <p>Alcohol use: unknown</p> <p>61.8% with clinical level of psychological distress as measured by Global Severity Index</p> <p><b>Eligibility criteria:</b> male; diagnosed with co-occurring mental and substance use disorders; had participated in 1 of 2 prison substance abuse treatment programmes; approved for placement in a community corrections facility and accepted by the provider agency for placement in a community corrections facility</p>
Interventions	<p>Re-entry modified therapeutic community vs parole supervision case management</p> <p><b>Experimental intervention:</b> consisted of a residential programme of 6 months' duration. Participants had progressively increasing independence, eventually being responsible for providing counsel, guidance, and coaching for new members. Participants also worked in the community and saved money for independent living. There were weekly group psychoeducational classes to address the interrelationship between mental disorders and substance abuse, as well as various other group and individual counselling sessions. Medication monitoring and psychiatric services were provided on-site. Participants were given assistance with housing and encouragement for employment (n = 71)</p> <p><b>Setting:</b> prison</p> <p><b>Length of treatment:</b> 3 to 7 days per week, 3 to 5 hours each day for 6 months</p> <p><b>Length of follow-up:</b> 12 months post prison release</p> <p><b>Control:</b> participants were released to a community corrections facility and left the facility during the day to go to work, have treatment, and report to parole officers. Control consisted of outreach and engagement activities, brokering community-based services, and direct provision of support and counselling services. There was a weekly relapse prevention group and daily medication monitoring. Psychiatric and substance abuse services were provided by outside agencies (community parole officers helped clients choose). Unlike in the intervention, criminal thinking and behaviour were not specifically addressed. The average participant attended 1 group per week and had monthly psychiatric assessments (n = 56)</p> <p><b>Setting:</b> transition from prison into the community</p> <p><b>Length of treatment:</b> 1 session per week for up to 6 months</p> <p><b>Length of follow-up:</b> 12 months post prison release.</p>
Outcomes	<p>Rate of re-incarceration</p> <p>Number of days until re-incarceration</p> <p>Involvement in self-reported criminal activity</p> <p>Number of days until self-reported criminal activity</p> <p>Alcohol and drug offences (self-reported)</p> <p>Other offences (self-reported)</p>

## Sacks 2011 (Continued)

### Notes

**Funding:** this project received support from the Department of Health and Human Services, National Institutes of Health, NIDA (Grant 5R01DA019982-[01-05])

**Conflict of interest:** no declarations of interest reported by study authors

**Country:** USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Random number list
Allocation concealment (selection bias)	Unclear risk	Not reported
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	No information about blinding presented
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	No information about blinding presented
Incomplete outcome data (attrition bias) All outcomes	Low risk	Intent-to-treat analyses conducted
Selective reporting (reporting bias)	Unclear risk	Outcomes reported in the methods section of the paper and in the outcomes list. No protocol obtained

## Stein 2011

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	189 adolescents  Mean age 17.12 years (SD 1.10). Range 14 to 19 years  85.7% male  32.8% white  88.9% marijuana use  63% alcohol use  68.5% had significant depressive symptoms during past week at baseline (CES-D)  <b>Eligibility criteria:</b> 14 to 19 years old, sentenced to juvenile correctional facility for 4 to 12 months, engaged in at least monthly marijuana use or binge-drinking in the year before incarceration, used any alcohol or marijuana in the month before incarceration (or before committing the offence leading to incarceration)
Interventions	Secure establishment-based motivational interviewing vs relaxation treatment

## Stein 2011 (Continued)

**Experimental intervention:** the intervention was designed specifically to reduce substance use and its associated risks and consequences. Treatment was manualised. Motivational interviewing focused on empathy, not arguing, developing discrepancy, self-efficacy, and personal choice (n = 96)

**Setting:** prison

**Length of treatment:** 90-minute baseline intervention and 60-minute booster session within 2 weeks of release

**Length of follow-up:** 3 months post release

**Control:** involved relaxation techniques as well as advice on risky behaviours associated with substance use. Intervention included progressive muscle relaxation, use of guided imagery, and feedback on use of techniques (n = 85)

**Setting:** prison

**Length of treatment:** 90-minute baseline intervention and 60-minute booster session within 2 weeks of release

**Length of follow-up:** 3 months post release

Outcomes	Mean number of joints per day  Mean percentage of days used marijuana
Notes	<b>Funding:</b> this research was supported by National Institute on Drug Abuse Grant R01 #13375 (to L.A.R. Stein, principal investigator)  <b>Conflict of interest:</b> no declaration of interest reported by study authors  <b>Country:</b> USA

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	"Random assignment using a random number table"
Allocation concealment (selection bias)	Unclear risk	"Random number was placed in an envelope and opened by research staff after the baseline assessment"  No information given about whether envelopes were sequentially numbered, opaque, or sealed
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	Follow-up assessments at 3 months were completed blind by researchers but not at any other time point
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	Follow-up assessments at 3 months were completed blind by researchers but not at any other time point
Incomplete outcome data (attrition bias) All outcomes	Low risk	8/71 were lost to follow-up in the RMTC group, and 9/56 were lost to follow-up in the PSCM group. ITT was conducted for the secondary outcome of criminal activity
Selective reporting (reporting bias)	Unclear risk	Measures reported in the paper but protocol could not be located

## Sundell 2008

Methods	<p><b>Study design:</b> RCT</p> <p><b>Study grouping:</b> parallel-group</p>
Participants	<p>156 adolescents</p> <p>Mean age 15.00 years (SD 1.35)</p> <p>61% male</p> <p>30/156 Asian</p> <p>% drug use not reported</p> <p>% alcohol use not reported</p> <p><b>Eligibility criteria:</b> target group was defined as youths 12 to 17 years of age who fulfilled the criteria for a clinical diagnosis of conduct disorder according to the <i>Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, Text Revision) (DSM-IV-TR;</i> American Psychiatric Association, 2000) and whose parent(s) or parent surrogate(s) were motivated to engage in an intervention</p>
Interventions	<p>Multi-systemic treatment (MST) Intervention vs treatment as usual</p> <p><b>Experimental intervention:</b> MST is an intensive family- and community-based treatment for adolescents with serious clinical problems that include criminal behaviour, violence, substance abuse, and serious emotional disturbance (e.g. Henggeler, Sheidow, &amp; Lee; in press). In the home and community, MST provides service delivery based on the family's needs. Therapists are available to families 24 hours a day, 7 days a week. By working with parents, teachers, and others, MST aims to restructure a youth's ecology to support prosocial development and decrease delinquent behaviour (n = 79)</p> <p><b>Setting:</b> community</p> <p><b>Length of treatment:</b> average between 4 and 6 months' duration</p> <p><b>Length of follow-up:</b> 7 months after referral</p> <p><b>Control:</b> youths assigned to the group receiving TAU were referred back to social services for determination of intervention. The most common intervention received by this group was individual counselling (1 to 2 hours every other week) provided by the case manager or a private counsellor and financed by the Social Welfare Administration (n = 20). The second most common was family therapy (n = 16). Other TAU services included mentorship with non-professional volunteers spending time with youths (normally 10 hours a month on 2 or more occasions; n = 12), out-of home care, and primarily residential care (n = 8). Less frequent services were aggression replacement training (n = 4), addiction treatment (n = 2), and special education services (n = 2). Thirteen youths in this group received no services. Of those 64 receiving services, 16 (25%) were prematurely interrupted (i.e. original services were replaced for a new intervention during 7-month follow-up) (n = 77)</p> <p><b>Setting:</b> community</p> <p><b>Length of treatment:</b> not reported</p> <p><b>Length of follow-up:</b> 7 months after referral</p>
Outcomes	<p>Self-report delinquency</p> <p>Alcohol and drug consumption</p> <p>Alcohol Use Disorder Identification Test (AUDIT)</p> <p>Drug Use Disorder Identification Test (DUDIT)</p>

## Sundell 2008 (Continued)

### Notes

**Funding:** support for this research was provided by the Institute for Evidence-Based Social Work Practice, National Board of Health and Welfare, Sweden, Mobilisering mot narkotika, Ministry of Health and Social Affairs, Sweden, and the cities of Go teborg, Halmstad, Malmo, and Stockholm, Sweden

**Conflict of interest:** none of the study authors had any financial interest in MST

**Country:** Sweden

### Risk of bias

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computer-generated randomisation
Allocation concealment (selection bias)	Low risk	Quote: "After research staff received completed instruments from both the youths and parents, research staff opened a sealed and numbered envelope that contained the results of the computer-generated randomization for that specific youth. In a central location separate from the data collection locations, the contents of the sealed envelopes were determined before the referral process began. The principal investigator was the only member of the research team to have access to the randomization sequence"
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	Not reported
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	Not reported
Incomplete outcome data (attrition bias) All outcomes	Low risk	The number of missing subjects at post measure varied between 14 (9%) and 19 (12%) for youths, and between 12 (8%) and 18 (12%) for guardians, with the exception of Guardian's Mental Health, for which the number of missing subjects was 30 (19%)
Selective reporting (reporting bias)	Unclear risk	No protocol available. Measures reported in the methods section of the paper matched outcomes in the results

## Wexler 1999

Methods	<b>Study design:</b> RCT  <b>Study grouping:</b> parallel-group
Participants	715 adults Mean age 30.9 years (SD 7.4) 100% male 37.8% white 100% drug-using Alcohol use not reported 100% psychiatric history <b>Eligibility criteria:</b> offenders with a drug problem who were 9 to 14 months from parole; offenders convicted of arson or sexual crimes against minors were not eligible
Interventions	Therapeutic community (TC) and voluntary residential aftercare vs no-treatment waiting list control



**Wexler 1999** (Continued)

**Experimental intervention:** TC included a 2- to 3-month orientation phase including clinical assessment of residential needs and problem areas and planning of interventions and goals. During the second phase, 5- to 6-month treatment stage, residents were provided opportunities to earn positions of increasing responsibility. Groups and counselling sessions focused on self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. During the re-entry phase (taking up to 3 months), residents used their planning and decision-making skills and worked with programme and parole staff to prepare for their return to the community. Graduates of the scheme were given the opportunity to participate in a community-based TC for up to 12 months (n = 247)

**Setting:** prison and release into the community TC

**Length of treatment:** total duration (including aftercare option) up to 24 months

**Length of follow-up:** 12, 24, and 36 months

**Control:** no-treatment waiting list control group (n = 290)

**Setting:** prison

**Length of treatment:** total duration up to 14 months

**Length of follow-up:** 12, 24, and 36 months

Outcomes	<p>Incarceration (official records)</p> <p>Arrest for any offence (self-report)</p> <p>Arrest for a drug offence (self-report)</p> <p>Drug use (self-report)</p>
Notes	<p><b>Funding:</b> this study was a co-operative effort by the Center for Therapeutic Community Research at National Development and Research Institutes, Inc., and the California Department of Corrections and Rehabilitation Office of Substance Abuse Programs. The evaluation was funded by the National Institute of Drug Abuse, Grant #PAODA07700-01</p> <p><b>Conflict of interest:</b> not reported</p> <p><b>Country:</b> USA</p>

**Risk of bias**

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Participants were "randomly" assigned and stratified by ethnic makeup
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of outcome assessment (detection bias) subjective outcomes	Unclear risk	No information on blinding provided
Blinding of outcome assessment (detection bias) objective outcomes	Unclear risk	No information on blinding provided
Incomplete outcome data (attrition bias)	Low risk	ITT analyses conducted

**Wexler 1999** (Continued)

## All outcomes

Selective reporting (reporting bias)	Unclear risk	Protocol not obtained. Measures reported in the methods section of the paper comparable with outcomes in the results section
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ACT: acceptance and commitment therapy; AGT: adolescent group therapy; AUDIT: Alcohol Use Disorder Identification Test; CBT: cognitive-behavioural therapy; CES-D: Center for Epidemiologic Studies Depression Scale; CSAT: Center for Substance Abuse Treatment; DBT: dialectical behavioural therapy; *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; DUDIT: Drug Use Disorder Identification Test; ITT: intention-to-treat; JDC: juvenile drug court; MBI: mindfulness-based intervention; MBRP: mindfulness-based relapse prevention; MDD: major depressive disorder; MDFT: multi-dimensional family therapy; MHTC: mental health treatment court; MI: motivational interviewing; MST: multi-systemic treatment; PANSS: Positive and Negative Symptoms Scale; R&R: Reasoning & Rehabilitation; RCT: randomised controlled trial; SCID: Structured Clinical Interview for DSM Disorders; SD: standard deviation; TAU: treatment as usual; TC: therapeutic community.

**Characteristics of excluded studies** [ordered by study ID]

Study	Reason for exclusion
<a href="#">Alemagno 2009</a>	Not measuring drug or crime outcomes
<a href="#">Alemi 2010</a>	Not a mental health population
<a href="#">Allen 2017</a>	Not measuring drug or crime outcomes
<a href="#">Althoff 2013</a>	Not a randomised controlled trial
<a href="#">Anonymous 1989</a>	Not a randomised controlled trial
<a href="#">Anonymous 2004</a>	Not an offender population
<a href="#">Anonymous 2014</a>	Conference proceeding only, without useful data
<a href="#">Anonymous 2015</a>	Conference proceeding only, without useful data
<a href="#">Anonymous 2015a</a>	Not a randomised controlled trial
<a href="#">Anonymous 2016</a>	Conference proceeding only, without useful data
<a href="#">Anonymous 2016a</a>	Not measuring drug or crime outcomes
<a href="#">Anonymous 2016b</a>	Not a randomised controlled trial
<a href="#">Bailey 1994</a>	Not a randomised controlled trial
<a href="#">Barrett 2015</a>	Not measuring drug or crime outcomes
<a href="#">Bartlett 2015</a>	Not measuring drug or crime outcomes
<a href="#">Bawor 2014</a>	Not an offender population
<a href="#">Bazazi 2017</a>	Not a randomised controlled trial
<a href="#">Berman 2004</a>	Not a mental health population
<a href="#">Bermudez 2014</a>	Not a randomised controlled trial

Study	Reason for exclusion
<a href="#">Brahen 1976</a>	Not a randomised controlled trial
<a href="#">Brodie 2009</a>	Not a mental health population
<a href="#">Brovko 2017</a>	Not measuring drug or crime outcomes
<a href="#">Brown 2013</a>	Not a mental health population
<a href="#">Brown 2014</a>	Not a randomised controlled trial
<a href="#">Burraston 2014</a>	Not a randomised controlled trial
<a href="#">Bustos 2016</a>	Not measuring drug or crime outcomes
<a href="#">Calcaterra 2014</a>	Not a randomised controlled trial
<a href="#">Calsyn 2005</a>	Not an offender population
<a href="#">Carrieri 2017</a>	Not an offender population
<a href="#">Carroll 2006</a>	Not a mental health population
<a href="#">Carroll 2012</a>	Not a mental health population
<a href="#">Chandler 2016</a>	Not a mental health population
<a href="#">Chaple 2014</a>	Not a mental health population
<a href="#">Chaple 2016</a>	Not a mental health population
<a href="#">Cheesman 2016</a>	Not a randomised controlled trial
<a href="#">Cihlar 2014</a>	Not a randomised controlled trial
<a href="#">Clair 2013</a>	Not a randomised controlled trial
<a href="#">Clair-Michaud 2016</a>	Not measuring drug or crime outcomes
<a href="#">Clark 2002</a>	Not a randomised controlled trial
<a href="#">Clayton 2013</a>	Not measuring drug or crime outcomes
<a href="#">Compton 2016</a>	Not a randomised controlled trial
<a href="#">Coulton 2017</a>	Not a mental health population
<a href="#">Curtis 2015</a>	Not a randomised controlled trial
<a href="#">Czuchry 2000</a>	Not measuring drug or crime outcomes
<a href="#">Czuchry 2003</a>	Not measuring drug or crime outcomes
<a href="#">D'Amico 2013</a>	Not a mental health population
<a href="#">Dakof 2010</a>	Not a mental health population

Study	Reason for exclusion
<a href="#">Davis 2015</a>	Not a randomised controlled trial
<a href="#">Day 2006</a>	Not an offender population
<a href="#">Demaret 2015</a>	Not an offender population
<a href="#">Di Paola 2014</a>	Not a mental health population
<a href="#">Dickson 2017</a>	Not a randomised controlled trial
<a href="#">Dolan 2003</a>	Not a mental health population
<a href="#">Dolan 2005</a>	Not a mental health population
<a href="#">Dole 1969</a>	Not a mental health population
<a href="#">Doyle 2015</a>	Not a randomised controlled trial
<a href="#">Doyle 2016</a>	Not a randomised controlled trial
<a href="#">Dunlop 2017</a>	Not an offender population
<a href="#">Easton 2007</a>	Not a randomised controlled trial
<a href="#">Easton 2017</a>	Not a mental health population
<a href="#">Egg 2000</a>	Not a mental health population
<a href="#">Franck 2012</a>	Not a mental health population
<a href="#">Friedmann 2015</a>	Conference proceeding only, without useful data
<a href="#">Friedmann 2017</a>	Not a mental health population
<a href="#">Ginsberg 2012</a>	Not measuring drug or crime outcomes
<a href="#">Ginsberg 2015</a>	Not measuring drug or crime outcomes
<a href="#">Ginsberg 2015a</a>	Not measuring drug or crime outcomes
<a href="#">Gisev 2015</a>	Not a randomised controlled trial
<a href="#">Gisev 2015a</a>	Not a randomised controlled trial
<a href="#">Gisev 2015b</a>	Not a randomised controlled trial
<a href="#">Goddard-Eckrich 2018</a>	Not measuring drug or crime outcomes
<a href="#">Goorden 2015</a>	Not an offender population
<a href="#">Gordon 2014</a>	Not measuring drug or crime outcomes
<a href="#">Gordon 2015</a>	Not a randomised controlled trial
<a href="#">Gordon 2017</a>	Not a mental health population

Study	Reason for exclusion
<a href="#">Gordon 2017a</a>	Not a mental health population
<a href="#">Gottfredson 2005</a>	Not a mental health population
<a href="#">Haig 2003</a>	Not a randomised controlled trial
<a href="#">Hanlon 1975</a>	Not a mental health population
<a href="#">Hanlon 1977</a>	Not a mental health population
<a href="#">Harada 2012</a>	Not measuring drug or crime outcomes
<a href="#">Heimer 2006</a>	Not a randomised controlled trial
<a href="#">Henderson 2010</a>	Not a mental health population
<a href="#">Henderson 2016</a>	Not a mental health population
<a href="#">Hendriks 2011</a>	Not an offender population
<a href="#">Henggeler 2006</a>	Not a mental health population
<a href="#">Herrman 2016</a>	Not an offender population
<a href="#">Himelstein 2014</a>	Not measuring drug or crime outcomes
<a href="#">Himelstein 2015</a>	Not a randomised controlled trial
<a href="#">Hoffman 1996</a>	Not an offender population
<a href="#">Holloway 2006</a>	Not a mental health population
<a href="#">Hser 2013</a>	Not an offender population
<a href="#">Jalali 2017</a>	Not measuring drug or crime outcomes
<a href="#">Jason 2007</a>	Not an offender population
<a href="#">Jason 2015</a>	Not a mental health population
<a href="#">Jason 2016</a>	Not a randomised controlled trial
<a href="#">Jerrell 1995</a>	Not an offender population
<a href="#">Joe 1997</a>	Not an offender population
<a href="#">Kearley 2018</a>	Not a mental health population
<a href="#">Kelly 2016</a>	Not measuring drug or crime outcomes
<a href="#">Kinlock 2007</a>	Not a mental health population
<a href="#">Kinlock 2009</a>	Not a mental health population
<a href="#">Knight 2016</a>	Not measuring drug or crime outcomes

Study	Reason for exclusion
<a href="#">Knudsen 2014</a>	Not measuring drug or crime outcomes
<a href="#">Knudsen 2016</a>	Not a randomised controlled trial
<a href="#">Kongsakon 2005</a>	Not measuring drug or crime outcomes
<a href="#">Konstenius 2014</a>	Not a mental health population
<a href="#">Kopak 2015</a>	Not a randomised controlled trial
<a href="#">Krebs 2017</a>	Not a randomised controlled trial
<a href="#">Kua 2014</a>	Not an offender population
<a href="#">Kubiak 2016</a>	Not a randomised controlled trial
<a href="#">Kurland 1975</a>	Not a mental health population
<a href="#">Kurniasanti 2014</a>	Not a randomised controlled trial
<a href="#">Lee 2011</a>	Not measuring drug or crime outcomes
<a href="#">Lee 2013</a>	Not a randomised controlled trial
<a href="#">Lee 2014</a>	Not measuring drug or crime outcomes
<a href="#">Lee 2014b</a>	Not measuring drug or crime outcomes
<a href="#">Lee 2014c</a>	Conference proceedings only, without useful data
<a href="#">Lee 2015</a>	Conference proceedings only, without useful data
<a href="#">Lee 2015a</a>	Not a mental health population
<a href="#">Lee 2015b</a>	Not a mental health population
<a href="#">Lee 2016</a>	Not a mental health population
<a href="#">Lee 2016a</a>	Not a mental health population
<a href="#">Lehman 2015</a>	Not measuring drug or crime outcomes
<a href="#">Lerch 2017</a>	Not a mental health population
<a href="#">Liddle 2011</a>	Not measuring drug or crime outcomes
<a href="#">Lintzeris 2006</a>	Not an offender population
<a href="#">Little 1993</a>	Not an offender population
<a href="#">Lo 2012</a>	Not a mental health population
<a href="#">Lobmann 2007</a>	Not a mental health population
<a href="#">Luciano 2014</a>	Not an offender population



Study	Reason for exclusion
<a href="#">Magura 2009</a>	Not a mental health population
<a href="#">March 2006</a>	Not a mental health population
<a href="#">Marinelli-Casey 2008</a>	Not a randomised controlled trial
<a href="#">Marlowe 2008</a>	Not a mental health population
<a href="#">Marlowe 2009</a>	Not a mental health population
<a href="#">Marsch 1998</a>	Systematic review
<a href="#">Martin 2010</a>	Not measuring drug or crime outcomes
<a href="#">Martin 2011</a>	Not an offender population
<a href="#">Martin 2014</a>	Not an offender population
<a href="#">Martin 2015</a>	Not measuring drug or crime outcomes
<a href="#">Martin 2017</a>	Not an offender population
<a href="#">Mazerolle 2000</a>	Not an offender population
<a href="#">McAuliffe 1990</a>	Not an offender population
<a href="#">McCollister 2014</a>	Not a randomised controlled trial
<a href="#">McCollister 2015</a>	Conference proceeding only, without useful data
<a href="#">McCollister 2016</a>	Not an offender population
<a href="#">McCollister 2017</a>	Not a randomised controlled trial
<a href="#">McDonald 2016</a>	Not a mental health population
<a href="#">McKenzie 2012</a>	Not a mental health population
<a href="#">Meade 2017</a>	Not a mental health population
<a href="#">Metrebian 2015</a>	Not an offender population
<a href="#">Mitchell 2013</a>	Not an offender population
<a href="#">Mitchell 2014</a>	Not an offender population
<a href="#">Murphy 2017</a>	Not a mental health population
<a href="#">Nemes 1999</a>	Not a mental health population
<a href="#">Nirenberg 2013</a>	Not measuring drug or crime outcomes
<a href="#">Nirenberg 2013a</a>	Not measuring drug or crime outcomes
<a href="#">Nosyk 2010</a>	Not an offender population

Study	Reason for exclusion
<a href="#">Nyamathi 2014</a>	Not a randomised controlled trial
<a href="#">Nyamathi 2014a</a>	Not a randomised controlled trial
<a href="#">Nyamathi 2015</a>	Not measuring drug or crime outcomes
<a href="#">Nyamathi 2016</a>	Not a randomised controlled trial
<a href="#">Nyamathi 2017a</a>	Not a mental health population
<a href="#">O'Brien 2015</a>	Not a randomised controlled trial
<a href="#">O'Brien 2017</a>	Not a randomised controlled trial
<a href="#">Owens 2016</a>	Not measuring drug or crime outcomes
<a href="#">Owens 2017</a>	Not measuring drug or crime outcomes
<a href="#">Page 1982</a>	Not measuring drug or crime outcomes
<a href="#">Parmar 2017</a>	Not a mental health population
<a href="#">Pettus-Davis 2017</a>	Not measuring drug or crime outcomes
<a href="#">Pierce 2018</a>	Not a randomised controlled trial
<a href="#">Pijl 2017</a>	Not a randomised controlled trial
<a href="#">Pitre 1997</a>	Not measuring drug or crime outcomes
<a href="#">Pitre 1998</a>	Not measuring drug or crime outcomes
<a href="#">Poblete 2017</a>	Not an offender population
<a href="#">Prendergast 2015</a>	Not measuring drug or crime outcomes
<a href="#">Prendergast 2017</a>	Not a mental health population
<a href="#">Rich 2015</a>	Not a mental health population
<a href="#">Roll 2005</a>	Not an offender population
<a href="#">Rounsaville 2008</a>	Not a mental health population
<a href="#">Rowe 2007</a>	Not an offender population
<a href="#">Rowland 2008</a>	Not a randomised controlled trial
<a href="#">Sajatovic 2013</a>	Not an offender population
<a href="#">Saxena 2014</a>	Not measuring drug or crime outcomes
<a href="#">Schaeffer 2014</a>	Not a mental health population
<a href="#">Schwartz 2014</a>	Not a mental health population

Study	Reason for exclusion
<a href="#">Schwartz 2016</a>	Not a mental health population
<a href="#">Schwartz 2016a</a>	Not a mental health population
<a href="#">Schwartz 2016b</a>	Not a mental health population
<a href="#">Scott 2017</a>	Not measuring drug or crime outcomes
<a href="#">Seitz-Brown 2015</a>	Conference proceedings only, without useful data
<a href="#">Shaul 2016</a>	Not a mental health population
<a href="#">Sheard 2007</a>	Not a randomised controlled trial
<a href="#">Sheard 2009</a>	Not a mental health population
<a href="#">Sheard 2009a</a>	Not a mental health population
<a href="#">Shearer 2003</a>	Not an offender population
<a href="#">Shearer 2007</a>	Not a randomised controlled trial
<a href="#">Sinha 2003</a>	Not a mental health population
<a href="#">Smith 2017</a>	Not an offender population
<a href="#">Somers 2013</a>	Not measuring drug or crime outcomes
<a href="#">Spohr 2015</a>	Not measuring drug or crime outcomes
<a href="#">Springer 2017</a>	Not measuring drug or crime outcomes
<a href="#">Stein 2011a</a>	Not a mental health population
<a href="#">Sticca 2014</a>	Not a randomised controlled trial
<a href="#">Stillwell 2017</a>	Not a randomised controlled trial
<a href="#">Strang 2000</a>	Not an offender population
<a href="#">Strang 2013</a>	Halted part of the way through
<a href="#">Swogger 2016</a>	Not a mental health population
<a href="#">Tolou-Shams 2011</a>	Not measuring drug or crime outcomes
<a href="#">Vagenas 2017</a>	Not measuring drug or crime outcomes
<a href="#">van Stelle 2004</a>	Not a randomised controlled trial
<a href="#">Vaucher 2016</a>	Not measuring drug or crime outcomes
<a href="#">Villagra 2013</a>	Not a mental health population
<a href="#">Warren 2006</a>	Not an offender population

Study	Reason for exclusion
<a href="#">Welsh 2014</a>	Not measuring drug or crime outcomes
<a href="#">Wimberly 2018</a>	Not measuring drug or crime outcomes
<a href="#">Witkiewitz 2014</a>	Not measuring drug or crime outcomes
<a href="#">Wolff 2012</a>	Not a randomised controlled trial
<a href="#">Wooditch 2015</a>	Not a randomised controlled trial
<a href="#">Wooditch 2017</a>	Not measuring drug or crime outcomes
<a href="#">Wright 2011</a>	Not a mental health population
<a href="#">Zlotnick 2003</a>	Not measuring drug or crime outcomes
<a href="#">Zlotnick 2009a</a>	Not a mental health population

RCT: randomised controlled trial

### Characteristics of ongoing studies *[ordered by study ID]*

#### [Baldus 2011](#)

Trial name or title	"CAN Stop" - Implementation and evaluation of a secondary group prevention for adolescent and young adult cannabis users in various contexts - study protocol
Methods	The CAN Stop study is a 4-armed randomised wait list controlled trial. The 4 arms are needed for the different help system settings, in which the CAN Stop training programme is evaluated: (a) the drug addiction aid and youth welfare system, (b) the outpatient medical system, (c) the in-patient medical system, and (d) prisons for juvenile offenders. Data are collected at 3 points: before and after training or treatment as usual and 6 months after completion of either intervention
Participants	Young adult cannabis users
Interventions	(a) the drug addiction aid and youth welfare system, (b) the outpatient medical system, (c) the in-patient medical system, and (d) prisons for juvenile offenders
Outcomes	Sociodemographics; Living situation; Social network; Problems with school, police, debts; Education; Prior counselling and therapies; Screening for acute psychosis; Subscale of the Diagnostisches Interview psychischer Störungen (DIPS; diagnostic Interview for psychiatric disorders); Substance use history; Society for Addiction Research and Therapy); Severity of dependence; Severity of dependence scale (Psychosocial adjustment; Youth self-report; Young adult self-report) (participants aged 18 to 21); Expected positive and negative effects of cannabis use; Comprehensive Cannabis Expectancy Questionnaire (CCEQ); Relationship to friends and peers; Questionnaire for health-related quality of life (Kiddo-KINDL Revised); Family relationships; Motivation for change in cannabis use; Questionnaire to protocol the willingness for change; Personal goals with regard to changes in substance use; Self-efficacy with regard to cannabis abstinence or limited cannabis use; Satisfaction with training; Peer resistance regarding cannabis use
Starting date	Not reported
Contact information	cbaldus@uke.uni-hamburg.de
Notes	Trial registration: ISRCTN: ISRCTN57036983

## Tinland 2013

Trial name or title	Evaluation of the Housing First program in patients with severe mental disorders in France: study protocol for a randomised controlled trial
Methods	Prospective randomised trial designed to assess the impact of a Housing First intervention on health outcomes and costs over a period of 24 months on homeless people with severe mental illness, compared to treatment as usual. The study is being conducted in 4 cities in France: Lille, Marseille, Paris, and Toulouse
Participants	Inclusion criteria are as follows: over 18 years of age, absolutely homeless or in precarious housing, possessing a 'high' level of need: diagnosis of schizophrenia or bipolar disorder and moderate to severe disability according to the Multnomah Community Ability Scale (score $\leq 62$ ) and at least 1 of the following 3 criteria: (1) having been hospitalised for mental illness 2 or more times in any single year over the preceding 5 years; (2) comorbid alcohol or substance use; and (3) having been recently arrested or incarcerated. A total of 300 individuals per group will be included
Interventions	Housing First Intervention or Treatment As Usual; the Housing First intervention provides immediate access to independent housing and community care
Outcomes	Primary outcome criterion is use of high-cost health services (i.e. number of hospital admissions and number of emergency department visits) during the 24-month follow-up period. Secondary outcome measures include health outcomes, social functioning, housing stability, and contact with police services. An evaluation of the cost-effectiveness and cost utility of Housing First will also be conducted
Starting date	The study started to recruit participants in August 2011; recruitment is ongoing
Contact information	pascal.auquier@univ-amu.fr
Notes	

## VanDorn 2017

Trial name or title	Jail-to-community treatment continuum for adults with co-occurring substance use and mental disorders: study protocol for a pilot randomised controlled trial
Methods	Adaptations to DDMI and IGT were guided by the Risk-Need-Responsivity model and the National Institute of Corrections' implementation competencies; development of the implementation framework and communication protocols were guided by the Evidence-Based Interagency Implementation Model for community corrections and the Inter-organizational Relationship model, respectively. Implementation and evaluation of protocols and adapted interventions will occur via an open trial and a pilot randomised trial. The clinical intervention consists of 2 in-jail DDMI sessions and 12 in-community IGT sessions. Twelve adults with CODs and 4 clinicians will participate in the open trial to evaluate the acceptability and feasibility of, and fidelity to, the interventions and research and communication protocols. The pilot controlled trial will be conducted with 60 inmates who will be randomised to either DDMI-IGT or treatment as usual. Baseline assessment will be conducted in jail, and 4 community-based assessments will be conducted during a 6-month follow-up period. Implementation, clinical, public health, and treatment preference outcomes will be evaluated
Participants	Inmate participants will be broadly representative of adults with co-occurring mental and substance use disorders in a large urban county jail
Interventions	Dual-diagnosis motivational interviewing (DDMI) and integrated group therapy (IGT) vs treatment as usual

**VanDorn 2017** (Continued)

Outcomes	<p>6 and 12 months HIV treatment (HIV-1 RNA levels, CD4 count, ART adherence, retention in care), substance abuse (time to relapse to opioid use, % opioid negative urine samples, opioid craving), adverse side effects and HIV risk behaviour (sexual and drug-related risks)</p> <p>The public health relevance is that outcomes from this study will establish the efficacy, safety, and tolerability of pharmacological therapy using naltrexone treatment among HIV+s and will establish depot-naltrexone treatment as an effective, evidence-based treatment for opioid dependence for released HIV+ prisoners</p>
Starting date	2012
Contact information	Yale University
Notes	







ART: Antiretroviral therapy; COD: co-occurring disorders; NTX: naltrexone.

## DATA AND ANALYSES

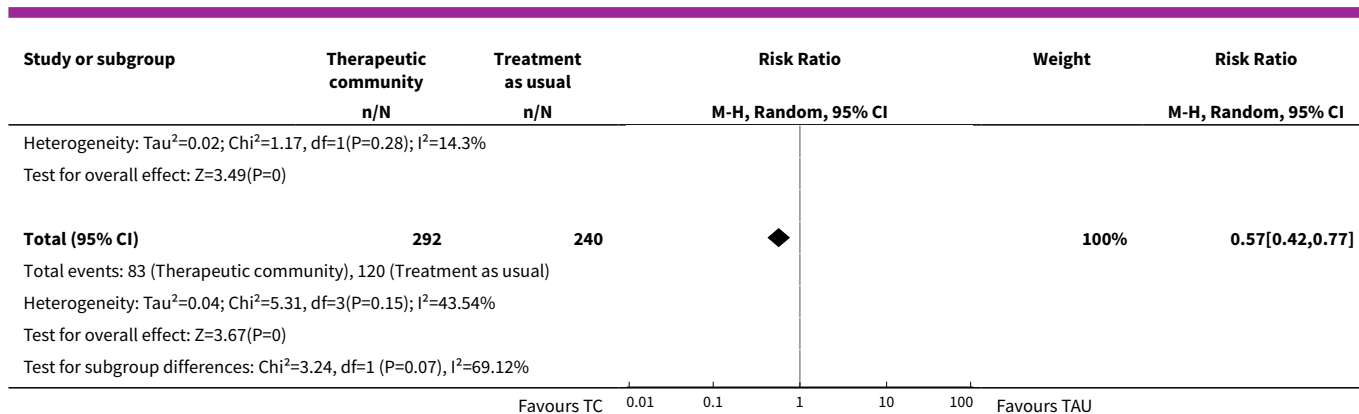
### Comparison 1. Therapeutic community and aftercare vs treatment as usual

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Criminal activity	2	532	Risk Ratio (M-H, Random, 95% CI)	0.57 [0.42, 0.77]
1.1 Any criminal activity	2	266	Risk Ratio (M-H, Random, 95% CI)	0.67 [0.53, 0.84]
1.2 Re-incarceration	2	266	Risk Ratio (M-H, Random, 95% CI)	0.40 [0.24, 0.67]

#### Analysis 1.1. Comparison 1 Therapeutic community and aftercare vs treatment as usual, Outcome 1 Criminal activity.

Study or subgroup	Therapeutic community n/N	Treatment as usual n/N	Risk Ratio M-H, Random, 95% CI	Weight	Risk Ratio M-H, Random, 95% CI
<b>1.1.1 Any criminal activity</b>					
Sacks 2004	35/75	43/64		37.74%	0.69[0.52,0.93]
Sacks 2011	28/71	35/56		32.76%	0.63[0.44,0.9]
<b>Subtotal (95% CI)</b>	<b>146</b>	<b>120</b>		<b>70.49%</b>	<b>0.67[0.53,0.84]</b>
Total events: 63 (Therapeutic community), 78 (Treatment as usual)					
Heterogeneity: Tau <sup>2</sup> =0; Chi <sup>2</sup> =0.17, df=1(P=0.68); I <sup>2</sup> =0%					
Test for overall effect: Z=3.49(P=0)					
<b>1.1.2 Re-incarceration</b>					
Sacks 2004	7/75	21/64		11.7%	0.28[0.13,0.63]
Sacks 2011	13/71	21/56		17.81%	0.49[0.27,0.89]
<b>Subtotal (95% CI)</b>	<b>146</b>	<b>120</b>		<b>29.51%</b>	<b>0.4[0.24,0.67]</b>
Total events: 20 (Therapeutic community), 42 (Treatment as usual)					
Favours TC 0.01 0.1 1 10 100 Favours TAU					

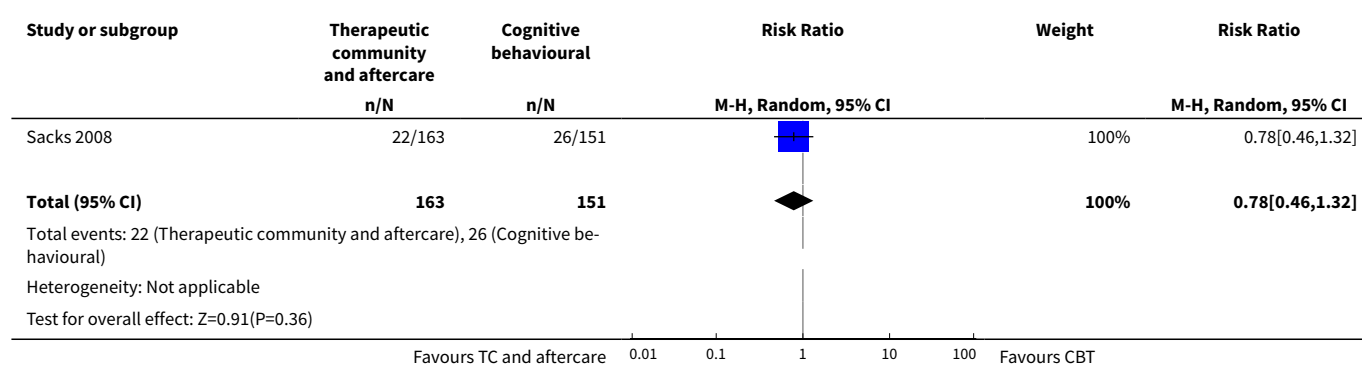




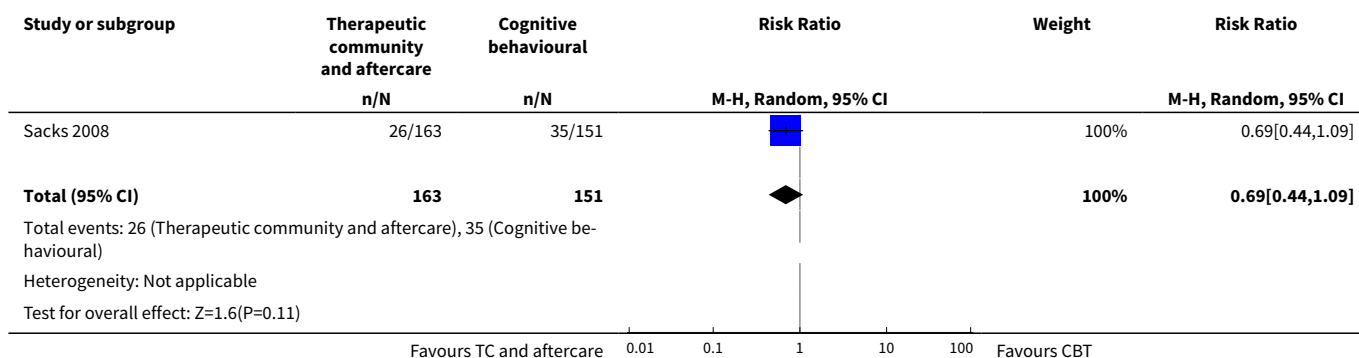
## Comparison 2. Therapeutic community and aftercare vs cognitive-behavioural therapy

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Self-reported drug use at 6 months	1	314	Risk Ratio (M-H, Random, 95% CI)	0.78 [0.46, 1.32]
2 Arrested any for 6 months	1	314	Risk Ratio (M-H, Random, 95% CI)	0.69 [0.44, 1.09]
3 Criminal activity at 6 months	1	314	Risk Ratio (M-H, Random, 95% CI)	0.74 [0.52, 1.05]
4 Drug-related crime	1	314	Risk Ratio (M-H, Random, 95% CI)	0.87 [0.56, 1.36]

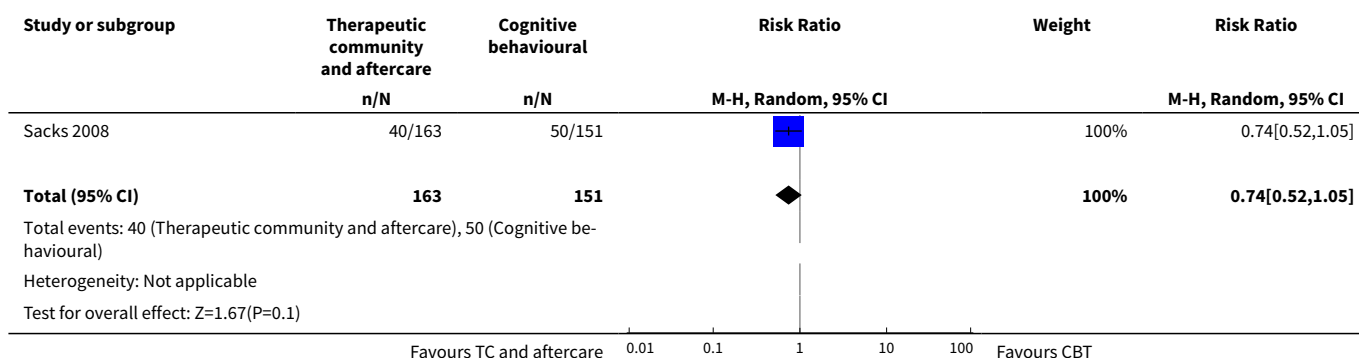
### Analysis 2.1. Comparison 2 Therapeutic community and aftercare vs cognitive-behavioural therapy, Outcome 1 Self-reported drug use at 6 months.



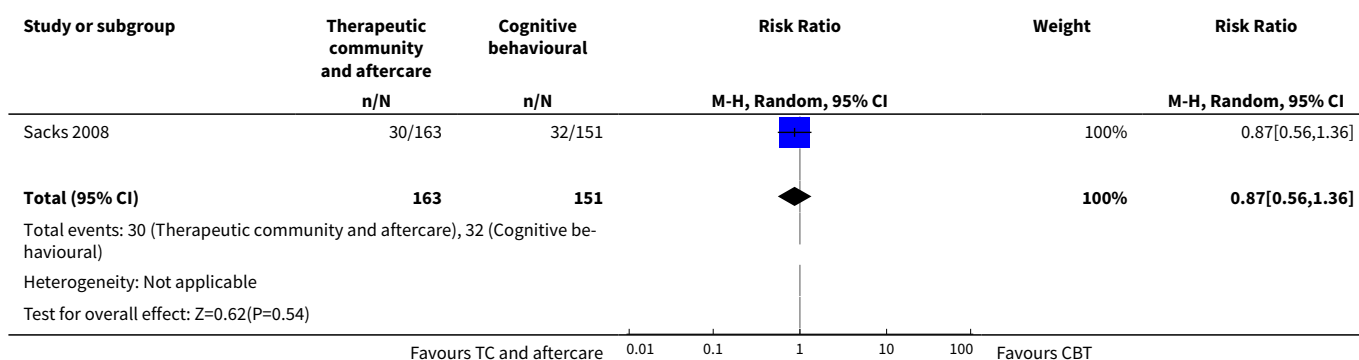
### Analysis 2.2. Comparison 2 Therapeutic community and aftercare vs cognitive-behavioural therapy, Outcome 2 Arrested any for 6 months.



### Analysis 2.3. Comparison 2 Therapeutic community and aftercare vs cognitive-behavioural therapy, Outcome 3 Criminal activity at 6 months.



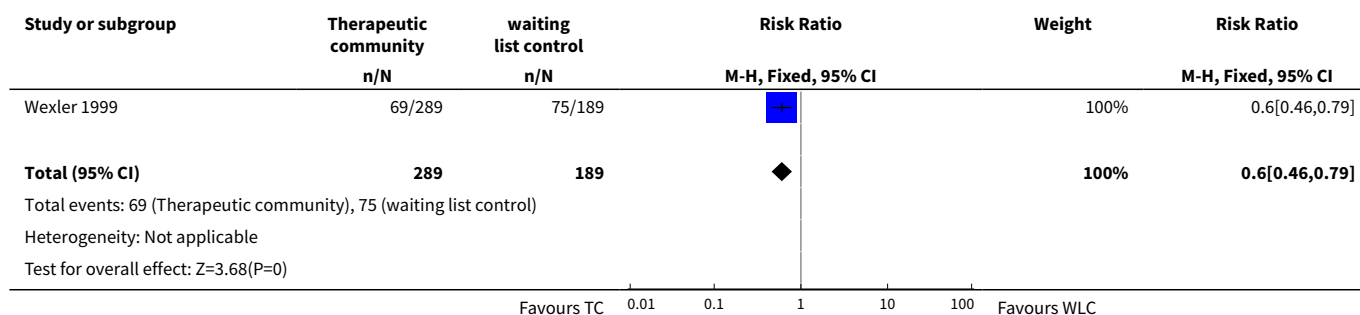
### Analysis 2.4. Comparison 2 Therapeutic community and aftercare vs cognitive-behavioural therapy, Outcome 4 Drug-related crime.



### Comparison 3. Therapeutic community vs waiting list control

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Re-incarceration at 36 months	1	478	Risk Ratio (M-H, Fixed, 95% CI)	0.60 [0.46, 0.79]

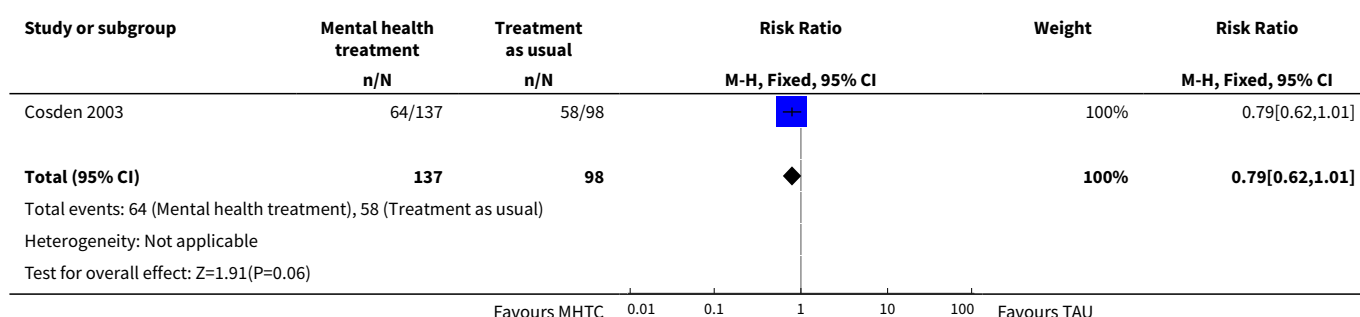
#### Analysis 3.1. Comparison 3 Therapeutic community vs waiting list control, Outcome 1 Re-incarceration at 36 months.



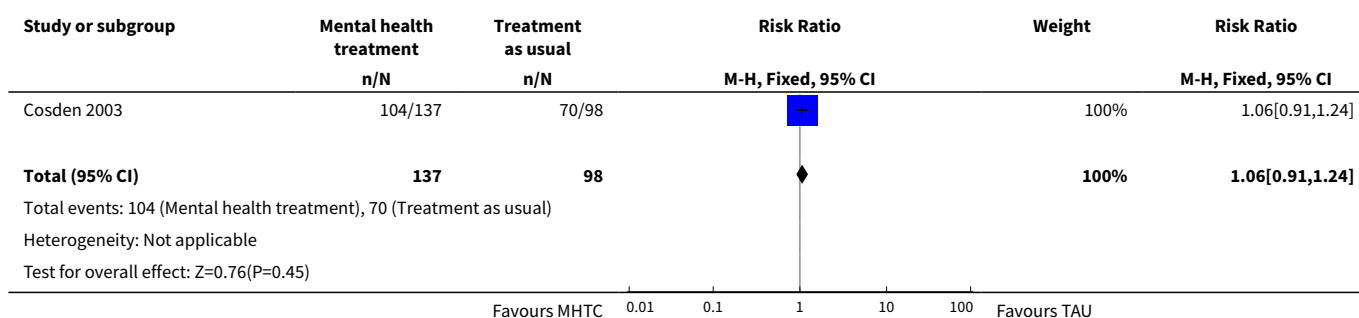
### Comparison 4. Mental health treatment court with assertive case management vs treatment as usual

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Committing a new crime	1	235	Risk Ratio (M-H, Fixed, 95% CI)	0.79 [0.62, 1.01]
2 Re-incarceration to jail at 12 months	1	235	Risk Ratio (M-H, Fixed, 95% CI)	1.06 [0.91, 1.24]
3 ASI drug use at 12 months	1	235	Mean Difference (IV, Fixed, 95% CI)	0.0 [-0.03, 0.03]

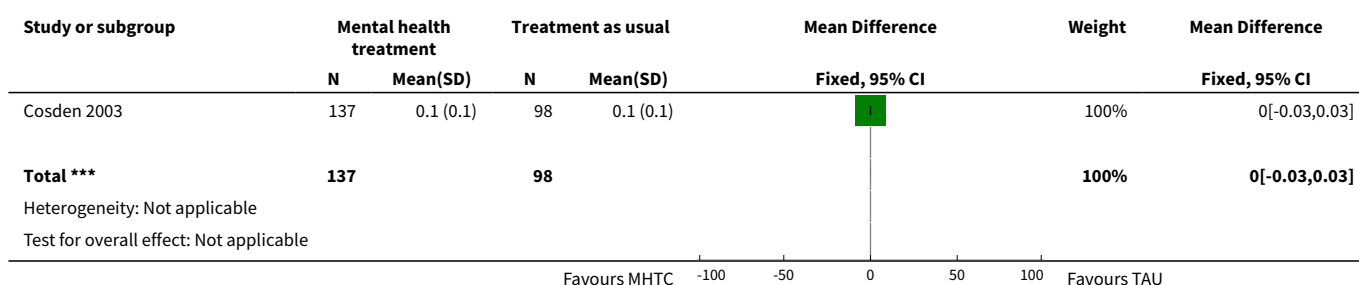
#### Analysis 4.1. Comparison 4 Mental health treatment court with assertive case management vs treatment as usual, Outcome 1 Committing a new crime.



### Analysis 4.2. Comparison 4 Mental health treatment court with assertive case management vs treatment as usual, Outcome 2 Re-incarceration to jail at 12 months.



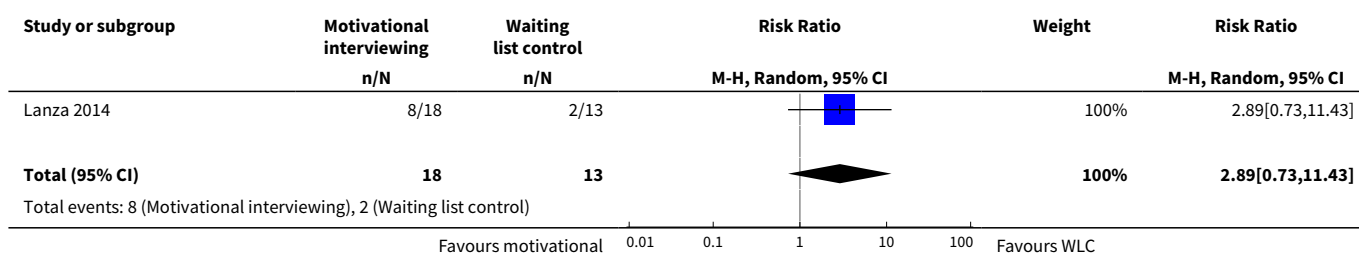
### Analysis 4.3. Comparison 4 Mental health treatment court with assertive case management vs treatment as usual, Outcome 3 ASI drug use at 12 months.

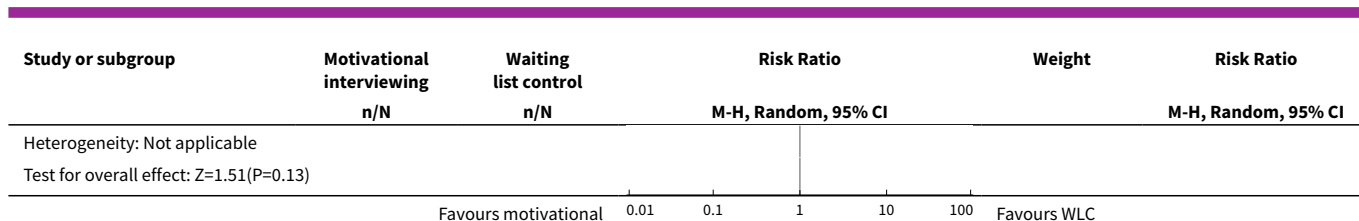


## Comparison 5. Motivational interviewing and cognitive skills vs waiting list control

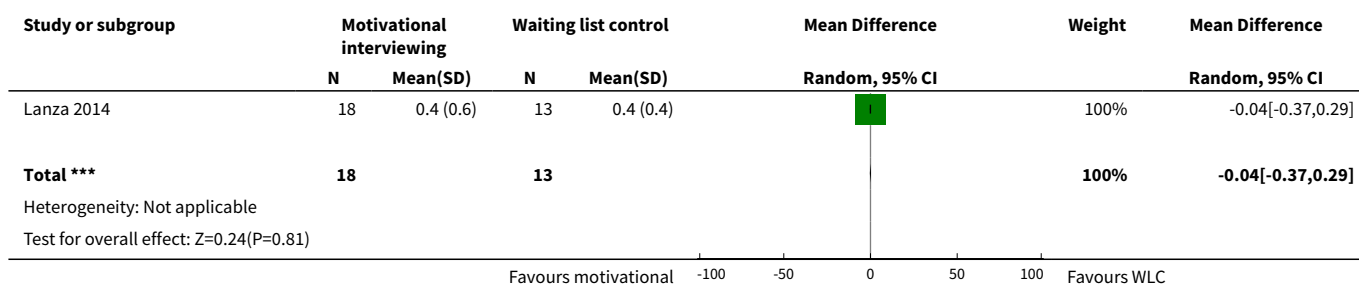
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Abstinence from drug use at 6 months	1	31	Risk Ratio (M-H, Random, 95% CI)	2.89 [0.73, 11.43]
2 ASI drug score at 6 months	1	31	Mean Difference (IV, Random, 95% CI)	-0.04 [-0.37, 0.29]

### Analysis 5.1. Comparison 5 Motivational interviewing and cognitive skills vs waiting list control, Outcome 1 Abstinence from drug use at 6 months.





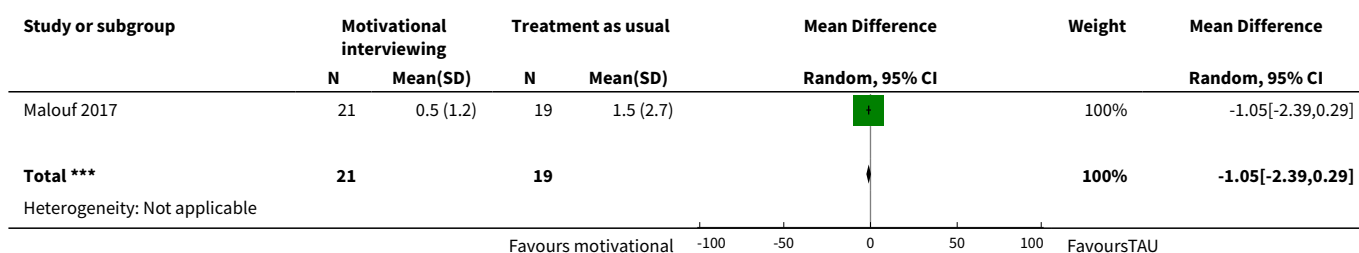
### Analysis 5.2. Comparison 5 Motivational interviewing and cognitive skills vs waiting list control, Outcome 2 ASI drug score at 6 months.

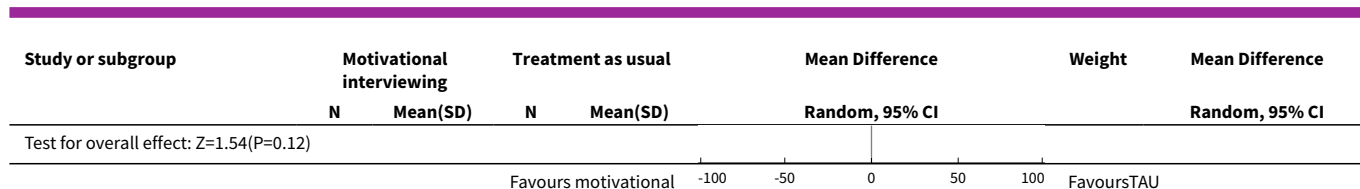


### Comparison 6. Motivational interviewing and cognitive skills vs treatment as usual

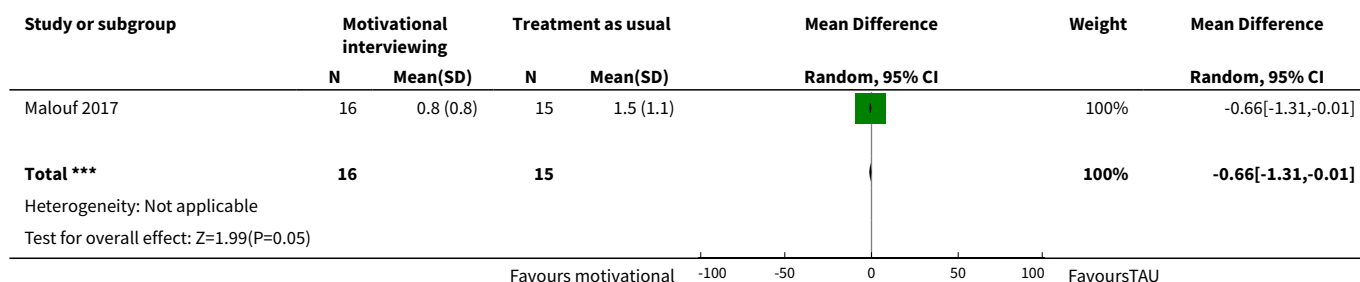
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Marijuana frequency at 3 months	1	40	Mean Difference (IV, Random, 95% CI)	-1.05 [-2.39, 0.29]
2 Arrest frequency 3 years post release	1	31	Mean Difference (IV, Random, 95% CI)	-0.66 [-1.31, -0.01]
3 Time to first arrest or offence 36 months post	1	31	Mean Difference (IV, Fixed, 95% CI)	0.87 [-0.12, 1.86]
4 Positive drug screen at 12 months	1	84	Mean Difference (IV, Fixed, 95% CI)	-0.70 [-3.50, 2.10]

### Analysis 6.1. Comparison 6 Motivational interviewing and cognitive skills vs treatment as usual, Outcome 1 Marijuana frequency at 3 months.

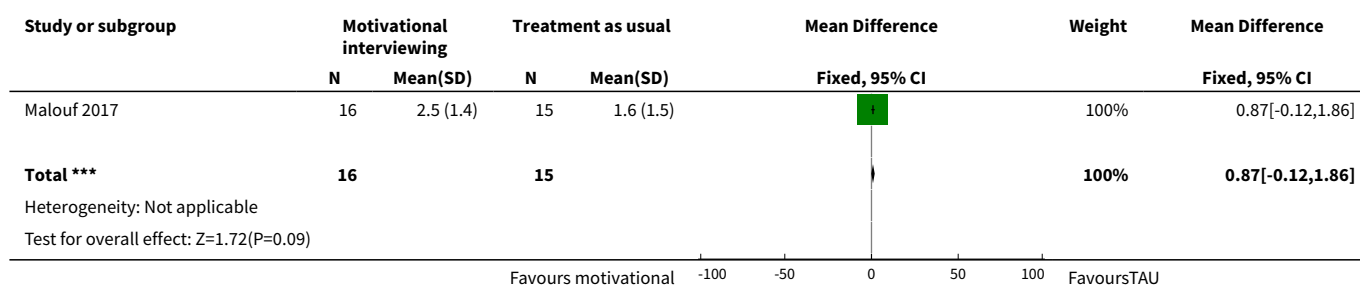




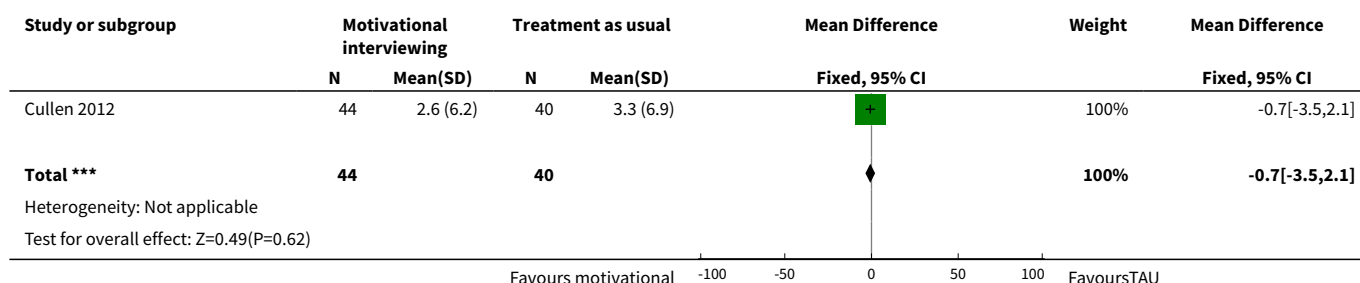
### Analysis 6.2. Comparison 6 Motivational interviewing and cognitive skills vs treatment as usual, Outcome 2 Arrest frequency 3 years post release.



### Analysis 6.3. Comparison 6 Motivational interviewing and cognitive skills vs treatment as usual, Outcome 3 Time to first arrest or offence 36 months post.



### Analysis 6.4. Comparison 6 Motivational interviewing and cognitive skills vs treatment as usual, Outcome 4 Positive drug screen at 12 months.

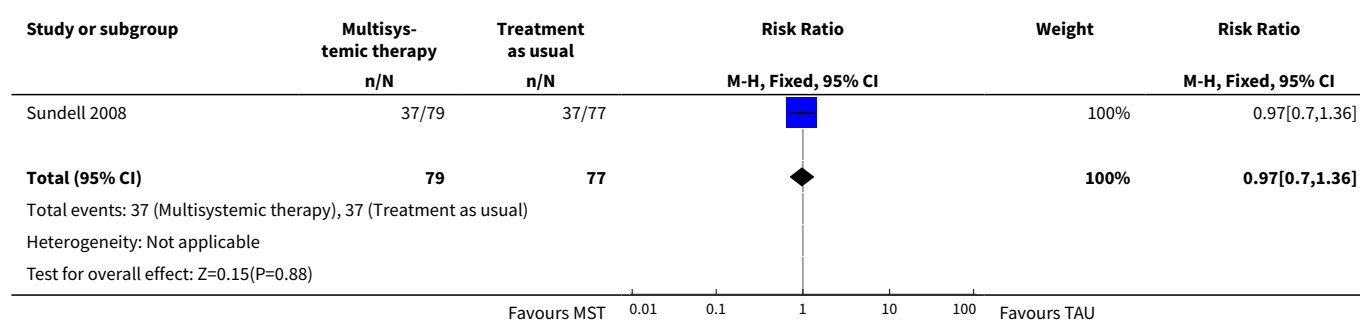




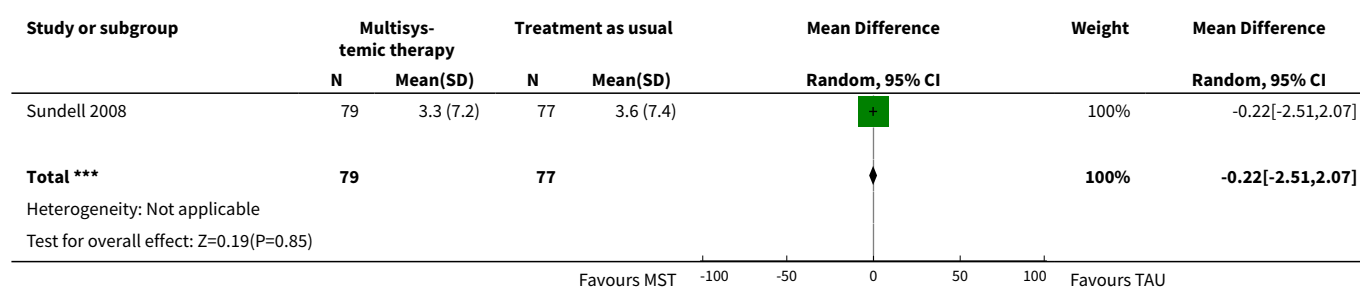
## Comparison 7. Multi-systemic therapy vs treatment as usual

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Arrest by police	1	156	Risk Ratio (M-H, Fixed, 95% CI)	0.97 [0.70, 1.36]
2 DUDIT scores	1	156	Mean Difference (IV, Random, 95% CI)	-0.22 [-2.51, 2.07]

### Analysis 7.1. Comparison 7 Multi-systemic therapy vs treatment as usual, Outcome 1 Arrest by police.



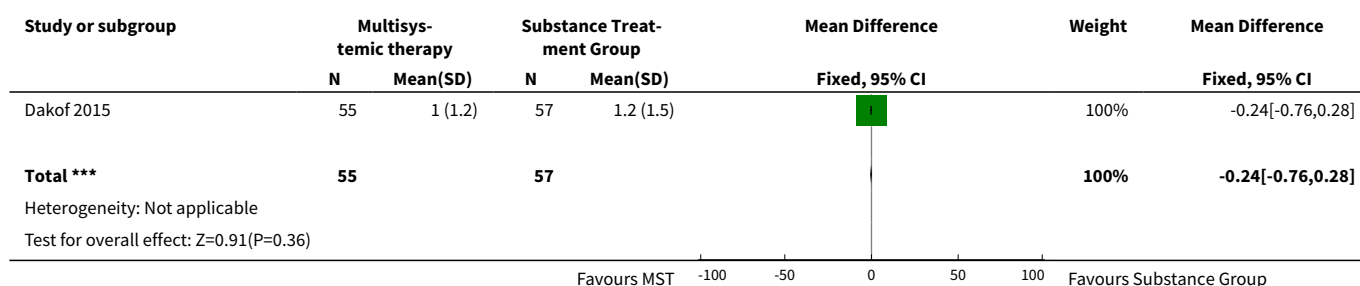
### Analysis 7.2. Comparison 7 Multi-systemic therapy vs treatment as usual, Outcome 2 DUDIT scores.



## Comparison 8. Multi-systemic therapy vs adolescent substance treatment group

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Arrests between 6 and 24 months	1	112	Mean Difference (IV, Fixed, 95% CI)	-0.24 [-0.76, 0.28]

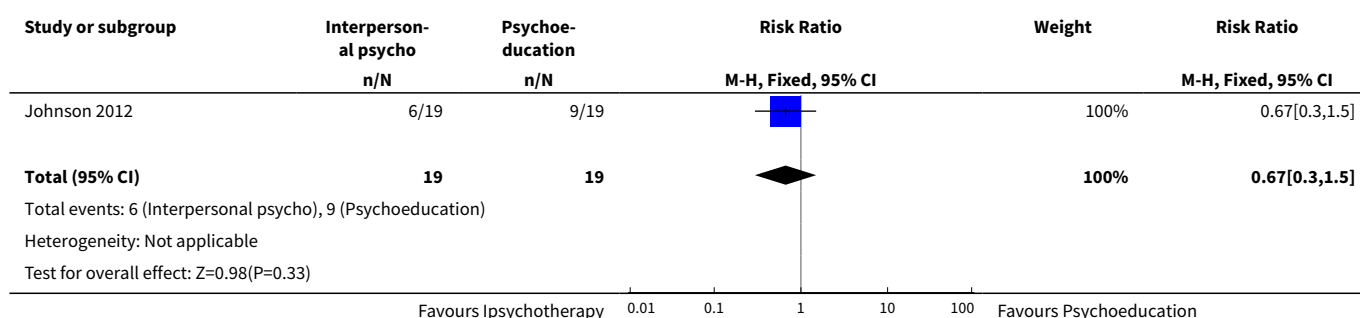
**Analysis 8.1. Comparison 8 Multi-systemic therapy vs adolescent substance treatment group, Outcome 1 Arrests between 6 and 24 months.**



**Comparison 9. Interpersonal psychotherapy vs psychoeducational controls**

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Substance abuse relapse at 3 months	1	38	Risk Ratio (M-H, Fixed, 95% CI)	0.67 [0.30, 1.50]

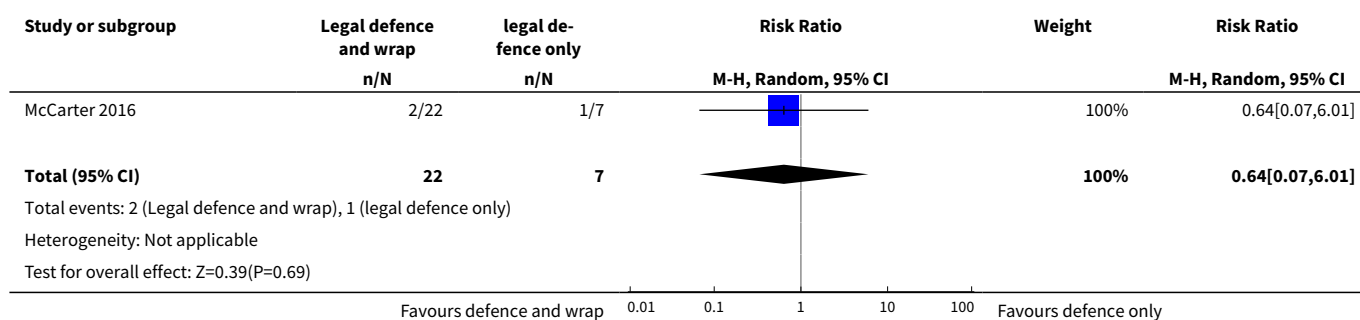
**Analysis 9.1. Comparison 9 Interpersonal psychotherapy vs psychoeducational controls, Outcome 1 Substance abuse relapse at 3 months.**



**Comparison 10. Legal defence services and wrap-around social work services vs legal defence work only**

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Number of new offences committed at 12 months	1	29	Risk Ratio (M-H, Random, 95% CI)	0.64 [0.07, 6.01]

### Analysis 10.1. Comparison 10 Legal defence services and wrap-around social work services vs legal defence work only, Outcome 1 Number of new offences committed at 12 months.



## ADDITIONAL TABLES

**Table 1. Mental health diagnoses**

Study, year	Criteria used for diagnoses	Description of mental health problem
Cosden 2003	Determined by a psychiatrist/psychologist on the basis of a clinical interview and observations	Mood disorder Schizophrenia Bipolar disorder Other Dual diagnosis
Cullen 2012	Primary clinical diagnosis of a psychotic disorder. Diagnosis mechanism not reported	Schizophrenia Schizoaffective disorder Bipolar disorder Other psychotic disorder
Dakof 2015	Diagnostic Interview Schedule for Children (DISC-2) - identifying presence of mental disorders according to the DSM-III Youth Self-Report	Presence of mental health disorders Externalising subscales
Johnson 2012	Hamilton Rating Scale for Depression Median duration of index episode in months Number of depressive episodes Number of previous suicide attempts DSM-IV Axis I disorders using the SCID-I/II	Criteria for a major depressive disorder at least 4 weeks after substance abuse treatment Minimum score of 18 on the Hamilton Rating Scale for Depression
Lanza 2014	DSM-IV Mini International Neuropsychiatric Interview Anxiety Sensitivity Index	Anxiety Mental health disorders Antisocial personality disorder

**Table 1. Mental health diagnoses** (Continued)

		Major depressive disorder
		Generalised anxiety disorder
Malouf 2017	Borderline Personality Disorder Features assessed with the Personality Assessment Inventory	Affective instability Identity problems Negative relationships Impulsivity
McCarter 2016	Youth Self-Report that contain scales orientated to the DSM-IV	Somatic complaints Anxiety and depression Social problems Internalising and externalising (thought and attention problems)
Sacks 2004	DIS	Diagnosis of lifetime Axis I or Axis II mental disorder Antisocial personality disorder
Sacks 2008	Global Severity Index Beck Depression Inventory Lifetime of mental health PTSD Symptom Scale - Interview Posttraumatic Stress Diagnostic Scale	Depression PTSD Lifetime of mental health
Sacks 2011	DSM-IV diagnostic criteria Beck Depression Inventory Post Traumatic Stress Disorder Symptom Scale Brief Symptom Inventory Global Severity Index	Depression PTSD Psychological distress
Stein 2011	CES-D Scale	Scores > 16 indicate presence of significant depression; 69.8% had significant depressive symptoms
Sundell 2008	DSM-IV diagnostic criteria Youth Self-Report	Conduct disorder Internalising and externalising Total behaviour problems
Wexler 1999; Prendergast 2003; Prendergast 2004	Not specified	Antisocial personality disorder Phobias PTSD Depression Dysthymia

**Table 1. Mental health diagnoses** (Continued)

Attention deficit hyperactivity disorder

CES-D: Center for Epidemiological Studies - Depression; DIS: Diagnostic Interview Schedule; *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; PTSD: post-traumatic stress disorder; SCID: Structured Clinical Interview for DSM Disorders.

## APPENDICES

### Appendix 1. MEDLINE (R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, and Ovid MEDLINE(R)

#### MEDLINE search

- 1 exp substance related disorders/ (274070)
- 2 street drugs/ (10355)
- 3 designer drugs/ (1439)
- 4 exp narcotics/ (120114)
- 5 ((substance\$ or drug\$ or narcotic\$) adj2 (addict\$ or depend\$ or disorder\$ or abuse\$ or abusing or misuse\$ or misusing or consumption\$ or withdraw\$ or withdrawal\$ or detox\$)).ti,ab. (100176)
- 6 (mdma or alcohol\$ or opiate\$ or opioid\$ or opium or heroin or methadone or cocaine or amphetamine\$ or marijuana or cannabis or crack or phencyclidine).ti,ab. (491028)
- 7 1 or 2 or 3 or 4 or 5 or 6 (713470)
- 8 crime/ (15534)
- 9 criminals/ (4125)
- 10 prisoners/ (16035)
- 11 (justice system or remand\$ or parole\$ or probation or court\$ or corrections or correctional or revocation).ti,ab. (56176)
- 12 (offend\$ or criminal\$ or convict\$ or felon\$).ti,ab. (37983)
- 13 (custody or custodial or gaol\$ or jail\$ or prison\$ or incarcerat\$ or inmate\$).ti,ab. (29693)
- 14 (reoffend\$ or reincarcerat\$ or recidiv\$ or ex-offender\$).ti,ab. (5525)
- 15 8 or 9 or 10 or 11 or 12 or 13 or 14 (126620)
- 16 7 and 15 (16717)
- 17 randomized controlled trial.pt. (516039)
- 18 controlled clinical trial.pt. (101743)
- 19 randomized.ab. (453171)
- 20 placebo.ab. (210619)
- 21 drug therapy.fs. (2199170)
- 22 randomly.ab. (312199)
- 23 trial.ab. (477783)

(Continued)

24 groups.ab. (1925728)

25 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 (4548008)

26 exp animals/ not humans.sh. (4814392)

27 25 not 26 (3934677)

28 16 and 27 (3760)

29 (201404\$ or 201405\$ or 201406\$ or 201407\$ or 201408\$ or 201409\$ or 201410\$ or 201411\$ or 201412\$).ed. (771773)

30 (2015\$ or 2016\$ or 2017\$).ed. (3473901)

31 ("20180101" or "20180102" or "20180103" or "20180104" or "20180105").ed. (19503)

32 29 or 30 or 31 (4265177)

33 28 and 32 (822)

## Appendix 2. Embase search strategy via Ovid

### Embase search

1 substance abuse/ (49037)

2 drug dependence/ (46621)

3 addiction/ (49762)

4 drug abuse/ (49453)

5 intravenous drug abuse/ (9700)

6 opiate addiction/ (14284)

7 heroin dependence/ (8918)

8 cocaine dependence/ (11405)

9 morphine addiction/ (3077)

10 cannabis addiction/ (8306)

11 alcoholism/ (114191)

12 alcohol abuse/ (25949)

13 ((substance\$ or drug\$ or narcotic\$) adj2 (addict\$ or depend\$ or disorder\$ or abuse\$ or abusing or misuse\$ or misusing or consumption\$ or withdraw\$ or withdraw\$ or detox\$)).ti,ab. (122248)

14 (mdma or alcohol\$ or opiate\$ or opioid\$ or opium or heroin or methadone or cocaine or amphetamine\$ or marijuana or cannabis or crack or phencyclidine).ti,ab. (598185)

15 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 (773484)

16 exp crime/ (77511)

17 criminal behavior/ (7677)

18 criminal justice/ (5597)



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(Continued)

- 19 prisoner/ or offender/ (25391)
- 20 (justice system or remand\$ or parole\$ or probation or court\$ or corrections or correctional or revocation).ti,ab. (56577)
- 21 (offend\$ or criminal\$ or convict\$ or felon\$).ti,ab. (44660)
- 22 (custody or custodial or gaol\$ or jail\$ or prison\$ or incarcerat\$ or inmate\$).ti,ab. (32476)
- 23 (reoffend\$ or reincarcerat\$ or recidiv\$ or ex-offender\$).ti,ab. (6561)
- 24 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 (186404)
- 25 clinical trial/ (968061)
- 26 randomized controlled trial/ (482319)
- 27 randomization/ (76536)
- 28 single blind procedure/ (30101)
- 29 double blind procedure/ (145050)
- 30 crossover procedure/ (53840)
- 31 placebo/ (316535)
- 32 randomi?ed controlled trial\$.tw. (170107)
- 33 rct.tw. (26496)
- 34 random allocation.tw. (1760)
- 35 randomly allocated.tw. (28885)
- 36 allocated randomly.tw. (2297)
- 37 (allocated adj2 random).tw. (874)
- 38 single blind\$.tw. (20390)
- 39 double blind\$.tw. (184823)
- 40 ((treble or triple) adj blind\$).tw. (751)
- 41 placebo\$.tw. (265371)
- 42 prospective study/ (415317)
- 43 or/25-42 (1860599)
- 44 case study/ (51268)
- 45 case report.tw. (353058)
- 46 abstract report/ or letter/ (1036148)
- 47 or/44-46 (1432272)
- 48 43 not 47 (1813215)
- 49 15 and 24 and 48 (1488)
- 50 ("201400" or "201500" or "201600" or "201701" or "201801" or "201802" or "201803").em. (28088822)
- 51 49 and 50 (1190)
-

### Appendix 3. PsycInfo search strategy

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**PsycInfo**


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- 1 Addiction/ (9382)
  - 2 Drug dependency/ (12153)
  - 3 Drug Usage/ (16822)
  - 4 Drug Abuse/ (44051)
  - 5 Alcohol Abuse/ (16779)
  - 6 Alcohol rehabilitation/ or drug rehabilitation/ (19802)
  - 7 ((substance\$ or drug\$ or narcotic\$) adj2 (addict\$ or depend\$ or disorder\$ or abuse\$ or abusing or misuse\$ or misusing or consumption\$ or withdraw\$ or withdraw\$ or detox\$)).ti,ab. (74728)
  - 8 (mdma or alcohol\$ or opiate\$ or opioid\$ or opium or heroin or methadone or cocaine or amphetamine\$ or marijuana or cannabis or crack or phencyclidine).ti,ab. (176992)
  - 9 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 (241511)
  - 10 crime/ (14125)
  - 11 criminal behavior/ (8381)
  - 12 recidivism/ (5324)
  - 13 prisoners/ or prisons/ or incarceration/ (16728)
  - 14 probation/ or parole/ (1864)
  - 15 criminals/ or female criminals/ or male delinquency/ or juvenile delinquency/ (30689)
  - 16 (justice system or remand\$ or parole\$ or probation or court\$ or corrections or correctional or revocation).ti,ab. (53371)
  - 17 (offend\$ or criminal\$ or convict\$ or felon\$).ti,ab. (69723)
  - 18 (custody or custodial or gaol\$ or jail\$ or prison\$ or incarcerat\$ or inmate\$).ti,ab. (37348)
  - 19 (reoffend\$ or reincarcerat\$ or recidiv\$ or ex-offender\$).ti,ab. (8414)
  - 20 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 (142208)
  - 21 (empirical study or treatment outcome clinical trial).md. (2237461)
  - 22 (random\$ adj4 trial\$).ti,ab. (44037)
  - 23 Placebo/ (5050)
  - 24 (random\* or sham or placebo\*).ti,ab,hw. (203386)
  - 25 ((singl\* or doubl\*) adj (blind\* or dumm\* or mask\*)).ti,ab,hw. (23778)
  - 26 21 or 22 or 23 or 24 or 25 (2291604)
  - 27 9 and 20 and 26 (11242)
  - 28 (201404\$ or 201405\$ or 201406\$ or 201407\$ or 201408\$ or 201409\$ or 201410\$ or 201411\$ or 201412\$).up. (164403)
  - 29 (2015\$ or 2016\$ or 2017\$).up. (645836)
  - 30 "20180101".up. (957)
-

(Continued)

31 28 or 29 or 30 (811196)

32 27 and 31 (2333)

#### Appendix 4. PASCAL, SciSearch, Social SciSciSearch, Wilson Applied Science and Technology Abstracts search strategy

##### PASCAL search

#1TOPIC: (substance\* NEAR/2 (addict\* or depend\* or disorder\* or abuse\* or abusing or misuse\* or misusing or consumption\* or withdraw\* or withdraw\* or detox\*)) OR TOPIC: (drug\* NEAR/2 (addict\* or depend\* or disorder\* or abuse\* or abusing or misuse\* or misusing or consumption\* or withdraw\* or withdraw\* or detox\*)) OR TOPIC: (narcotic\* NEAR/2 (addict\* or depend\* or disorder\* or abuse\* or abusing or misuse\* or misusing or consumption\* or withdraw\* or withdraw\* or detox\*))

DocType=All document types; Language=All languages;

#2TOPIC: (mdma or alcohol\* or opiate\* or opioid\* or opium or heroin or methadone or cocaine or amphetamine\* or marijuana or cannabis or crack or phencyclidine)

DocType=All document types; Language=All languages;

#3#2 OR #1

DocType=All document types; Language=All languages;

#4TOPIC: ("justice system" or remand\* or parole\* or probation or court\* or corrections or correctional or revocation) OR TOPIC: (crime or criminal or offender\* or criminal\* or convict\* or felon\*) OR TOPIC: (custody or custodial or gaol\* or jail\* or prison\* or incarcerat\* or inmate\*) OR TOPIC: (reoffend\* or reincarcerat\* or recidiv\* or ex-offender\*)

DocType=All document types; Language=All languages;

#5#4 AND #2

DocType=All document types; Language=All languages;

#### Appendix 5. CENTRAL Register of Controlled trials search strategy via the Cochrane Library

##### CENTRAL search

#1 MeSH descriptor: [Substance-Related Disorders] explode all trees

#2 MeSH descriptor: [Street Drugs] explode all trees

#3 MeSH descriptor: [Designer Drugs] explode all trees

#4 MeSH descriptor: [Narcotics] explode all trees

#5 (substance\* or drug\* or narcotic\*) near/2 (addict\* or depend\* or disorder\* or abuse\* or abusing or misuse\* or misusing or consumption\* or withdraw\$ or withdraw\* or detox\*):ti,ab,kw (Word variations have been searched)

#6 mdma or alcohol\* or opiate\* or opioid\* or opium or heroin or methadone or cocaine or amphetamine\* or marijuana or cannabis or crack or phencyclidine:ti,ab,kw (Word variations have been searched)

#7 #1 or #2 or #3 or #4 or #5 or #6

#8 MeSH descriptor: [Crime] explode all trees

#9 MeSH descriptor: [Criminals] explode all trees

#10 MeSH descriptor: [Prisoners] explode all trees

#11 (justice system) or remand\* or parole\* or probation or court\* or corrections or correctional or revocation:ti,ab,kw (Word variations have been searched)

(Continued)

#12 custody or custodial or gaol\* or jail\* or prison\* or incarcerat\* or inmate\*.ti,ab,kw (Word variations have been searched)

#13 reoffend\* or reincarcerat\* or recidiv\* or ex-offender\*.ti,ab,kw (Word variations have been searched)

#14 offend\* or criminal\* or convict\* or felon.ti,ab,kw (Word variations have been searched)

#15 #8 or #9 or #10 or #11 or #12 or #13 or #14

#16 #7 and #15

## Appendix 6. ASSIA search strategy

### ASSIA search

(ti(substance\* NEAR/2 (addict\* OR depend\* OR disorder\* OR abuse\* OR abusing OR misuse\* OR misusing OR consumption\* OR withdraw\* OR withdraw\* OR detox\*)) OR ab(substance\* NEAR/2 (addict\* OR depend\* OR disorder\* OR abuse\* OR abusing OR misuse\* OR misusing OR consumption\* OR withdraw\* OR withdraw\* OR detox\*)) OR ti(drug\* NEAR/2 (addict\* OR depend\* OR disorder\* OR abuse\* OR abusing OR misuse\* OR misusing OR consumption\* OR withdraw\* OR withdraw\* OR detox\*)) OR ab(drug\* NEAR/2 (addict\* OR depend\* OR disorder\* OR abuse\* OR abusing OR misuse\* OR misusing OR consumption\* OR withdraw\* OR withdraw\* OR detox\*)) OR ti(narcotic\* NEAR/2 (addict\* OR depend\* OR disorder\* OR abuse\* OR abusing OR misuse\* OR misusing OR consumption\* OR withdraw\* OR withdraw\* OR detox\*)) OR ab(narcotic\* NEAR/2 (addict\* OR depend\* OR disorder\* OR abuse\* OR abusing OR misuse\* OR misusing OR consumption\* OR withdraw\* OR withdraw\* OR detox\*)) OR ti(mdma OR alcohol\* OR opiate\* OR opioid\* OR opium OR heroin OR methadone OR cocaine OR amphetamine\* OR marijuana OR cannabis OR crack OR phencyclidine) OR ab(mdma OR alcohol\* OR opiate\* OR opioid\* OR opium OR heroin OR methadone OR cocaine OR amphetamine\* OR marijuana OR cannabis OR crack OR phencyclidine)) AND (ti((justice system) OR remand\* OR parole\* OR probation OR court\* OR corrections OR correctional OR revocation) OR ab((justice system) OR remand\* OR parole\* OR probation OR court\* OR corrections OR correctional OR revocation) OR ti(crime OR offend\* OR criminal OR convict\* OR felon\*) OR ab(crime OR offend\* OR criminal\* OR convict\* OR felon\*) OR ti(custody OR custodial OR gaol\* OR jail\* OR prison\* OR incarcerat\* OR inmate\*) OR ab(custody OR custodial OR gaol\* OR jail\* OR prison\* OR incarcerat\* OR inmate\*) OR ti(reoffend\* OR reincarcerat\* OR recidiv\* OR ex-offender\*) OR ab(reoffend\* OR reincarcerat\* OR recidiv\* OR ex-offender\*)).

## Appendix 7. Health Management Information Consortium (HMIC) search strategy via Ovid

### HMIC

1 designer drugs/ (6)

2 exp narcotics/ (365)

3 ((substance\$ or drug\$ or narcotic\$) adj2 (addict\$ or depend\$ or disorder\$ or abuse\$ or abusing or misuse\$ or misusing or consumption\$ or withdraw\$ or withdraw\$ or detox\$)).ti,ab. (3032)

4 (mdma or alcohol\$ or opiate\$ or opioid\$ or opium or heroin or methadone or cocaine or amphetamine\$ or marijuana or cannabis or crack or phencyclidine).ti,ab. (6910)

5 1 or 2 or 3 or 4 (9003)

6 crime/ (450)

7 prisoners/ (652)

8 (justice system or remand\$ or parole\$ or probation or court\$ or corrections or correctional or revocation).ti,ab. (3327)

9 (offend\$ or criminal\$ or convict\$ or felon\$).ti,ab. (2875)

14 limit 13 to yr="2014 -Current" (14)

(Continued)

S4

TI ( justice system) or crime or remand\* or parole\* or probation or court\* or corrections or correctional or revocation ) OR AB ( justice system) or crime or remand\* or parole\* or probation or court\* or corrections or correctional or revocation ) OR TI ( offend\* or criminal\* or convict\* or felon\* ) OR AB ( offend\* or criminal\* or convict\* or felon\* ) OR TI ( custody or custodial or gaol\* or jail\* or prison\* or incarcerat\* or inmate\* ) OR AB ( custody or custodial or gaol\* or jail\* or prison\* or ...

Search modes - Boolean/Phrase

S5

S3 AND S4

## Appendix 10. LILACS

**LILACS search (via <http://lilacs.bvsalud.org/en/>).**

tw:((remand or prison or prisoner or prisoners or prisão or cárcere or cárcel or detenidos or detentas or acusados or presidiáriosso-bre or presidiarias or preso or Privados or reclusos or offender\$ or infratoras or infratora or infratores or delinquentes or infrator or criminal\$ or probation or probatorio or estagio or court or courts or tribunal or tribunals or secure establishment\$ or secure facilit\$ or reoffend\$ or reincarcerat\$ or recidivi\$ or reincidencia or recidivante or reincidência or ex-offender\$ or jail or jails or gaol or gaols or incarcerat\$ or encarcerados or covict or convicts or convicted or felon or felons or conviction\$ or reconviction\$ or Convicções or convicções or inmate\$ or internos or high security or prisoners or law enforcement or jurisprudence))) AND (tw:((Substance abuse\$ or substance misuse\$ or substance use\$ or usuários de substâncias or drug dependanc\$ or drug abuse\$ or drug use\$ or drug misuse\$ or drug addict\$ or narcotics addict\$ or narcotics use\$ or narcotics misuse\$ or narcotics abuse\$ or chemical dependenc\$ or opiates or heroin or crack or cocaine or amphetamines or cocaine or heroína or opioides or anfetaminas or opiáceos or opióides or addiction or adicción or adicciones or dependência or farmacodependente or adición or adição or dependence disorder\$ or drug involved or Sub-stance-related disorders or amphetamine-related disorders or cocaine-related disorders or marijuana abuse or opioid-related disorders or phencyclidine abuse or substance abuse intravenous or street drugs or designer drugs or cocaine or amphetamines or anal-gesics)))

## Appendix 11. CINHAL Plus

S1	TI ( substance* N2 (addict* or depend* or disorder* or abuse* or abusing or misuse* or misusing or consumption* or withdraw* or withdraw* or detox*) ) OR AB ( substance* N2 (addict* or depend* or disorder* or abuse* or abusing or misuse* or misusing or consumption* or withdraw* or withdraw* or detox*) ) OR TI ( drug* N2 (addict* or depend* or disorder* or abuse* or abusing or misuse* or misusing or consumption* or withdraw* or withdraw* or detox*) ) OR AB ( drug* N2 (addict* or depend* or disord ...
S2	TI ( mdma or alcohol* or opiate* or opioid* or opium or heroin or methadone or cocaine or amphetamine* or marijuana or cannabis or crack or phencyclidine ) OR AB ( mdma or alcohol* or opiate* or opioid* or opium or heroin or methadone or cocaine or amphetamine* or marijuana or cannabis or crack or phencyclidine )
S3	S1 OR S2
S4	TI ( justice system) or crime or remand* or parole* or probation or court* or corrections or correc-tional or revocation ) OR AB ( justice system) or crime or remand* or parole* or probation or court* or corrections or correctional or revocation ) OR TI ( offend* or criminal* or convict* or felon* ) OR AB ( offend* or criminal* or convict* or felon* ) OR TI ( custody or custodial or gaol* or jail* or prison* or incarcerat* or inmate* ) OR AB ( custody or custodial or gaol* or jail* or prison* or ...
S5	S3 AND S4

## Appendix 12. Criteria for assessing risk of bias

Item	Judgement	Description
1. Random sequence generation (selection bias)	Low risk	The investigators describe a random component in the sequence generation process such as random number table; computer random number generator; coin tossing; shuffling cards or envelopes; throwing dice; drawing of lots; minimisation
	High risk	The investigators describe a non-random component in the sequence generation process such as odd or even date of birth; date (or day) of admission; hospital or clinic record number; alternation; judgement of the clinician; results of a laboratory test or a series of tests; availability of the intervention
	Unclear risk	Insufficient information about the sequence generation process to permit judgement of low or high risk
2. Allocation concealment (selection bias)	Low risk	Investigators enrolling participants could not foresee assignment because 1 of the following, or an equivalent method, was used to conceal allocation: central allocation (including telephone, web-based, and pharmacy-controlled, randomisation); sequentially numbered drug containers of identical appearance; sequentially numbered, opaque, sealed envelopes
	High risk	Investigators enrolling participants could possibly foresee assignments because 1 of the following methods was used: open random allocation schedule (e.g. a list of random numbers); assignment envelopes without appropriate safeguards (e.g. if envelopes were unsealed or nonopaque or were not sequentially numbered); alternation or rotation; date of birth; case record number; any other explicitly unconcealed procedure
	Unclear risk	Insufficient information to permit judgement of low or high risk. This is usually the case if the method of concealment is not described or is not described in sufficient detail to allow a definitive judgement
3. Blinding of outcome assessor (detection bias)  Objective outcomes	Low risk	No blinding of outcome assessment, but the review authors judge that the outcome measurement is not likely to be influenced by lack of blinding  Blinding of outcome assessment ensured, and unlikely that blinding could have been broken
4. Blinding of outcome assessor (detection bias)  Subjective outcomes	Low risk	No blinding of outcome assessment, but the review authors judge that the outcome measurement is not likely to be influenced by lack of blinding  Blinding of outcome assessment ensured, and unlikely that blinding could have been broken
	High risk	No blinding of outcome assessment, and the outcome measurement is likely to be influenced by lack of blinding  Blinding of outcome assessment, but likely that the blinding could have been broken, and the outcome measurement is likely to be influenced by lack of blinding
	Unclear risk	Insufficient information to permit judgement of low or high risk
7. Incomplete outcome data (attrition bias)	Low risk	No missing outcome data  Reasons for missing outcome data unlikely to be related to true outcome (for survival data, censoring unlikely to be introducing bias)



(Continued)

For all outcomes except retention in treatment or dropout

Missing outcome data balanced in numbers across intervention groups, with similar reasons for missing data across groups

For dichotomous outcome data, the proportion of missing outcomes compared with observed event risk not enough to have a clinically relevant impact on the intervention effect estimate

For continuous outcome data, plausible effect size (difference in means or standardised difference in means) among missing outcomes not enough to have a clinically relevant impact on observed effect size

Missing data have been imputed through appropriate methods

All randomised participants are reported/analysed in the group they were allocated to by randomisation, irrespective of non-compliance and co-interventions (intention-to-treat)

High risk

Reason for missing outcome data likely to be related to true outcome, with either imbalance in numbers or reasons for missing data across intervention groups

For dichotomous outcome data, the proportion of missing outcomes compared with observed event risk enough to induce clinically relevant bias in intervention effect estimate

For continuous outcome data, plausible effect size (difference in means or standardised difference in means) among missing outcomes enough to induce clinically relevant bias in observed effect size

'As-treated' analysis done with substantial departure of the intervention received from that assigned at randomisation

Unclear risk

Insufficient information to permit judgement of low or high risk (e.g. number randomised not stated, no reasons for missing data provided; number of dropout not reported for each group)

8. Selective re-reporting (reporting bias)

Low risk

The study protocol is available and all of the study's prespecified (primary and secondary) outcomes that are of interest in the review have been reported in the prespecified way

The study protocol is not available, but it is clear that published reports include all expected outcomes, including those that were prespecified (convincing text of this nature may be uncommon)

High risk

Not all of the study's prespecified primary outcomes have been reported

1 or more primary outcomes are reported via measurements, analysis methods, or subsets of the data (e.g. subscales) that were not prespecified

1 or more reported primary outcomes were not prespecified (unless clear justification for their reporting is provided, such as an unexpected adverse effect)

1 or more outcomes of interest in the review are reported incompletely so they cannot be entered in a meta-analysis

The study report fails to include results for a key outcome that would be expected to have been reported for such a study

Unclear risk

Insufficient information to permit judgement of low or high risk

## WHAT'S NEW

Date	Event	Description
12 March 2019	New search has been performed	This update represents an additional 5 trials, bringing the total number of trials in this review to 13. The search strategies are complete up until 6 February 2019. The 13 trials represent 2501 participants and 21 publications.
12 March 2019	New citation required but conclusions have not changed	Conclusions have not changed

## HISTORY

Review first published: Issue 1, 2014

Date	Event	Description
2 June 2015	Amended	Amended the byline
18 May 2015	New citation required but conclusions have not changed	Conclusions have not changed
11 July 2014	New search has been performed	This review has been updated to May 2014. Through this process, 3 trials have been added, bringing the total number of trials for this review to 8 and representative publications to 14
28 May 2012	New search has been performed	This review has been updated using searches to 21 March 2013. The review represents 1 in a family of 4 reviews. These reviews cover pharmacological and non-pharmacological interventions and drug-using female offenders. This review of interventions with drug-using offenders with co-occurring mental illness contains 5 randomised controlled trials. These trials represent a total of 1502 participants
2 October 2011	New search has been performed	The updated version of this review produced a new document with additional findings reflecting searches up to 11 November 2011. Five new authors have been added to this version of the review. These include Steven Duffy, Rachael McCool, Matthew Neilson, Catherine Hewitt, and Marrison Martyn-St James
1 July 2011	Amended	This review has been converted to new review format
8 June 2011	New search has been performed	This review has been substantially updated
19 May 2006	New citation required and conclusions have changed	Substantive amendments have been made

## CONTRIBUTIONS OF AUTHORS

Searches were constructed and conducted by KW. The independent review team inspected the search hits by reading titles and abstracts. Each potentially relevant study located in the search was obtained as a full article and was independently assessed for inclusion by the review team. In the case of discordance, a third independent review author arbitrated. When it was not possible to evaluate the study because of language problems or missing information, it was classified as 'translation/information required to determine decision' until a translation or further details were provided. The team of review authors conducted data extraction for these papers. Results were compiled and organised by AEP, LB, and CH, the review team, and all review authors contributed towards the final draft text.

## DECLARATIONS OF INTEREST

Amanda E Perry has no interests to declare related to this work.

Marrissa Martyn-St James has no interests to declare related to this work.

Julie M Glanville has no interests to declare related to this work.

Kath Wright has no interests to declare related to this work.

Catherine Hewitt has no interests to declare related to this work.

Lucy Burns has no interests to declare related to this work.

Santosh Kumar has no interests to declare related to this work.

Pratish Thakkar has no interests to declare related to this work.

Anne Aboaja has no interests to declare related to this work.

Caroline Pearson has no interests to declare related to this work.

Shilpi Swami has no interests to declare related to this work.

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### Internal sources

- No sources of support supplied

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## DIFFERENCES BETWEEN PROTOCOL AND REVIEW

We decided to limit our search for this update on studies on effectiveness, because we verified from previous updates that the data on cost and cost-effectiveness are too sparse and heterogeneous to provide any meaningful information. Performance bias was not assessed.

## INDEX TERMS

### Medical Subject Headings (MeSH)

Case Management; Crime [prevention & control] [statistics & numerical data]; Diagnosis, Dual (Psychiatry); Law Enforcement; Mental Disorders [\*therapy]; Motivational Interviewing; Psychotherapy; Randomized Controlled Trials as Topic; Substance-Related Disorders [\*therapy]; Therapeutic Community

### MeSH check words

Adolescent; Adult; Female; Humans; Male; Young Adult