Judges' Guide to
ADULT MENTAL HEALTH JARGON

NCSC National Center for State Courts

This guide is intended to serve as a resource for judges to better understand mental health, to more effectively communicate with individuals with mental health needs appearing before them, and to provide insight on mental health to guide initiatives in their communities. This guide provides an overview which is divided into nine parts: Overarching Concepts; Screening and Assessment; Diagnoses; Mental Health Treatment and Intervention; Treatment and Supports; Local Informational Interview Prompts; Self-Reflection and Assessment; Commonly Used Acronyms; and Medication Table.

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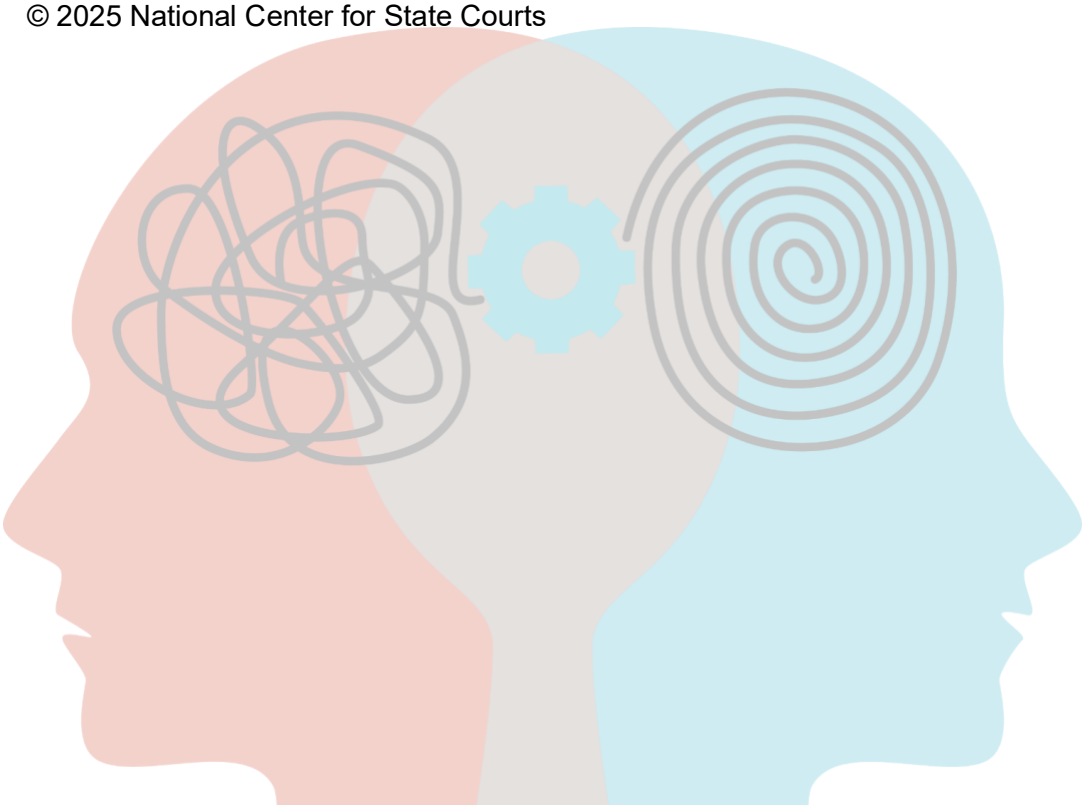

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Introduction

Overview

Individuals seen in civil, family, and criminal courts have important distinctions from the larger U.S. population. Particularly in family and criminal courts, these individuals are more likely to be from populations that are marginalized because of their race, ethnicity, disability status, or socioeconomic class, to name a few. Disproportionately, their psychological development has been shaped within families and communities facing myriad forms of societal disadvantage, a reality that tragically pairs increased risk of mental illness and trauma's cognitive, emotional, and behavioral impacts with decreased access to mental illness detection, diagnosis, or effective intervention access. Mental health issues are the rule, not the exception, in court-involved adults. And many will have multiple conditions, also referred to as comorbidity or co-occurring disorders, including substance use disorders.

Trauma is so ubiquitous it merits universal precautions and raises the likelihood of mental illness across diagnostic classes, including trauma- and stressor-related, mood, anxiety, and even psychotic disorders. Thus, awareness of the ways that trauma and mental illness can impact those before you is critical to understanding the predisposing, precipitating, and perpetuating factors at play. Further, in criminal court, these considerations are critical in the formation of dispositions that promote and foster protective factors and recovery and, in turn, decrease the likelihood of recidivism.

In the diagnostic sections within this guide, information that aids in taking a developmental lens is incorporated, as the identities, personalities, and mental health struggles of adults often originate or are shaped during childhood and adolescence. This approach strengthens the understanding of the thoughts, feelings, and behaviors of court-involved individuals.

Limitations

Mental health is broadly defined, multi-faceted, complex, and subject to the influence of local factors. This guide is far from definitive or exhaustive, and it reflects the current state of affairs in highly dynamic scientific, assessment,

treatment, and population health landscapes. It is not a substitute for the tremendous value derived from regular engagement with stakeholders from your community who have valuable expertise – be it based on experience (e.g., peers, families, court-involved individuals), professional skills (e.g., case managers, social workers, therapists), or scholarship (e.g., expert researchers and academics). The *Judges' Guide to Adult Mental Health Jargon* is intended for informational use only. Individual diagnoses, assessments, and treatment recommendations can be made only by mental health professionals with direct knowledge of the individual for whom services are being considered.

Structure

This guide is divided into nine parts.

1  Overarching Concepts	2  Screening and Assessment	3  Diagnoses
4  Mental Health Treatment and Intervention	5  Treatment and Supports	6  Local Informational Interview Prompts
7  Self-Reflection and Assessment	8  Commonly Used Acronyms	9  Medication Table

Overarching Concepts

Development and Mental Health

All people operate on a multi-dimensional continuum between mental health and mental illness, and mental health is not merely the absence of mental illness. In adults, mental health includes having healthy emotional, intellectual, and social functioning; advancing occupationally to the best of their ability; and playing a positive, developmentally appropriate role in their families and communities.

This conceptualization of mental health underscores the importance of multiple societal systems, reaching far beyond mental healthcare as traditionally or clinically defined. Interventions and resource allocation impacting education, housing, food, environmental exposures, and family support are, in effect, mediators of mental health.

Co-Occurring Mental Illness and Substance Use Disorder

Co-occurring disorders are far more common than many realize, and knowing the scope is essential for creating public health strategies and clinical interventions. Co-occurring disorders, also called dual diagnoses, occur when individuals experience both a substance use disorder (SUD) and another mental health disorder simultaneously. Co-occurring disorders may include any combination of twoor more SUDs and mental illnesses identified in the DSM-5-TR. Importantly, no specific combinations of mental and substance use disorders are uniquely defined as co-occurring disorders. It is crucial to address both conditions for effective treatment.

According to SAMHSA's 2022 National Survey on Drug Use and Health, approximately 21.5 million adults in the United States have a co-occurring disorder. People with mental illness are at a higher risk of developing an SUD compared to those without mental illness. Similarly, individuals with substance use disorders are particularly vulnerable to developing primary conditions or chronic diseases.

Trauma and Decision-Making

When repeated early and often, trauma has the potential to negatively affect the development of one's personality and sense of self as well as greatly influence one's worldview, assessment of threat, and decision-making.

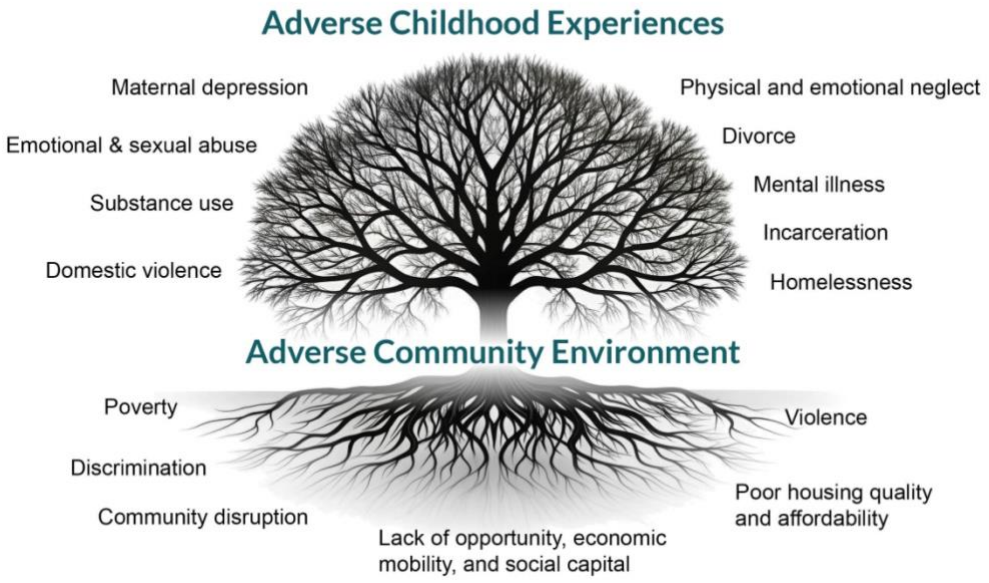
Early traumatic exposure can cause dysfunction in a child's fight or flight response system, and such exposure can also cause dysfunction in an adult. When those traumas are followed by more traumas, and especially if no therapeutic or corrective action is taken, these symptoms from the dysfunction may become deeply entrenched. As a matter of survival, in an environment where they are unsafe, individuals functionally may need to respond with either aggression or retreat immediately, reacting rather than responding. This response requires the involvement of multiple body systems including the brain, the endocrine system, and the sympathetic nervous system.

Screening and Assessment

Screening

Screening is quick and involves a set of inquiries meant to identify issues that warrant additional follow up. There are screens for a variety of topics: emotional problems, specific psychiatric disorders, and trauma history to name a few.

While court and medical settings routinely employ screening, it is important to be mindful of the limitations of screening. Given the prevalence of Adverse Childhood Events (ACEs) in court-involved individuals, the challenges with accessing care, the potential impact of mental illness symptoms on under-reporting, lack of rapport with the screener, and stigma related to mental health and healthcare, a negative screen on a screening instrument does not mean there are no problems.



Additionally, screens developed based on populations that differ from the court-involved population may not ask about issues that were not relevant to the study population but are highly relevant to the populations that are over-represented in court. Screens are never diagnostic and are often administered

by people who do not have the professional qualifications required to make mental health diagnoses.

That said, screening can be helpful when positive results flag issues in need of further assessment. In sum, universal screening is a best practice; positive screens are helpful; and negative screens may require additional investigation during assessment.

Assessment

Mental health assessment will vary to some degree based on the setting (e.g., emergency room, jail/prison, mental health clinic), purpose (e.g., answer forensic question posed by a judge, initiate mental health treatment by community provider, establish eligibility for social services), and qualifications of the evaluator (e.g., psychologist who can do testing, psychiatrist who can advise on psychopharmacological interventions).

Mental health assessments completed by a trained mental health professional for a specific referral question are much more in-depth than a screener and can result in a clinical diagnosis, opinion to the court, or treatment recommendations depending on the purpose of the assessment. Mental health assessments often synthesize information from the individual's self-report, collateral sources, and involve or take into account psychological testing or medical tests.

Diagnoses

Diagnostic Categories

The DSM-5-TR is the primary manual used by mental health clinicians to make diagnoses in the context of a diagnostic interview. The diagnoses are grouped into categories, with the most relevant being Anxiety Disorders, Depressive Disorders, Trauma- and Stressor-Related Disorders, Substance-Related and Addictive Disorders, Neurocognitive Disorders, Neurodevelopmental Disorders, Personality Disorders, Schizophrenia Spectrum and Other Psychotic Disorders, and Bipolar and Related Disorders.

Diagnoses and the Diagnostic Process

The diagnostic process relies on the gathering of information by a trained mental health professional – as well as access to one. This information is then used to explain patterns in an individual's thoughts, feelings, or behaviors taking into account biological, psychological and social factors. When adults say they have no psychiatric history, it may just be that there has been no access to a mental health professional or treatment system.

While the identification of diagnostic criteria for mental illness(es) are part of the process, diagnoses have to take into account the whole picture. Thus, the information gathered should include information about many aspects of the individual's history: birth/perinatal, medical conditions, head injuries, family, social, trauma, psychiatric treatment, and educational.

In clinical settings, clinicians typically have limited time for assessments. Thus, histories gathered, especially as it relates to trauma, are often incomplete.

The symptoms of different mental illnesses may vary in intensity and associated impairment over time. Some diagnoses, such as Major Depressive Disorder or PTSD, completely resolve in certain circumstances. Others, such as Intellectual Disability, Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder are chronic.

Forensic Mental Health Assessment and Court Orders/Instructions

In the case of court-ordered evaluations, the clinician is trained to use their psychological or psychiatric knowledge, training, and experience to answer a specific question for the court. It is important that the evaluating clinician knows what decision you intend to use the evaluation to inform and what specific question is being asked of them to answer. Court orders to forensic evaluators should include specific instructions about the purpose of the evaluation and the opinion requested, ideally citing a specific statute. Vague requests for a "psychological evaluation" can lead to irrelevant, potentially prejudicial, and minimally useful reports that may not aid the trier of fact.

Psychological Testing

Psychological testing, which is typically completed by clinical psychologists but may be completed by other trained professionals based on state regulations and licensures, involves asking predetermined questions or tasks that have been administered to a test group. Based on responses and performance of that test group population, norms and outliers have been determined. Sometimes the topic of the test is readily apparent to the individual; at other times, it is not. The tests help to provide information about what is going on with an individual but often cannot identify *why*. The results also must be interpreted in the context of the individual's overall presentation and history by a qualified professional. Thus, it is critical that testing is accompanied by a clinical interview and an individualized interpretation of the results by a clinical evaluator.

Common Diagnoses

Anxiety Disorders

Anxiety disorders are characterized by excessive worry or anxiety that causes significant distress or impairment. They can take many forms including but not limited to generalized anxiety disorder, panic disorder, and social anxiety. These disorders often have onset in early childhood, but given the internalizing nature of the symptoms, they may go unnoticed by caregivers. Anxiety is often misunderstood. Anxiety is distressing, and therefore, individuals may also display symptoms outwardly (i.e., externalize). In some cases, this can take the form of irritability, poor attention, impulsivity, and/or aggression. Adults with anxiety often

"self-medicate" by using alcohol, cannabis, opiates, or other illicit substances to ameliorate their distress (see Substance-Related and Addictive Disorders). Avoidance is another common maladaptive coping mechanism.

Depressive Disorders

These conditions are characterized by a depressed mood that is consistent, impairing, and associated with cognitive (e.g., decreased concentration; thoughts of hopelessness, worthlessness and/or irrational guilt), physical (decreased sleep, decreased energy, decreased appetite), and behavioral characteristics (slowed movement, suicidality). Individuals may also demonstrate irritability or being easily angered, especially when they struggle to identify and process emotions.

Depression can be chronic (Persistent Depressive Disorder) or episodic (Major Depressive Disorder), and it is often harder to treat in people with a history of trauma disorders. There is a strong correlation with depression and trauma, one that is even stronger than the correlation with the diagnosis of Post-Traumatic Stress Disorder (PTSD). Of note, at times, individuals who have not had access to care may have been self-medicating their symptoms with substances, and it is their substance use that is first identified even when the depression precedes it.

Trauma- and Stressor-Related Disorders

The most well-known of the trauma- and stressor-related disorders is Post Traumatic Stress Disorder (PTSD). With this class of conditions, there has been a clear external precipitating factor (i.e., traumatic event), yet these disorders still have a biological basis. It may be helpful to think of the trauma and/or stressor as something that was disruptive and damaging to the functioning of the brain and neuroendocrine system (i.e., hormonal system). Of note, PTSD as conceptualized by the DSM presumes the trauma is circumscribed.

Thus, when the trauma has happened over a prolonged period of time, individuals may have trauma-related symptoms with significant negative impacts on their functioning without meeting the full diagnostic criteria for PTSD or that meet and go beyond those criteria. Given the disproportionate exposure to adverse childhood experiences faced by adults involved with the legal system, there should always be a high index of suspicion for a trauma- and stressor-

related disorder in any adult presenting with behavioral or emotional issues. Adults interfacing with the legal system often have experienced multiple traumatic events in childhood or adolescence. Adults who have experienced trauma and adverse childhood experiences often "self-medicate" by using alcohol, cannabis, or other illicit substances in order to ameliorate their distress (see Substance-Related and Addictive Disorders).

- **Post-Traumatic Stress Disorder (PTSD)** With this diagnosis, there have been prolonged effects (greater than one month) of experiencing or witnessing an event that involved threatened death or threatened or actual serious injury or sexual violence to the individual or to others. Symptoms include reliving the traumatic event (e.g., nightmares, flashbacks); avoiding situations, people, places, conversations, or objects that recall the traumatic event; negative emotions and moods; and heightened arousal (e.g., irritability, startle responses, poor sleep) in situations associated with the traumatic memory.
- **Acute Stress Disorder** This diagnosis requires exposure to a traumatizing event and has symptoms of PTSD that last one month or less after the traumatic exposure.
- **Adjustment Disorder** Adjustment Disorder occurs in response to a stressful life event. It is characterized by a distinct change in previously observed mood, anxiety levels, and/or conduct. Practically, an Adjustment Disorder diagnosis signals the observed mental health symptoms are a reaction or response to a current or past stressor, and the individual is not thought to meet criteria for another, more severe, mental health condition.

Substance-Related and Addictive Disorders

Many people use substances without having a diagnosable mental disorder. Substance use becomes a behavioral health disorder when there is continued use despite adverse consequences and associated impairment in functioning. In adults, this may take the form of decreased judgment that results in increased likelihood of criminal activities and/or spending excessive amounts of money to obtain the substance.

The earlier a brain is exposed to addictive psychoactive substances, the higher the risk of progression from substance use to a substance use disorder, which is

colloquially known as addiction. Trauma histories also increase this risk, likely due to the powerful impact of negative reinforcement. With negative reinforcement, aversive or distressing experiences (e.g., an individual's mental symptoms of unhappiness, insomnia, and physical manifestations of anxiety), are taken away by an action (e.g., smoking marijuana or cocaine). Use of drugs to decrease psychological symptoms is commonly referred to as self-medication and is a common issue.

Biologically, there is a strong influence of genetics upon the likelihood of an individual to become dependent on a substance. Moreover, if substance use begins at a young age (childhood or adolescence), the active development occurring during this time makes it easier for addictive substances to take hold. Psychologically, the use of substances to cope decreases an individual's ability to try out, practice, and develop more adaptive coping mechanisms. And socially, the mood changes associated with substance use, behaviors to obtain the substance, and excessive time spent gaining access to or using it can derail one's occupational and social functioning.

Substance use disorders are best understood as chronic, treatable medical conditions that usually have co-occurring mental health disorders. It is imperative that individuals are provided with accessible, effective alternatives for addressing their symptoms. And given the chronic nature of the disorder, it is essential that treatment and court plans account for the possibility of relapse rather than enacting punitive measures that disrupt or derail the rehabilitation process.

Of note, in an attempt to mitigate stigma, the DSM-5-TR and most mental health documentation have minimized the use of terms such as "addiction" or "substance abuse." The term "substance use disorder" is now much more commonly used.

Substance intoxication results in reversible behavioral or psychological changes in an individual due to the effects of a substance on the central nervous system. When used in excess, intoxication can lead to overdose which can be fatal. More commonly, it results in temporary cognitive, emotional, and behavioral changes.

Substance withdrawal consists of behavioral and psychological changes in an individual due to cessation or significant reduction in the use of a substance after heavy and prolonged use. Unmanaged and untreated withdrawal symptoms can

be highly distressing and may contribute to recurrent substance use, as it temporarily alleviates the symptoms. For some substances, namely alcohol and benzodiazepines, withdrawal can be life-threatening.

Intoxication and withdrawal symptoms can mimic other central nervous system syndromes and be mistaken for other diagnoses. Sedating substances (e.g., alcohol or benzodiazepines) can produce depressive symptoms while the use of stimulants (e.g., cocaine or methamphetamine) can produce anxiety, mania, or psychotic symptoms.

Neurocognitive Disorders

People with dementia suffer from memory impairment, typically regarding recent events, as well as from other cognitive impairments, such as difficulties with speaking, motor function, recognition, or planning and carrying out tasks. There are many causes of dementia, including Alzheimer's disease, vascular disease (from strokes or high blood pressure), Parkinson's disease, other medical or neurologic conditions (e.g., HIV infection), and substance use disorders. There is no treatment that reverses or completely stops dementia, but some medications slow the speed of progression. Additionally, some of the behavioral disturbances associated with neurocognitive disorders may be treated with psychiatric medications, environmental interventions, and therapy.

Neurodevelopmental Disorders

These disorders have onset during childhood and influence how the brain develops and functions. They include but are not limited to Intellectual Developmental Disorder (Intellectual Disability), Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder (ADHD) and Specific Learning Disorders. These are long-term conditions that may require interventions spanning across home, educational, and mental health settings. Some may have only required these interventions during childhood and/or adolescence, whereas others may require interventions indefinitely through adulthood.

- **Intellectual Disability (ID)** This condition represents a general impairment in cognitive functioning (reasoning, learning, problem-solving) that is paired with functional impairment (e.g., difficulty or inability to perform daily activities of living such as bathing, managing funds, completing laundry, etc.). It accounts for age and compares the individual against the broader

population. Individuals with ID may have difficulty understanding directives, which may be viewed by others as oppositional or defiant. Alternatively, individuals with ID can be overly acquiescent and say they understand more than they truly do, which is particularly relevant to competency to stand trial. They are also more vulnerable to being manipulated, coerced, or abused by others. Additionally, if their educational or home environment as a child, adolescent, and adult, did or does not appropriately accommodate them (account for their disability), their ability to self-regulate and function overall can be impaired.

The DSM-5-TR definition of Intellectual Disability emphasizes adaptive functioning and does not require a specific level of performance on an intelligence test; however, the DSM-5-TR notes that persons with an intellectual disability typically have IQ scores at or below 65-75.

- **Specific Learning Disorders** With Specific Learning Disorders, the individual experiences impairment in a specific academic domain, such as reading or math, compared to their same-aged peers. Depending on the specific learning disorder, this may result in the individual having difficulty understanding written communication from the courts or their attorneys or reading and understanding requirements of supervised release.

- **Language Disorder** Language Disorders fall into three broad categories: expressive (difficulty communicating to other people), receptive (difficulty understanding other people), or mixed (a combination of expressive and receptive). Adults with Language Disorders may seem ambivalent, disengaged, or oppositional because they do not understand and therefore cannot follow directives or because of the challenges they have in expressing themselves verbally. As a child or adolescent, if their educational or home environments did not appropriately accommodate them, the resultant frustrations with communication may have contributed to acting out behaviors seen in adults' historical records. These same challenges can make it hard for them to keep jobs as adults. These disorders are over-represented in court-involved individuals.

- **Autism Spectrum Disorder (ASD)** The distinguishing characteristics of ASD are social deficits. Additionally, compared to those without ASD, adults with this condition are more likely to have language, intellectual, and/or

sensory problems. Individuals with ASD have difficulty picking up on social cues and understanding nonverbal communication. They are attempting to navigate a world that is often confusing and frustrating, not only because of their unique perspective, but also because people around them intuitively communicate in ways that they cannot and do not understand. They are also susceptible to manipulation, coercion, and abuse. Further, they may not fully comprehend social and power dynamic factors relevant to certain sexual behaviors or interpersonal relationships. Individuals diagnosed with ASD can fall into a wide range of abilities and functional abilities, from nonverbal to fully integrated members of society with jobs and a family.

- **ADHD** This condition is characterized by problems with inattention, hyperactivity, and impulsivity. ADHD symptoms are understood to often persist in adulthood. In addition to the core symptoms, individuals with ADHD often struggle with regulating their emotions, as their emotions are more intense. Individuals with ADHD often have co-occurring mood (e.g., Major Depressive Disorders), anxiety (e.g., Generalized Anxiety Disorder, Social Anxiety, Obsessive Compulsive Disorder), and neurodevelopmental (e.g., Learning Disorders) disorders. Untreated ADHD is associated with increased risk for the development of substance use disorders. Given the poor access to youth mental healthcare, especially for those in marginalized populations, many with the condition are not diagnosed in childhood or adolescence.

Personality Disorders

Personality disorders are a pattern of interpersonal behaviors and ways of viewing stressors that deviate markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and often leads to distress or impairment. If clinicians are following diagnostic criteria, personality disorders should not be diagnosed in minors. By definition, these conditions represent enduring patterns of behaviors, and given a youth's developmental immaturity, their brain's ongoing maturation, and the changes expected in adolescence and early adulthood, it is not appropriate for such diagnoses to be applied to youth. Sometimes, however, they will be reflected in a youth's mental health records or evaluations. A key characteristic of these disorders is that the associated behaviors deviate markedly from the "expectations of the individual's culture." Thus, what was

modeled and normalized in the adult's environment as a child/adolescent must be considered.

Of special relevance to courts are the diagnoses of Antisocial Personality Disorder and Borderline Personality Disorder. Notably, a history of neglect or abuse in childhood or adolescence is frequently present in people with these conditions and/or their symptoms.

- **Antisocial Personality Disorder** An individual with antisocial personality disorder displays a pervasive pattern of disregard for the rights of others and a failure to abide by lawful behavior, without remorse for their behavior. Symptoms may include deceitfulness, impulsivity, and aggressiveness. Of note, there can be a great deal of overlap with these symptoms and those of other conditions such as Substance Use Disorder, Intellectual Disability, and Fetal Alcohol Spectrum Disorders, all of which are over-represented in the criminal court-involved adult population.

- **Borderline Personality Disorder** A person with borderline personality disorder displays a pattern of unstable interpersonal relationships. They also have emotional dysregulation which is extreme reactions to situational stressors. Symptoms may include dramatic efforts to avoid abandonment (whether real or perceived by the patient), unstable self-image, self-damaging impulsivity, suicidal behavior, intense anger, and severe dissociative symptoms. People with borderline personality disorder may also engage in self-mutilating behavior, such as cutting and burning or suicidal gestures or behaviors.

Schizophrenia Spectrum and Other Psychotic Disorders

Psychotic Disorders are characterized by problems with the thought process. People with these conditions may have perceptual abnormalities (e.g., hearing voices, seeing things that are not real), delusions or fixed false beliefs, or disorganization in their thoughts and/or behavior. The onset is usually during late adolescence or early adulthood. At the time of onset, there is an associated decline in functioning. In some cases, psychotic symptoms may occur because of substance intoxication, substance withdrawal, or certain medical conditions. They may also be associated with depressive or bipolar disorders. In these cases, the psychotic symptoms are expected to resolve as the underlying issues are treated or resolve. Sometimes the re-experiencing and hypervigilance symptoms

associated with trauma can be confused for the perceptual abnormalities and paranoia seen in psychotic disorders.

With primary psychotic disorders such as Schizophrenia or Schizoaffective Disorder, while symptom intensity or make-up may fluctuate over time, these are understood to be and treated as chronic conditions. In addition to the more apparent symptoms, more subtle symptoms can include decreased emotional facial expression, reduction in quantity of words spoken, reduced goal-directed activity due to decreased motivation, asociality, and reduced experience of pleasure. The assessment of symptoms should occur in the context of an individual's culture, values, and overall community as experience-based reactions and behaviors can be misinterpreted as psychotic symptoms.

- **Schizophrenia** Schizophrenia is characterized by delusions, hallucinations, disorganized thinking, a lack of physical coordination, and a decrease in functional ability. This decrease may be represented by difficulty at work or at home, difficulty speaking, interpersonal problems, an inability to make decisions, or a lack of emotional expression or display emotion that does not match the situation. The hallucinations are mostly auditory, with individuals hearing voices that say negative things. Delusions are often paranoid in nature. People with schizophrenia have difficulty telling the difference between what is real and what is not and also may display inappropriate affect or mood, such as smiling or laughing, or becoming angry and agitated, when it is not warranted.

- **Schizoaffective Disorder** An individual with schizoaffective disorder has simultaneous symptoms of schizophrenia (e.g., delusions, hallucinations, and disorganized thinking) and those of a major depressive disorder or bipolar disorder.

- **Brief Psychotic Disorder** Individuals with Brief Psychotic Disorder may experience delusions, hallucinations, difficulty speaking, or a lack of physical coordination for more than one day but are completely resolved within less than one month. An individual may feel disoriented, have memory problems, and experience changes in sleeping patterns, eating habits, and energy levels.

Bipolar and Related Disorders

Individuals with Bipolar and related disorders have distinct periods of abnormal mood states that are associated with disturbances in social and occupational functioning. There can be some overlap between Bipolar Disorder and severe ADHD or trauma symptoms, however, the decreased *need* for sleep and the episodic nature of mania or hypomania in Bipolar Disorder are distinguishing features. Severe mood disorders may be accompanied by psychotic symptoms.

- **Bipolar I Disorder** An individual with bipolar I disorder experiences episodes of mania and major depression and mania. During a manic episode, symptoms may include euphoria or irritability, increased activity/high energy (e.g., writing for hours at a time, painting walls), more thoughts or thinking faster than normal, rapid speech, poor judgment, hypersexuality, distractibility, increased risk-taking behaviors (e.g., overspending, reckless driving), grandiosity, a decreased need for sleep (to be differentiated from decreased sleep which is a non-specific symptom present in many mental health conditions), and potential delusions. Depressive symptoms may include persistent sadness, decreased energy or concentration, less interest in pleasurable activities, and feelings of hopelessness, guilt, or worthlessness. A person may experience physical symptoms, lose their appetite, and have suicidal thoughts or attempt suicide. A person may experience depressive and manic symptoms at the same time, known as a mixed state. Of note, people with Bipolar Disorder spend more time in depressed episodes than in manic ones.

- **Bipolar II Disorder** An individual with bipolar II disorder has episodes of hypomania (i.e., the mania symptoms seen in Bipolar disorder), but has fewer of them, can be milder than a manic episode, and/or for a shorter period of time. They also have major depressive disorder episodes. The individual typically presents with depressive symptoms and seldom reports impairment from hypomanic periods.

General Medical Conditions

A mental illness may be related to a person's current medical conditions. Understanding general medical conditions may inform treatment (e.g., which medications a person can take due to other illnesses or prescribed medications) and aid the recovery process. Examples of general medical conditions that are

important in making mental health treatment decisions include diabetes, HIV/AIDS, and seizure disorder. Some medical conditions also may mimic a mental illness. For example, individuals in a diabetic crisis may exhibit slurred speech, appear confused, and lose physical coordination. An individual with a seizure disorder may appear psychotic or report psychotic symptoms. Elderly individuals are especially susceptible to urinary tract infections; untreated UTIs can result in psychotic symptoms. Also, people with mental illness often suffer from more medical problems and complications than people without psychiatric diagnoses. Medical problems can also complicate the treatment of psychiatric conditions because of increased susceptibility to medication side effects or interactions. Finally, the medications used to treat mental illness can themselves predispose a person to medical problems, worsen them, or even cause them. The understanding that health of mind and health of body are inseparable has led to the creation of Certified Community Behavioral Health Clinics (CCBHCS) and to integrating mental health into primary care clinics.

Provisional and Other Disorder Diagnoses

Clinicians use the term "provisional" in treatment and evaluation records to convey a degree of uncertainty in the diagnosis. In these cases, the clinician may not have sufficient information to make a diagnosis or the symptoms have not been present long enough to meet diagnostic criteria.

The mental health field, and even the DSM-5-TR, recognizes that the full range of disorders of thinking, mood, and behavior cannot be captured in a single diagnostic compendium. Some presentations do not fit within the diagnostic boundaries. As such, the clinician may choose to communicate this with "unspecified disorder" or "other specified disorder."

Mental Health Treatment and Intervention

Therapeutic Modalities Availability

The availability of different therapeutic modalities will vary greatly by geography and insurance coverage or other payor. Courts need local information about the kinds of treatments in the community and the accessibility of that treatment to publicly insured or uninsured individuals.

Levels of Mental Healthcare

There is a continuum of mental healthcare services. One guiding principle of treatment is to treat individuals in the least restrictive environment and to maintain their ties to important people (e.g., children, family members, professional supports, and friends) and experiences (e.g., work, recreational activities). Often, when symptoms are substantially distressing and impairing despite interventions, an increased level of care will be required for relief or to address safety concerns.

In order from less intensive and restrictive to more intensive and restrictive, the levels of care are as follows:

1. **Primary care or work-based health interventions.** Counselors in either setting may respond to screens that indicate the need for psychosocial supports. In primary care settings, primary care providers may prescribe medications for certain mental health conditions, typically depression and anxiety.

2. **Outpatient treatment in a mental health clinic.** These settings include mental health professionals who may provide psychotherapy, case management, and/or specialty psychopharmacologic interventions. This treatment is office based. There are a growing number of CCBHCs which provide greater access to behavioral healthcare than typical outpatient clinics. CCBHCs are designed to ensure access to coordinated comprehensive behavioral healthcare including crisis services available 24

hours a day, 7 days a week; comprehensive behavioral health services which reduces multiple providers; and care coordination to help people navigate behavioral healthcare, physical healthcare, social services, and other systems in which they are involved.

3. **Wraparound services.** These services are an enhanced form of outpatient treatment. Compared to outpatient treatment, individuals are engaged more frequently, and in addition to clinic-based services, they receive support in the community (e.g., at home) and more intensive case management.

4. **Intensive Outpatient Program (IOPs), Partial Hospitalization Program (PHPs), and Assertive Community Treatment (ACT) Teams.** These programs typically include individual psychotherapy, psychopharmacology, and group therapy interventions. Individuals are seen more frequently by the clinicians prescribing their medications, so medication adjustments may be made more quickly. In IOPs, individuals attend treatment between nine and 20 hours per week. In PHPs, individuals are in a hospital or treatment setting most of the day for most days of the week. In both, individuals still spend the night at home. ACT teams serve individuals with serious and persistent forms of mental illness, often co-morbid with substance use disorders, who are at high risk of psychiatric hospitalization. The multidisciplinary team members can intervene 24 hours a day and often have contact with the individual several times a week.

5. **Group Homes.** Group homes allow individuals to reside in a residential setting in the community, usually with other individuals who have similar symptoms and struggles. Individuals in group homes receive varying levels of professional support and supervision. Psychiatrists, therapists, or counselors may see these individuals in the group home or in a mental health clinic.

6. **Acute inpatient hospitalization.** This level of care temporarily removes individuals from their homes and is very costly. For these reasons, it is reserved for situations where there are concerns about safety (suicidality, self-injurious behavior, recklessness, and/or aggression), or an individual's symptoms are so impairing they are unable to care for themselves. The patients are in locked units and their contact with family and friends is restricted. Though the specific mechanisms vary by state, clinicians are able

to force individuals to receive these services without their consent when it is determined to be clinically necessary. Typically, patients are discharged within two weeks from these settings.

7. **Inpatient and Forensic Psychiatric Hospitals.** Treatment in these facilities is reserved for individuals with severe mental illness that have not responded to community-based treatment. Generally, there are very limited long-term beds in state hospitals for general psychiatric treatment. Individuals within forensic psychiatric hospitals are mandated by the legal system for competency restoration; stabilization of symptoms impairing the safety of an incarcerated person or others in the facility; or after an individual is determined to be not guilty by reason of insanity. While these hospitalizations are typically longer than other hospitalizations, the primary focus of a forensic hospitalization is on the resolution of the court issue, not necessarily long-term mental health, decreased recidivism, or successful societal reentry.

Mental Health Evaluations in Emergency Room Settings

At times, symptoms require immediate assessment. In communities that do not have 24/7 mobile mental health assessment, individuals may be taken to emergency departments (EDs) or crisis units. Generally, these assessments are not in depth and are better understood as a triage to determine if the level of symptoms and impairment merit inpatient care. There is minimal, if any, treatment that occurs in these settings. The need for emergency assessment is a clear indicator that an individual is in need of ongoing mental health services, even in cases where they are discharged and not hospitalized. When an individual already receiving services has repeated ED or crisis unit visits, even in the absence of subsequent hospitalization, this indicates that a higher level of care is needed.

Community-Based Crisis Services

Building a robust community crisis care continuum is the goal for any community. Most communities, however, are lacking pieces of a full crisis care system. Understanding community-based crisis services is crucial for first responders who are traditionally the first point of contact for someone in a mental health crisis. Incorporating mental health clinicians improves the response including identifying a mental health crisis and deflecting the individual to a crisis center.

Mobile crisis and outreach services are an essential component of the crisis continuum of care, providing community-based support to individuals experiencing a crisis wherever they are. This includes crisis contact centers, mobile crisis teams (MCTs) and outreach services, and crisis stabilization services that work together to coordinate care. These services are on-demand and rapid where the MCT response begins upon the acceptance of a dispatch request initiated by a crisis contact (call, electronic message, or chat); mobile where the MCT goes to the individual in crisis in the community (i.e., the response is not limited to specific locations such as EDs or settings that are secure and/or staffed by behavioral health crisis clinicians); in-person where at least one crisis staff person must meet face-to-face with the individual in crisis (i.e., not a 100% telephonic, online, or telehealth interaction); and inclusive of a licensed or credentialed provider.

Medications

For court-involved individuals, psychiatric medications can be part of their treatment plan. Medications may be used in conjunction with other interventions such as therapy and case management. Medications can decrease symptoms and in turn decrease their negative impact on functioning and mitigate distress. In some cases, appropriate psychopharmacologic intervention greatly improves the effectiveness of other mental health and psychosocial interventions. That said, medications can cause side effects and/or pose risks that are meaningful to an individual and their caretakers. These side effects can cause people to stop taking medications, even if they are helpful for the target symptoms. This is why a trained clinician's regular monitoring of medication, the medication's impacts (both good and bad), patient and caregiver perceptions of their effectiveness, and the consistency with which they are administered and taken are critical.

Medications Used for Depression and Anxiety

Antidepressants are first-line medications for both depression and anxiety disorders. The most commonly prescribed antidepressants are in a subclass called selective serotonin reuptake inhibitors (SSRIs). These medications are relatively well-tolerated (i.e., do not cause significant side effects in most people), do not require routine or ongoing lab monitoring, and usually will not be fatal in the case of overdose. Antidepressants take time to work, and an individual will

not perceive benefit immediately. Sufficient trials take at least 4-6 weeks and require the individual to take the medication daily.

Benzodiazepines may be used for anxiety but do not have antidepressant properties; and unlike antidepressants, benzodiazepines carry a risk of abuse, tolerance, and diversion (i.e., the individual selling the medication). Benzodiazepines can also result in cognitive dulling and decreased alertness. They are more likely to cause serious medical complications in overdose, especially when taken with opiates or when used in the elderly. For all of these reasons, these medications are prescribed much less frequently than antidepressants. People who are prescribed and take benzodiazepines perceive they are helpful in the short term, but long-term studies related to symptom improvement and function show better evidence for the use of antidepressants for anxiety.

Medications Used for Post-Traumatic Stress Disorder (PTSD)

While they do not have FDA approval for the use of PTSD, antidepressant medications do have studies supporting their use in the treatment of this disorder. For some symptoms related to re-experiencing trauma symptoms (i.e., flashbacks and nightmares), or trauma associated with increased activation of the fight or flight system (hypervigilance and irritability), a class of medications called alpha-2 agonists may be used. Typically, side effects are minimal if present at all; however, alpha-2 agonists may cause sedation, decreased blood pressure, orthostatic hypotension (that manifests as light headedness), and constipation.

Medications Used for Bipolar Spectrum Disorders and Psychosis

Medications from two broad categories are commonly used for Bipolar Spectrum Disorders – mood stabilizers and atypical antipsychotic medications. Depending on the medication, there may be oral or long-acting injectable versions. Of the various psychiatric medication classes, these groups are associated with the highest incidence of side effects. For people with the potential to become pregnant, some mood stabilizers, namely lithium and Depakote, can cause severe birth defects in a developing fetus. The antipsychotics have the potential to cause movement disorders. Many of these medications require routine lab monitoring and are associated with risks of weight gain and other medical complications. For individuals who are experiencing Bipolar Depression, antidepressants may also be prescribed along with a mood stabilizer.

True primary psychotic disorders, Schizophrenia and Schizoaffective Disorder, are more common in the adult criminal court-involved population compared to the general population. When present, these disorders are treated with antipsychotic medications, which fall into two broad categories: atypical and typical antipsychotics. The atypical antipsychotics are newer medications and were originally thought to have fewer side effects. However, they can cause weight gain, diabetes-like symptoms, and cholesterol problems. A member of this class, risperidone (brand name Risperdal) has also been associated with the development of breast tissue in males. Depending on the medication and dose, the typical (older) antipsychotics can have an increased risk of associated muscle problems and movement disorders. In addition to undesirable side effects and the need for additional lab testing, adherence to medication regimens is often complicated by a lack of insight for the need for treatment.

Given the substantial side effects associated with these medication classes, it is important their use is clearly justified.

Medications Used for Attention Deficit Hyperactivity Disorder (ADHD)

The medications most commonly used for ADHD fall into two broad categories – stimulants and alpha-2 agonists. Stimulants are the most effective for treating all aspects of the disorder – inattention, hyperactivity, and impulsivity. At the appropriate dose, the benefit of these medications on ADHD symptoms can be seen within a few hours. Stimulants are generally well tolerated, but they are commonly associated with decreased appetite. This makes meal and snack planning and a well-balanced breakfast important. They can also be associated with insomnia. In some individuals, there may be increased irritability or anxiety or even flattening of their personality. When this is the case, switching to another medication for ADHD is often helpful for the side effects while still addressing the symptoms.

While it is true that stimulants have addictive potential as well as street value, when one considers the significant impairment associated with untreated ADHD symptoms and the effectiveness of these medications, treatment should be provided when indicated. In fact, studies have found that the risk of addiction in people with untreated ADHD is higher or the same as the risk in those who have had their ADHD treated with stimulants. When medications are taken as prescribed (e.g., pills taken orally and at the frequency instructed) and at the

doses indicated for ADHD treatment, individuals will not get high from them. Many ADHD medications come in longer acting forms. Because of psychopharmacological principles, these longer acting forms have lower risk of abuse and a diminished street value. When there is concern of diversion (i.e., an individual selling the stimulant medication), drug screens (which should be positive for stimulants) can be given to verify the medication is being taken.

The Use of Medication for Aggression

In some instances, psychiatric medications may be prescribed for aggression based on studies that have demonstrated their effectiveness; however, no medications are FDA approved specifically for this use. Generally, the pharmacologic approach to aggression starts with the identification of the underlying mental health condition. For example, aggression may be associated with irritability from Bipolar Disorder, impulsivity from ADHD, paranoia from a psychotic disorder, or hypervigilance from PTSD.

Treatment and Supports

The Judges' Guide to Mental Health Jargon: A quick reference for justice system practitioners (3rd ed.)[1] was used as a reference for many of the following descriptions of mental health treatment and supports.

Treatments

AIDS Drug Assistance Program (ADAP)

Administered by the federal Health Resources and Services Administration (HRSA), the AIDS Drug Assistance Program provides medications for the treatment of HIV/AIDS to people without adequate health insurance or financial resources. Program funds may also be used to purchase health insurance or pay for services such as case management and mental health interventions that enhance access to and adherence with drug treatments. ADAP funds are handled by each state and territory giving them control over the formulary and distribution of medications.

Assertive Community Treatment (ACT)

Assertive Community Treatment, or Program for Assertive Community Treatment (PACT), is an intensive, team-based form of direct service Case Management that provides comprehensive, community-based treatment to people with serious mental illness and co- occurring disorders. The ACT team approach includes shared caseloads, the participation of psychiatrists, and the availability of medication management. It is intended for people who are functionally impaired and at high risk of inpatient hospitalization. Individuals receive services within their own community and home settings. Team members include specialists in psychiatry, social work, nursing, substance use treatment, and vocational rehabilitation.

[1] Judges' Criminal Justice/Mental Health Leadership Initiative. (2014). Judges' guide to mental health jargon: A quick reference for justice system practitioners (3rd ed.), Delmar, NY: Policy Research Associates.

Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy involves recognizing current destructive patterns of thinking and behaving and replacing them with more realistic or helpful ones. There are multiple types of CBT. CBT models that target criminogenic needs include Thinking for a Change (T4C), Reasoning and Rehabilitation (R&R), Moral Reconation Therapy (MRT), and Relapse Prevention.

Cognitive Processing Therapy

Cognitive Processing Therapy is a cognitive behavioral treatment for post-traumatic stress disorder (PTSD) that targets counterproductive coping strategies people may develop in response to a traumatic experience. The therapy helps individuals identify and question stuck points and problematic thinking as well as associated problems such as guilt and anger. The therapy includes a psychoeducation component about PTSD and the effect it can have on an individual's attitudes, thinking, and beliefs.

Day Treatment

Individuals in a Day Treatment program, also called Partial Hospitalization, reside at home while attending a treatment program during the day.

Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy employs cognitive behavioral techniques to address self-harm behaviors and skill deficits. DBT helps the individual to better identify and manage destructive behavior and emotions by applying new skills to tolerate difficult life events and improve interactions with others. This therapy was first developed for treating borderline personality disorder but is now used to treat many psychiatric disorders.

Forensic Assertive Community Treatment (FACT)

Forensic Assertive Community Treatment is an adaptation of Assertive Community Treatment (ACT) with the additional goal of reducing arrest and incarceration. FACT is dependent upon case managers who are criminal-justice savvy.

Integrated Treatment for Co-occurring Disorders

Treatment of co-occurring disorders is integrated when mental health and substance use treatment takes place concurrently, with interventions coordinated among all providers. Integrated Dual Disorders Treatment is a specific evidence-

based practice that integrates addiction treatment within the context of treatment for serious mental illnesses.

Involuntary Outpatient Commitment (IOC)

Involuntary Outpatient Commitment, also known as Assisted Outpatient Treatment (AOT), involves a civil court order directing an individual with a serious mental illness to comply with a community-based treatment plan, due to treatment history and safety concerns. Failure to comply with the treatment plan may result in involuntary hospitalization.

Multisystemic Therapy (MST)

Developed for justice-involved adolescents with substance use disorders who engage in violent acts, Multisystemic Therapy is a family-based treatment program that emphasizes the importance of social networks, skills development for parents, and coping strategies for adolescents. It takes a multifaceted approach, often engaging family, school, community agencies, and mental health clinicians.

Partial Hospitalization

Individuals in Partial Hospitalization attend a hospital treatment program during the day and reside at home. This is also referred to as Day Treatment.

Prolonged Exposure Therapy

Prolonged Exposure Therapy for post-traumatic stress disorder (PTSD) is a cognitive behavioral treatment program that focuses on thoughts, feelings, and situations related to the traumatic event. The therapy provides education about the nature of trauma and trauma reactions, training in controlled breathing, repeated discussion of the traumatic event, and exposure practice in situations that are safe but have been avoided by the individual. Of note, a good therapeutic rapport and actual safety and stability are needed before this therapy can be undertaken, otherwise it could worsen the symptoms.

Psychosocial Rehabilitation

Psychosocial Rehabilitation is an individualized intervention approach for providing time-unlimited services that are strengths-based and focus on the development of personal support networks, enhanced quality of life, and full recovery.

Substance Use Treatment

Treatment is the use of any therapeutic intervention in the health, behavior, personal and/or family life of an individual suffering from Substance Use Disorder. It aims to support recovery, periods of abstinence and sobriety, and/or physical and mental health with the ultimate goal of restoring or reaching maximum functional ability.

Supports

Case Management

Case Management is a means of coordinating the services available in a community to ensure continuity of mental healthcare across a non-integrated service system. There are two basic service models of Case Management: the broker model and the direct services model. In the broker model, the role of the case manager is to develop a service plan, link an individual with mental illness to services, monitor those services, and determine whether other services are needed. The direct services model employs a multidisciplinary team of professionals to provide individualized treatment services. Treatment is offered in the community rather than in traditional service settings. Length of treatment may be indefinite, and case managers in direct service models have reduced caseloads compared to case managers in broker models.

Clubhouses

Clubhouses are local resource centers that provide a support system for people with mental illness. Clubhouses may help their members find work, housing, or educational opportunities. They have a greater emphasis on social support than on medical interventions, and they often have a strong peer component.

Forensic Intensive Case Management (FICM)

Forensic Intensive Case Management is an adaptation of Intensive Case Management (ICM) for justice-involved people with serious mental illness. This form of Case Management focuses on mental health and criminal justice outcomes.

Intensive Case Management (ICM)

Intensive Case Management is a form of Case Management that involves assertive outreach. ICM employs case managers with individual caseloads who broker

mental health treatment and other services. When ICM is adapted for forensic populations, it is known as Forensic Intensive Case Management.

Peer Support

There is no single model of Peer Support services. The support provided by a peer may help reduce emergency hospitalization and criminal justice involvement, increase self-care skills, and build strong support networks. Peers also help treatment providers to understand the perspective and experiences of an individual with mental illness.

Peer Specialist

A Peer Specialist is an individual who is living with mental illness and provides support to another individual with mental illness. In a criminal justice/mental health program, a Peer Specialist often has personal experience with the criminal justice system. Some states and communities have developed certified peer specialist trainings, such as the Georgia Certified Peer Specialist Project and the Howie T. Harp Peer Advocacy Center's Forensic Peer Specialist Training. Peers are able to provide mental health support and expand the care team in a manner that is less cost-intensive than other professionals. Additionally, their firsthand knowledge of navigating the system as patients or people with criminal records greatly informs the treatment and engagement process. Lastly, they are also more likely to be more representative of the communities served compared to other mental health or court personnel.

Peer Support

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Social Skills Training

Social Skills Training may aid people with serious mental illness in developing complex interpersonal skills.

Supported Employment

Supported Employment includes professional psychosocial assistance to people with serious mental illness for identifying, applying for, and succeeding in community-based occupational roles.

Vocational Rehabilitation

Vocational Rehabilitation helps individuals with disabilities, including mental illness, first find, and then maintain employment. Some services provide pre-employment training and skill building prior to an employment placement.

Insurance and Income

Medicaid

Medicaid, administered by the Centers for Medicare & Medicaid Services (CMS), provides medical and other benefits to people with low income who have inadequate or no medical insurance. In states that did not expand Medicaid, low income alone does not qualify someone for Medicaid, and only adults who have been determined to be disabled by the government can obtain it. Although the federal government establishes general guidelines, Medicaid program requirements and eligibility are uniquely established by each state. No two states have identical Medicaid programs.

Medicare

The Centers for Medicare and Medicaid Services (CMS) administer Medicare, a health insurance program for people 65 years of age and older, some people with disabilities under 65, and people with end-stage renal disease. Unlike Medicaid, Medicare is administered nationally so there is very little variance from state to state. It generally pays higher than Medicaid and may come with more treatment options.

Social Security Disability Insurance (SSDI)

Administered by the federal Social Security Administration (SSA), Social Security Disability Insurance provides wage replacement income for people with an eligible disability who have paid FICA taxes (i.e., have a history of employment that has paid into the federal payroll tax system). This program provides benefits

to family members when a primary wage earner becomes disabled or dies and to eligible children or adults disabled since childhood.

Supplemental Security Income (SSI)

An income supplement program of the federal Social Security Administration (SSA), Supplemental Security Income is funded by general tax revenues to help low-income elderly people and people with eligible disabilities. The program provides income intended to meet basic needs; however, the amount is not always sufficient to do so. It is important to have a sense of what real living costs are in a given area so shortfalls are identified and their potential impacts understood.

Screening and Assessment

Criminogenic Needs

Criminogenic needs are dynamic risk factors that are directly linked to criminal behavior. Justice-involved persons with mental illness often have more criminogenic needs than individuals without mental illness. Examples include justice-involved peers, substance use disorder, and dysfunctional family dynamics.

Criminogenic Risk

Individuals involved with the criminal justice system differ in their likelihood of committing another crime. The probability that an individual will reoffend is referred to as his or her criminogenic risk. Criminogenic risk factors are categorized as either static or dynamic. Static risk factors are those that are unalterable, such as an individual's criminal history, demographics, and age at first arrest. Dynamic risk factors are those that can change over time and are amenable to interventions. It is important to consider that many criminogenic risk factors, such as criminal record history, are shaped by societal inequities like disproportionate minority contact of Black and Brown youth by the juvenile justice system.

Evidence-Based Practices (EBP)

The term Evidence-Based Practices refers to interventions that, through research, are found to be beneficial, effective, and replicable for people with serious mental illness. Assertive Community Treatment (ACT) is an example of an EBP. The ACT team approach includes shared caseloads, the participation of a multi-member, multidisciplinary treatment team (nurses, vocational

rehabilitation, social workers, peer specialists, psychiatrists and/or physician assistants and nurse practitioners) and frequent community-based contacts. It is an effective but highly intensive model, so it reserved for people who are functionally impaired and at high risk of inpatient hospitalization.

Mental Status Examination (MSE)

A Mental Status Examination assesses an individual's present mental state through evaluation of appearance, behavior, speech, mood, perceptions, thought process, and cognition. This is the part of the clinical note that is much less dependent on what the individual reports and instead relies on the observations of the mental health professional.

Education and Recovery

Family Psychoeducation

Family Psychoeducation is a practice of working in partnership with families to help them understand mental health conditions, their manifestations, and their management. Additional family work supports their development of positive coping skills for navigating the psychosocial issues associated with mental illness and for supporting the recovery process.

Illness Management and Recovery (IMR)

Illness Management and Recovery is a set of practices that provides people with serious mental illness skills to manage their illness to achieve recovery goals. Practices include psychoeducation, behavioral tailoring, relapse prevention skills, social skills training, and the development of coping strategies. IMR is often referred to as Wellness Management and Recovery (WMR) and Symptom Self-Management.

Recovery

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery from mental disorders and/or substance use disorders as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Wellness Recovery Action Plan (WRAP)

Wellness Recovery Action Plan is a self-management program that focuses on reducing symptoms through planned responses, increasing personal empowerment, and improving quality of life. An individual may be certified as a WRAP facilitator and lead WRAP group sessions.

Housing Models

Emergency Housing

Emergency housing is short-term housing made available in response to a crisis. It is provided either in emergency shelters or motel rooms funded for such purposes.

Housing Choice Voucher Program

Housing Choice Voucher Program provides housing assistance secured from a local housing authority or other provider in the form of direct payments to landlords. Housing Choice is intended to allow people with low incomes to rent market-rate housing. Practically, particularly in gentrifying urban areas, people with vouchers may still have difficulty identifying landlords or housing options that accept these vouchers. And people with them may be on waitlists for extended periods of time before they can use them.

Housing First

This model rightfully recognizes housing stability as a critical social determinant of health and mental health. Providing immediate access to permanent housing for people living with mental illness and who are homeless is the hallmark of this approach. Professional and/or peer services are available following the placement to provide psychosocial interventions and support tailored to individual needs. Housing is contingent only upon meeting the lease terms, rather than remaining treatment compliant.

Housing Ready

Housing Ready approaches are transitional and highly structured. Such programs often require individuals to progress through several types of housing placements before gaining access to permanent housing.

Low-Demand Housing

Low-Demand Housing allows people in need of support services to determine the type and intensity of services they receive instead of requiring them to comply with preexisting service plans. Most people accept support services when they are allowed to access them voluntarily and without coercion.

Permanent Supportive Housing

Permanent Supportive Housing is affordable rental housing with support services at various levels of intensity. The services, such as Case Management or Vocational Rehabilitation, may be offered on site or at locations in the community. Single Room Occupancy (SRO), group homes, Housing Choice subsidized apartments, and shared housing may be used by Permanent Supportive Housing programs.

Recovery Housing

Recovery housing programs provide stable, transitional housing for individuals in recovery from substance use disorders where peer-peer tenant support is key. Some program models include the Substance Abuse and Mental Health Services Administration (SAMHSA)-recognized National Alliance of Recovery Residence (NARR) levels of care, Oxford Houses, and HUD Continuum of Care (CoC)-recognized recovery housing for individuals and families exiting homelessness. While there may be some financial assistance for the first month or two, most Recovery Houses require tenants to pay their own rent and expenses.

Shelter Plus Care Program (S+C)

The Shelter Plus Care Program provides housing and long-term support services for people who are homeless and living with disabilities (e.g., people with serious mental illnesses, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families.

Single Room Occupancy (SRO)

This is permanent housing that provides an individual with a single room in which to live.

Transitional Housing

Transitional Housing programs are bridge placements where professional staff helps to determine when people are ready to move beyond an emergency shelter or institutional setting (such as a correctional institution) into a more independent living situation. Transitional Housing programs emphasize the importance of people developing independent living skills and, for those with severe mental illness, achieving some degree of symptom stability prior to placement into permanent housing. Such programs may offer apartment-style, group, or shared family housing.

Self-Help Groups

Alcoholics Anonymous (AA)

Alcoholics Anonymous is a voluntary self-help organization for people recovering from alcoholism. It employs a 12-step model of recovery.

Double Trouble in Recovery (DTR)

Double Trouble in Recovery is a self-help organization for people with co-occurring disorders.

Dual Recovery Anonymous (DRA)

Dual Recovery Anonymous is a self-help organization for people with co-occurring disorders.

Narcotics Anonymous (NA)

Narcotics Anonymous is a self-help organization for people recovering from substance use disorders.

National Alliance on Mental Illness (NAMI)

The National Alliance on Mental Illness provides mental health support, education and advocacy and is the nation's largest grass roots organization on mental illnesses. Their website provides information on state and local chapters where family, parent, and individual support groups and meetings can be found.

Recovery Organizations

Recovery organizations are locally driven recovery community organizations that provide direct provision or referral to support groups and are often peer led. While these originated with a focus with substance use disorder recovery they are as strong with mental health supports in the community. As noted earlier, co-morbidity is very high so people need both types of supports (SUD and MH) seamlessly.

Trauma Interventions

Trauma-Informed Services

Trauma-Informed Services anticipate and respond to the needs of people with histories of trauma. Trauma-Informed Services involve understanding, anticipating, and responding to the issues, expectations, and special needs a person who has been victimized may have in a particular setting. At a minimum, trauma-informed services should endeavor to do no harm – to avoid retraumatizing survivors or criticizing their efforts to manage their traumatic reactions. They represent an overall treatment approach that deliberately recognizes and accounts for the high prevalence of trauma in marginalized and court-involved populations. They can be incorporated in any process or interaction and are not restricted to the mental healthcare system or to mental health professionals.

Trauma-Specific Services

Trauma-Specific Services are menta health interventions that have been developed and studied for targeting specific behavioral, intrapsychic, and interpersonal consequences of exposure to abuse. The following are some examples of prominent Trauma-Specific Services.

- **Seeking Safety**
  A present-focused intervention to aid the recovery of people with trauma histories and a substance use disorder, Seeking Safety can be individual or group focused.

> Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

This trauma-specific intervention can be conducted with an individual or with groups. The seven-step psychoeducational skills approach emphasizes FREEDOM: Focus, Recognize triggers, Emotion self-check, Evaluate thoughts, Define goals, Options, and Make a contribution. TARGET has been adapted for use with justice-involved people with trauma histories.

> Trauma Recovery and Empowerment Model (TREM)

The Trauma Recovery and Empowerment Model is a trauma-specific group intervention that addresses the impact of sexual, physical, and emotional abuse. The program employs psychoeducational and skill-building approaches to promote empowerment and recovery. TREM has been adapted for several populations, including the M-TREM for men.

Local Informational Interview Prompts

Local informational interviews can improve the court personnel's understanding of the systems serving court-involved individuals, as well as highly relevant system limitations. Court workers and decision-makers typically have far greater access to resources and more positive experiences with societal systems compared to the populations over-represented in courts. Accounting for this reality best positions the court to create plans that are more likely to be doable and helpful for court-involved individuals.

Suggested Subjects for Informational Interviews

Relevant expertise may be based on lived experience (individuals with mental illness in recovery or forensic peers), professional experience relevant to Social Determinates of Mental Health (case manager, social worker, clinic coordinator), or mental health system expertise (psychologist, therapist, clinical social worker). People in these roles have valuable and complementary perspectives that can help courts improve their structural competency.

Source: CDC, https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html

Potential Interview Questions

Social Determinants of Health

1. What are the strengths of the local housing, public transportation, and primary healthcare systems? What are the limitations?

2. What proportion of families live in poverty or near poverty in the community?

3. What proportion of families experience food insecurity (a well-characterized driver of illegal behaviors) in the community?

4. What are the community-level exposures to traumas (e.g., crime map data showing assaults, burglaries, shootings in the neighborhood where an individual lives)?

5. What are community beliefs about the court and healthcare systems?

6. What are the community's experiences with the court and healthcare systems?

7. What environmental toxins have been identified in the community?

8. Do people in the community have access to devices and broadband internet required for matters such as online enrollment for social services programs, access to educational materials, etc.?

The Mental Healthcare System

1. What are the strengths of the local mental healthcare system? What are the limitations?

2. Who are the major providers of mental healthcare services for individuals who are uninsured or publicly insured? What are their strengths and limitations?

3. What components of the continuum of mental healthcare are available to self-pay, privately insured, publicly insured, and uninsured individuals? What kinds of therapeutic modalities are available?

4. What are wait times for initial appointments? What are the experiences of individuals trying to initiate treatment engagement? And of those who are already receiving services?

5. What specialty transportation services are available for attending treatment (e.g., Medicaid transport)? What are the strengths and limitations of those services?

6. Are psychiatric medications for individuals being prescribed by primary care physicians, advanced practice providers (nurse practitioners and PAs), or adult psychiatrists?

Self-Reflection and Assessment

Generally speaking, decision-makers in court have some form of societal standing and privilege that most court-involved families do not. Be it due to race, socioeconomic status, or other forms of marginalization, lived experiences will diverge greatly. This paves the way for misunderstanding and suboptimal outcomes. One way of accounting for this reality is deliberate inclusion and representation in court teams. This may take the form of concerted efforts to recruit people from the communities served and/or the incorporation of advocates and peers into legal teams. Even with best efforts disparities will persist, thus ongoing self-reflection and assessment is imperative. Some potential questions are included.

1. What are my associations (both explicit and potential implicit ones) about poor individuals? About Black, Brown and Indigenous individuals?

2. To which individuals am I more likely to give the benefit of the doubt?

3. How intentional have I been about accounting for individuals with disabilities in court?

4. How has structural and/or interpersonal racism impacted me? The members of my professional team?

5. How has structural and/or interpersonal racism impacted individuals' access to appropriate mental healthcare?

6. What are the ways in which thinking in a "race-neutral" manner or from a middle-class perspective can limit my understanding of an individual? Of the circumstances of illegal acts?

7. What was my personal experience with the educational system like during my youth? How might this be different than the individuals in court?

8. What assumptions do I make about children who are not academically engaged? How might an apparent lack of individual engagement be better understood in the context of the quality, resources, testing, and accommodations available to the youth in their school system?

9. What do I and my team know about the educational outcomes by school and zip codes in the communities over-represented in our court system?

10. What choices and priorities went into my decision about where I live? How have those decisions impacted my life? For those I serve in court, what choices and priorities go into the decisions about where they live?

11. How do housing, education, and occupational opportunities in the community impact me? Impact the individuals in my court?

12. What value judgements do I place on people with substance use disorder? What assumptions do I make about their character, morals, or capacity for rehabilitation?

13. Which types of traumas do I tend to acknowledge or have sympathy for? Which types of traumas might I overlook?

Commonly Used Acronyms

AA	Alcoholics Anonymous
ACEs	Adverse Childhood Experiences
ACT	Assertive Community Treatment (same as PACT)
ADAP	AIDS Drug Assistance Program
ADHD	Attention-Deficit/Hyperactivity Disorder
ALF	Adult Living Facility (supportive housing)
AOT	Assisted Outpatient Treatment
ASD	Autism Spectrum Disorder
ASPD	Antisocial Personality Disorder
CCBHC	Certified Community Behavioral Health Clinics
CBT	Cognitive Behavioral Therapy
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (Federal)
CMS	Centers for Medicare and Medicaid Services (Federal)
COD	Co-occurring Disorders
CSAP	Center for Substance Abuse Prevention (Federal)
CSAT	Center for Substance Abuse Treatment (Federal)
CSB	Community Service Board
CSG	Council of State Governments
DBT	Dialectical Behavioral Therapy
DRA	Dual Recovery Anonymous
DSM	Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association)

DTR	Double Trouble in Recovery
EBP	Evidence-Based Practice
FACT	Forensic Assertive Community Treatment
FAS	Fetal Alcohol Syndrome
FICM	Forensic Intensive Case Management
FQHC	Federally Qualified Health Center
GAINS	SAMSHA's GAINS Center Gathering information, Assessing what works, Interpreting/ integrating the facts, Networking, Stimulating change
HHS	U.S. Department of Health and Human Services (Federal)
HRSA	Health Resources and Services Administration (Federal)
HUD	U.S. Department of Housing and Urban Development (Federal)
ICM	Intensive Case Management
IDDT	Integrated Dual Disorders Treatment
IMR	Illness Management and Recovery
IOC	Involuntary Outpatient Commitment
JPLI	Judges and Psychiatrists Leadership Initiative
MET	Motivational Enhancement Therapy
MSE	Mental Status Examination
MST	Multisystemic Therapy
MTC	Modified Therapeutic Community
M-TREM	Men's Trauma Recovery and Empowerment Model
NA	Narcotics Anonymous
PACT	Program of Assertive Community Treatment (same as ACT)

PTSD	Post-Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOMH	Social Determinates of Mental Health
SMHA	State Mental Health Agency/Authority
SMI	Serious Mental Illness
SNRI	Serotonin and Norepinephrine Reuptake Inhibitors
SPMI	Serious and Persistent Mental Illness
SRO	Single Room Occupancy
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSRI	Selective Serotonin Reuptake Inhibitors
TARGET	Trauma Affect Regulation: Guide for Education and Therapy
TC	Therapeutic Community
TREM	Trauma Recovery and Empowerment Model
WHODAS	World Health Organization Disability Assessment Schedule
WMR	Wellness Management and Recovery
WRAP	Wellness Recovery Action Plan

Medication Table

Common Medications Used in the Treatment of Mental Illness

Trade Name	Generic Name	Type of Medication
Abilify	Aripiprazole	Antipsychotic
Ambien	Zolpidem	Sleep
Anafranil	Clomipramine	Antidepressant
Artane	Trihexyphenidyl	Side Effect
Atarax	Hydroxyzine	Anti-Anxiety Sleep
Ativan	Lorazepam	Anti-Anxiety
Aventyl	Nortriptyline	Antidepressant
Benadryl	Diphenhydramine	Anti-Allergy Side Effect
Buspar	Buspirone	Anti-Anxiety
Celexa	Citalopram	Antidepressant
Clozaril	Clozapine	Antipsychotic
Cogentin	Benztropine	Side Effect
Dalmane	Flurazepam	Sleep
Depakene	Valproic Acid	Mood Stabilizer
Depakote	Valproic Acid	Mood Stabilizer
Desyrel	Trazodone	Antidepressant Sleep
Effexor	Venlafaxine	Antidepressant
Elavil	Amitriptyline	Antidepressant
Eskalith	Lithium	Mood Stabilizer
Fanapt	Iloperidone	Antipsychotic
Gabitril	Tiagabine	Mood Stabilizer

Trade Name	Generic Name	Type of Medication
Geodon	Ziprasidone	Antipsychotic
Halcion	Triazolam	Sleep
Haldol	Haloperidol	Antipsychotic
Invega	Paliperidone	Antipsychotic
Klonopin	Clonazepam	Anti-Anxiety
Lamictal	Lamotrigine	Mood Stabilizer
Latuda	Lurasidone	Antipsychotic
Loxitane	Loxapine	Antipsychotic
Latuda	Lurasidone	Antipsychotic
Lexapro	Escitalopram	Antidepressant
Librium	Chlordiazepoxide	Anti-Anxiety
Lithobid	Lithium	Mood Stabilizer
Loxitane	Loxapine	Antipsychotic
Luvox	Fluvoxamine	Antidepressant
Mellaril	Thioridazine	Antipsychotic
Moban	Molindone	Antipsychotic
Navane	Thiothixene	Antipsychotic
Neurontin	Gabapentin	Mood Stabilizer
Pamelor	Nortriptyline	Antidepressant
Paxil	Paroxetine	Antidepressant
Pristiq	Desvenlafaxine	Antidepressant
Prolixin	Fluphenazine	Antipsychotic
ProSom	Estazolam	Sleep
Prozac	Fluoxetine	Antidepressant
Remeron	Mirtazapine	Antidepressant
Restoril	Temazepam	Sleep

Trade Name	Generic Name	Type of Medication
Risperdal	Risperidone	Antipsychotic
Seroquel	Quetiapine	Antipsychotic
Sonata	Zaleplon	Sleep
Stelazine	Trifluoperazine	Antipsychotic
Tegretol	Carbamazepine	Mood Stabilizer
Thorazine	Chlorpromazine	Antipsychotic
Tofranil	Imipramine	Antidepressant
Topamax	Topiramate	Mood Stabilizer
Trilafon	Perphenazine	Antipsychotic
Trileptal	Oxcarbazepine	Mood Stabilizer
Valium	Diazepam	Anti-Anxiety
Vistaril	Hydroxazine	Anti-Anxiety
Wellbutrin	Bupropion	Antidepressant
Xanax	Alprazolam	Anti-Anxiety
Zoloft	Sertraline	Antidepressant
Zyprexa	Olanzapine	Antipsychotic

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