

Judges' Guide to Mental Health Jargon

A Quick Reference for
Justice System Practitioners

Third Edition

Updated for DSM-5

Judges' Criminal Justice / Mental Health
Leadership Initiative

SAMHSA's GAINS Center for
Behavioral Health and Justice
Transformation

The Council of State Governments
Justice Center

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A Quick Reference for Justice System Practitioners
Third Edition — Updated for DSM-5

This work was conducted by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc., in collaboration with the Council of State Governments (CSG) Justice Center. Support for this work came from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). The material contained in this publication does not necessarily represent the position of the CSG, the CSG Justice Center, or the CMHS.

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The **Judges' Criminal Justice/Mental Health Leadership Initiative (JLI)** provides support for the expanding leadership role of judges in community and state response strategies to the criminal justice system involvement of people with serious mental illness. The JLI facilitates information sharing and networking opportunities among judges and promotes the growth of judicial leadership. JLI is coordinated by the Council of State Governments (CSG) Justice Center. ♦



SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc. (PRA) since 1995, is a national locus for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders in contact with the justice system.

The GAINS Center's primary focus is on expanding access to community-based services for adults diagnosed with co-occurring mental illness and substance use disorders at all points of contact with the justice system. The Center emphasizes the provision of consultation and technical assistance to help communities achieve integrated systems of mental health and substance abuse services for individuals in contact with the justice system. ♦

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The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments (CSG) Justice Center, is an unprecedented national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illness who come into contact with the criminal justice system. The landmark *Consensus Project Report* was released in June 2002. Since then, Justice Center staff working on the Consensus Project have supported the implementation of practical, flexible criminal justice/mental health strategies through on-site technical assistance; the dissemination of information about programs, research, and policy developments in the field; continued development of policy recommendations; and educational presentations. ♦

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How to Use This Guide

The *Judges' Guide to Mental Health Jargon* is intended to serve as a resource for judges involved with criminal justice/mental health initiatives in their communities. The guide is divided into seven parts: Acronyms, Treatment and Supports, Diagnoses, Medications, Frequently Asked Questions, Resources, and Index. Endnotes are located at the back of the Index tab. Each section consists of entries that provide a concise overview and direction for accessing more information (when available) within the guide. The *Judges' Guide to Mental Health Jargon* is intended for informational uses only; diagnoses and treatment recommendations can only be made by mental health clinicians.

Acronyms

AA	Alcoholics Anonymous <i>Go To: Treatment and Supports – Self-Help Groups, p. 33</i>
ACT	Assertive Community Treatment (same as PACT) <i>Go To: Treatment and Supports – Evidence-Based Practices, p. 20</i>
ADAP	AIDS Drug Assistance Program <i>Go To: Treatment and Supports – Income Benefits and Supports, p. 27</i>
ADHD	Attention-Deficit/Hyperactivity Disorder <i>Go To: Diagnoses – Specific Mental Disorders – Neurodevelopmental Disorders, p. 55</i>
AOT	Assisted Outpatient Treatment <i>Go To: Treatment and Supports – Involuntary Outpatient Commitment, p. 30</i>

ASD	Autism Spectrum Disorder <i>Go To: Diagnoses – Specific Mental Disorders – Neurodevelopmental Disorders, p. 56</i>
ASPD	Antisocial Personality Disorder <i>Go To: Diagnoses – Personality Disorders, p. 71</i>
CBT	Cognitive Behavioral Therapy <i>Go To: Treatment and Supports, p. 18</i>
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (Federal)
CMS	Centers for Medicare and Medicaid Services (Federal)
COD	Co-occurring Disorders <i>Go To: Frequently Asked Questions – What Are Co-occurring Disorders?, p. 101</i>
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 <i>Go To: Treatment and Supports – Cognitive Behavioral Therapy, p. 18</i>
DRA	Dual Recovery Anonymous <i>Go To: Treatment and Supports – Self-Help Groups, p. 34</i>
DSM	Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association) <i>Go To: Diagnoses, p. 45</i>
DTR	Double Trouble in Recovery <i>Go To: Treatment and Supports – Self-Help Groups, p. 34</i>
EBP	Evidence-Based Practice <i>Go To: Treatment and Supports, p. 20</i>
FACT	Forensic Assertive Community Treatment <i>Go To: Treatment and Supports – Case Management, p. 16</i>

FAS	Fetal Alcohol Syndrome
FICM	Forensic Intensive Case Management <i>Go To: Treatment and Supports – Case Management, p. 16</i>
FQHC	Federally Qualified Health Center
GAINS	SAMHSA’s GAINS Center <i>Gathering information, Assessing what works, Interpreting/integrating the facts, Networking, Stimulating change</i>
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 <i>Go To: Treatment and Supports – Case Management, p. 17</i>
IDDT	Integrated Dual Disorders Treatment <i>Go To: Treatment and Supports – Evidence-Based Practices, p. 23</i>

IMR	Illness Management and Recovery <i>Go To: Treatment and Supports – Evidence-Based Practices, p. 22</i>
IOC	Involuntary Outpatient Commitment <i>Go To: Treatment and Supports, p. 30</i>
JLI	Judges' Criminal Justice/Mental Health Leadership Initiative
MET	Motivational Enhancement Therapy <i>Go To: Treatment and Supports – Substance Use Treatment, p. 36</i>
MSE	Mental Status Examination <i>Go To: Treatment and Supports, p. 30</i>
MST	Multisystemic Therapy <i>Go To: Treatment and Supports, p. 31</i>
MTC	Modified Therapeutic Community <i>Go To: Treatment and Supports – Substance Use Treatment – Therapeutic Community, p. 37</i>

M-TREM	Men's Trauma Recovery and Empowerment Model <i>Go To: Treatment and Supports – Trauma Interventions – Trauma-Specific Services, p. 40</i>
NA	Narcotics Anonymous <i>Go To: Treatment and Supports – Self-Help Groups, p. 34</i>
PACT	Program of Assertive Community Treatment (same as ACT) <i>Go To: Treatment and Supports – Evidence-Based Practices – Assertive Community Treatment, p. 21</i>
PTSD	Post-Traumatic Stress Disorder <i>Go To: Diagnoses – Trauma- and Stressor-Related Disorders, p. 59</i>
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SMHA	State Mental Health Agency/ Authority

SMI	Serious Mental Illness <i>Go To: Frequently Asked Questions – What Is Serious Mental Illness?, p. 101</i>
SNRI	Serotonin and Norepinephrine Reuptake Inhibitors <i>Go To: Medications – Medications to Treat Mental Illness – Anti-Depressants, p. 81</i>
SPMI	Serious and Persistent Mental Illness
SRO	Single Room Occupancy <i>Go To: Treatment and Supports – Housing Models, p. 27</i>
SSDI	Social Security Disability Insurance <i>Go To: Treatment and Supports – Income Supports and Benefits, p. 29</i>
SSI	Supplemental Security Income <i>Go To: Treatment and Supports – Income Supports and Benefits, p. 29</i>
SSRI	Selective Serotonin Reuptake Inhibitors <i>Go To: Medications – Medications to Treat Mental Illness – Anti-Depressants, p. 81</i>

TARGET	Trauma Affect Regulation: Group Education and Therapy <i>Go To: Treatment and Supports – Trauma Interventions – Trauma-Specific Services, p. 39</i>
TC	Therapeutic Community <i>Go To: Treatment and Supports – Substance Use Treatment, p. 37</i>
TREM	Trauma Recovery and Empowerment Model <i>Go To: Treatment and Supports – Trauma Interventions – Trauma-Specific Services, p. 40</i>
WHODAS	World Health Organization Disability Assessment Schedule <i>Go To: Diagnoses – Other Components of a Diagnosis – Global Measure of Disability, p. 77</i>
WMR	Wellness Management and Recovery <i>Go To: Treatment and Supports – Evidence-Based Practices – Illness Management and Recovery, p. 22</i>
WRAP	Wellness Recovery Action Plan <i>Go To: Treatment and Supports, p. 41</i>

Treatment and Supports

Case Management

Case Management is a means of coordinating the services available in a community to ensure continuity of mental health care 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.¹ The direct services model employs a multi-disciplinary 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.

Assertive Community Treatment (ACT)

For more information on:

Assertive Community Treatment (ACT)

*Go To: Treatment and Supports –
Evidence-Based Practices, p. 20*

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.

For more information on:

Forensic Assertive Community Treatment (FACT)

*Go To: Treatment and Supports –
Evidence-Based Practices, p. 21*

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.

For more information on:
Intensive Case Management (ICM)

Go To: Treatment and Supports – Case Management, p. 17

Intensive Case Management (ICM)

Intensive Case Management is a form of Case Management that involves assertive outreach. Intensive Case Management employs case managers with individual caseloads who broker mental health treatment and other services. When Intensive Case Management is adapted for forensic populations it is known as Forensic Intensive Case Management (FICM).^{2, 3}

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.

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, including Rational Emotive Behavior Therapy (REBT) and Dialectical Behavioral Therapy (DBT). CBT models that target criminogenic needs include Thinking for a Change (T4C); Reasoning and Rehabilitation (R&R); Moral Reconnection Therapy (MRT); and Relapse Prevention.

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.

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.

Criminogenic Risk

Individuals involved with the criminal justice system differ in their likelihood of committing another crime. The probability that an individual will re-offend 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.

Criminogenic Needs

Criminogenic needs are dynamic risk factors that are directly linked to criminal behavior. Justice-involved persons with mental illness have more criminogenic needs than individuals without mental illness.

Day Treatment

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

Evidence-Based Practices (EBPs)

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. The following practices are identified as EBPs.

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.⁴ Individuals receive services within their own community and home settings. Team members include specialists in psychiatry, social work, nursing, substance abuse treatment, and vocational rehabilitation.

Forensic Assertive Community Treatment (FACT) is an adaptation of ACT, with the additional goal of reducing arrest and incarceration.

Consumer-Operated Services

Consumer-Operated Services are “peer-run service programs that are owned, administratively controlled, and operated by mental health consumers and emphasize self-help as their operational approach.”⁵

For more information on:

Peer Specialists

Go To: Treatment and Supports, p. 31

Peer Support

Go To: Treatment and Supports, p. 32

Family Psychoeducation

Family Psychoeducation is a practice of working in partnership with families to help them develop positive coping skills for handling problems posed by mental illness and skills for supporting the recovery process.⁶

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.⁷

Integrated Dual Disorders Treatment (IDDT)

Treatment of co-occurring disorders is integrated when mental health and substance use treatment takes place concurrently, with interventions coordinated among all providers. IDDT is a specific evidence-based practice that integrates addiction treatment within the context of treatment for serious mental illnesses.

Medication Treatment, Evaluation, and Management (MedTEAM)

Medication Treatment, Evaluation, and Management is an evidence-based practice for the delivery of medications management services to individuals with serious mental illness. MedTEAM's focus is on evidence, clinical expertise, consumer experience, and shared decision-making.⁸

Permanent Supportive Housing

Permanent Supportive Housing is an affordable housing strategy in which individuals live as tenants, with tenancy

obligations and rights, and have access to voluntary support services at various levels of intensity.

For more information on:

Housing Models

Go To: Treatment and Supports, p. 24

Supported Employment

Supported Employment is competitive employment with supports for people with serious mental illness.⁹

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 a purpose.

Housing Choice Voucher Program

The 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 allows people with a low income to rent market-rate housing.

Housing First

Providing immediate access to permanent housing for people who are homeless is the hallmark of the Housing First approach. Support services are available following the placement to provide housing stability and meet individual needs. Housing is contingent only upon meeting the terms of a lease rather than with treatment compliance.

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 pre-existing service plans. Most people accept support

services when they are allowed to access them voluntarily and without coercion. Permanent Supportive Housing is a form of Low-Demand Housing.

Permanent Supportive Housing

Permanent Supportive Housing is affordable rental housing with support services. 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.

For more information on:

Permanent Supportive Housing

Go To: Treatment and Supports- Evidence-Based Practices, p. 23

Shelter Plus Care Program (S+C)

The Shelter Plus Care Program provides housing and long-term support services for people who are homeless 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 determine when people are ready to move beyond an emergency shelter or institutional setting into a more independent living situation. Transitional Housing programs emphasize the importance of people developing independent living skills and achieving some clinical equilibrium prior to placement into permanent housing. Such programs may offer apartment-style, group, or shared family housing.

Income Supports and Benefits

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 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.

Medicaid

Medicaid, administered by the Centers for Medicare & Medicaid Services (CMS), provides medical benefits to some people with low income who have inadequate or no medical insurance. Although the federal government establishes general guidelines, Medicaid program requirements and eligibility are established by each state. The Patient Protection and Affordable Care Act was signed into law by President Obama in 2010 and gives states the option

of expanding Medicaid to include a larger number of low-income individuals.

Medicare

The Centers for Medicare & 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.

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. 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 to meet basic needs.

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.

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.

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.¹⁰

Partial Hospitalization

For more information on:

Partial Hospitalization

*Go To: Treatment and Supports – Day Treatment,
p. 20*

Peer Specialist

A Peer Specialist, is an individual with mental illness who 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.

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.

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 and talking over of the traumatic event, and exposure practice in situations that are safe but have been avoided by the individual.

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.

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”¹¹

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 for 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.

Social Skills Training

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

Substance Use Treatment^a

Narcotic Antagonist Treatment

Treatment of narcotic addiction by using a medication that blocks the effects of opiates to which a person is addicted.

^a Unless otherwise cited, the sources for information in this section on the treatment and recovery practices for people with substance use disorders are the following:

Center for Substance Abuse Treatment. (2004).

What is substance abuse treatment? A booklet for families.

(DHHS Publication No. (SMA) 04-3995). Rockville, MD: Substance Abuse and Mental Health Services Administration.

National Institute on Drug Abuse. (2006). NIDA InfoFacts: Treatment approaches for drug addiction. Retrieved August 12, 2006, from www.nida.nih.gov/PDF/InfoFacts/Treatment06.pdf

National Institute on Drug Abuse. (1999). *Principles of drug abuse treatment: Principles of effective treatment*. Bethesda, MD: Author.

Detoxification

Detoxification provides short-term treatment for withdrawal symptoms once an individual ceases substance use

Motivational Enhancement Therapy

The focus of Motivational Enhancement Therapy is to address motivation for and compliance with treatment for substance use.

Opiate Agonist Maintenance

Opiate Agonist Maintenance is a program for persons addicted to opiates and conducted through outpatient programs that provide a long-acting medication, such as methadone or buprenorphine, to prevent opiate withdrawal. Some programs include a counseling component with referrals to other supports and treatment.

Outpatient Behavioral Treatment

Outpatient Behavioral Treatment may range from drug education to Day Treatment. Counseling programs may be designed for individuals or groups, and include components of Cognitive Behavioral Therapy

or Motivational Enhancement Therapy, among others.

Relapse Prevention

Relapse Prevention is a Cognitive Behavioral Therapy (CBT) that focuses on the adaptation of behaviors to maintain abstinence. Relapse Prevention strategies include self-monitoring to recognize drug cravings and coping skills in high-risk situations.

Supportive Expressive Psychotherapy

Supportive Expressive Psychotherapy, a short-term form of psychotherapy that focuses on identifying specific emotions and behaviors related to an individual's drug use, may aid an individual's recovery from co-occurring disorders.

Therapeutic Community (TC)

The Therapeutic Community approach is a highly structured, residential substance use treatment model with an emphasis on personal accountability and responsibility to the community. Modified Therapeutic

Communities (MTC) have been developed for people with co-occurring disorders, adolescents, and veterans.

Trauma Interventions

Trauma-Informed Services

Trauma-Informed Services 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 that 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.¹²

Trauma-Specific Services

Trauma-Specific Services are “interventions designed to address the specific behavioral, intrapsychic, and interpersonal consequences of exposure to sexual, physical, and

prolonged emotional abuse.”¹³ The following are prominent Trauma-Specific Services.

Seeking Safety

A present-focused intervention to aid in the recovery of people with trauma histories and a substance use disorder, Seeking Safety can be individual- or group-focused.¹⁴

Trauma Affect Regulation: Group 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: **f**ocus, **r**ecognize triggers, **e**motion self-check, **e**valuate thoughts, **d**efine goals, **o**ptions, and **m**ake a contribution. TARGET has been adapted for use with justice-involved people with trauma histories.¹⁵

Trauma Recovery and Empowerment Model (TREM)

The Trauma Recovery and Empowerment Model (TREM) 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.¹⁶ TREM has been adapted for several populations, including the MTREM for men.

Vocational Rehabilitation

Vocational Rehabilitation assists individuals with disabilities, including mental illness, in finding employment. Some services provide pre-employment training and skill building prior to an employment placement. The evidence-based practice of Supported Employment provides ongoing, time-unlimited support to an individual who is searching for or maintaining competitive employment.

For more information on:

Supported Employment

*Go To: Treatment and Supports –
Evidence-Based Practices, p. 24*

Wellness Recovery Action Plan (WRAP)

Wellness Recovery Action Plan (WRAP) 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.¹⁷

Diagnoses^b

Psychiatric evaluations are performed with the aim of understanding how a person's biology, environment, and personality interact. Establishing a diagnosis has clinical utility; it helps determine treatment plans and prognosis. Having a diagnosis is not the same as needing treatment; an individual may not meet all diagnostic criteria, but still need treatment. The *Diagnostic and Statistical Manual of Mental Disorders*, with its fifth edition published in 2013 (DSM-5), provides guidelines for making diagnoses to inform treatment and management decisions. It provides a common language for communicating types of mental disorders and their criteria. DSM-5 organization employs a lifespan approach by grouping diagnoses that occur early in life, those that manifest in adolescence and young adulthood, and those that occur in adulthood and later in life. Unlike its previous editions, DSM-5 uses a nonaxial assessment system that documents all diagnoses (formerly Axis I,

^b Unless otherwise cited, the source for information in this section is from: American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*, (5th ed.). Arlington, VA: American Psychiatric Publishing.

II, and III) and then prompts separate notations for 1) key psychosocial factors that influence the course and prognosis (formerly Axis IV) and 2) the degree of disability associated with the disorder (formerly Axis V). These critical dimensions will be discussed in more detail below.

Specific Mental Disorders

This section is not a comprehensive review of mental illnesses. Provided here is a brief overview of disorders that are more likely to be encountered in criminal justice settings.

Adjustment Disorders

An individual with an adjustment disorder experiences emotional or behavioral symptoms related to a life stressor that has occurred within the past three months; the symptoms are either greater than the expected response or cause significant impairment in social or occupational functioning. Adjustment disorders last no more than six months beyond the end of the stressor.

Anxiety Disorders

An individual with an anxiety disorder has excessive fear with associated behavioral disturbances.

Generalized Anxiety Disorder

For a person with a generalized anxiety disorder, symptoms may include excessive anxiety and worry over events, work, finances, or relationships. The anxiety is difficult to control, and may be accompanied by feelings of restlessness, irritability, fatigue, inability to concentrate, and difficulty sleeping.

For information on recovery from and treatment of generalized anxiety disorder:

Anti-Anxiety Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 79*

Anti-Depressant Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 80*

Cognitive Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Obsessive-Compulsive Disorder (OCD)

A person with obsessive-compulsive disorder can have either obsessions or compulsions. Obsessions are persistent thoughts, impulses, or images that intrude into daily life and cause severe distress. People with OCD try to ignore or suppress these obsessions, which they know come from their own minds, but are often unsuccessful in doing so. Compulsions are repetitive behaviors (such as hand washing or checking to see that doors have been locked) or acts (such as counting or praying) that a person feels driven to perform

to prevent a dreaded act or to avoid unbearable distress. These thoughts and actions are time consuming and can prevent people from attending to other aspects of their lives.

For information on recovery from and treatment of obsessive-compulsive disorder:

Anti-Depressant Medication

*Go to: Medications –
Medications to Treat Mental
Illness, p. 80*

Cognitive-Behavioral Therapy (CBT)

*Go to: Treatment and Supports,
p. 18*

Panic Disorder

A person with panic disorder experiences recurrent unexpected panic attacks followed by a period of one month or more of persistent worry and behavior change in an effort to avoid the panic attacks. A panic attack is a period of intense

fear and discomfort in the absence of real danger. During an attack a person may tremble, sweat, feel short of breath, experience choking sensations or chest pain, experience nausea or dizziness, or feel that they are “going crazy” or dying.

For information on recovery from and treatment of panic disorder:

Anti-Anxiety Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 79*

Anti-Depressant Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 80*

Cognitive Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Bipolar and Related Disorders^{18, 19}

Individuals with bipolar and related disorders have fluctuations in their moods that are

associated with disturbances in social and occupational functioning.

Bipolar I Disorder

An individual with bipolar I disorder experiences episodes of major depression and mania. 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 his/her appetite, and have suicidal thoughts or attempt suicide. During a manic episode, symptoms may include elation or irritability, increased activity, more thoughts or thinking faster than normal, rapid speech, poor judgment, and decreased sleep. A person may experience depressive and manic episodes at the same time, known as a mixed state.

Bipolar II Disorder

An individual with bipolar II disorder has intermittent fluctuations in mood consisting of one or more major depressive disorders and at least one hypomanic episode. If the individual with this pattern has a full blown manic episode, he or she meets criteria for a Bipolar I Disorder. The individual typically presents with depressive symptoms and seldom reports impairment from hypomanic periods.

For information on recovery from and treatment of bipolar disorder:

Anti-Depressant Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 80*

Cognitive Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Mood Stabilizer Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 86*

Depressive Disorders

Individuals with depressive disorders experience sad, empty, or irritable moods that impact the way they think and feel, resulting in disability in social and occupational functioning.

Major Depressive Disorder

An individual with a major depressive disorder may experience chronic and highly disabling symptoms that interfere with the ability to conduct social activities, work, eat, and sleep. Symptoms may include a persistent sadness or feelings of emptiness, guilt, or lack of worth; a loss of interest in pleasurable activities; difficulty concentrating; insomnia or over-sleeping; and physical symptoms that are non-responsive to treatment. An

individual with major depressive disorder may experience suicidal thoughts or attempt suicide.

For information on recovery from and treatment of major depressive disorder:

Anti-Depressant Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 80*

Cognitive Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Malingering

While not a diagnosable mental disorder, malingering is a factor that must be considered when dealing with psychiatric illness in a courtroom setting. The *DSM-5* defines malingering as “the intentional reporting of symptoms for personal gain.” This distinguishes malingering from factitious disorders, which, while deceptive, are not connected to obvious

external rewards. There is no treatment for malingering, but it is important to be sure that a person has a psychiatric diagnosis – and active symptoms – before entering into treatment with medications or therapy.

Neurocognitive Disorders

Individuals with neurocognitive disorders have deficits in thinking and memory that have developed later in life. These diagnoses are unique among DSM-5 categories in that they have clear underlying brain pathology. They are further delineated as either major or mild in nature.

Dementia

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/neurologic conditions
(e.g., HIV infection), and substance
abuse.

There is no treatment for dementia,
but some medications are thought
to help slow the speed at which
dementia progresses. Additionally,
some of the behavioral disturbances
associated with dementia may be
treated with various psychiatric
medications and therapy.

For information on management of
dementia:

Anti-Depressant Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 80*

Anti-Psychotic Medications:

*Go To Medications –
Medications to Treat Mental
Illness, p. 83*

Cognitive Enhancer Medications:

*Go To Medications –
Medications to Treat Mental
Illness, p. 85*

Cognitive Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Neurodevelopmental Disorders

These conditions usually appear early in life and is characterized by deficits that interfere with school performance and interpersonal functioning. However, these disorders may not be identified until later in life; as such, there is a great deal of interest in the adult manifestations of these conditions.

**Attention-Deficit/Hyperactivity
Disorder (ADHD)**

People with attention-deficit/hyperactivity disorder have difficulty paying attention to details, following through on projects, and organizing tasks and activities. They often lose things and are easily distracted. In

some cases, they are fidgety and restless and have trouble controlling impulses to speak or move around.

For information on recovery from and treatment of ADHD:

Medications Used to Treat ADHD

*Go To: Medications –
Medications Used to Treat
Mental Illness, p. 88*

Cognitive-Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Social Skills Training

*Go To: Treatment and
Supports, p. 34*

Autism Spectrum Disorder (ASD)

Individuals with autism spectrum disorder have persistent deficits in social interaction and communication. Language development delays and poor comprehension of speech may be present. People with autistic disorder

have trouble reading social cues, such understanding body language and nonverbal gestures. They cannot interact with peers and have a lack of interest in the usual forms of social interaction. Autistic disorder, Asperger syndrome, and pervasive developmental disorder are now grouped within the autism spectrum disorder category.

There are no specific treatments for autism spectrum disorders, but some medications and therapies can help reduce behaviors that are upsetting to the person with the disorder and/or alleviate the distress that can accompany some of the symptoms.

For information on management of the symptoms of Autism Spectrum Disorder:

Antidepressant Medications

*Go To: Medications –
Medications Used to Treat
Mental Illness, p. 80*

Antipsychotic Medications

*Go To: Medications –
Medications Used to Treat
Mental Illness, p. 83*

Medications Used to Treat ADHD

*Go To: Medications –
Medications Used to Treat
Mental Illness, p. 88*

Cognitive-Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Social Skills Training

*Go To: Treatment and
Supports, p. 34*

Trauma- and Stressor-Related Disorders

An individual with a trauma- and stressor-related disorder experiences profound psychological distress following exposure to a traumatic or stressful event. Dysphoria, a

lack of interest in normal activities, and anger are the prominent symptoms, distinguishing these disorders from those in which anxiety is the predominant reaction.

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder may occur following the experience or witnessing of threatening events, such as physical or sexual assaults, military combat, natural disasters, acts of terrorism, or serious accidents. Following the traumatic event(s), some people will develop stress reactions that do not remit and may worsen. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. People with PTSD have symptoms that disrupt their family, social, and/or work life.

For information on recovery from and treatment of post-traumatic stress disorder:

Anti-Anxiety Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 79*

Antidepressant Medication

*Go To: Medications –
Medications to Treat Mental
Illness, p. 80*

Cognitive Behavioral Therapy (CBT)

*Go To: Treatment and
Supports, p. 18*

Trauma-Specific Treatment

*Go To: Treatment and Supports
– Trauma Interventions, p. 38*

Schizophrenia Spectrum and Other Psychotic Disorders²⁰

Individuals with diagnoses in this category have abnormalities in one or more of the following

domains: delusions; hallucinations; disorganized thinking and speech; abnormal motor behavior, including catatonia; and negative symptoms, including diminished emotional expression.

Brief Psychotic Disorder

People with brief psychotic disorder may experience delusions, hallucinations, difficulty speaking, or a lack of physical coordination for more than one day but less than one month. An individual may feel disoriented, have memory problems, and experience changes in sleeping patterns, eating habits, and energy levels. Symptoms last for more than one day yet people with brief psychotic disorder experience a full recovery within one month.

Schizoaffective Disorder

An individual with schizoaffective disorder experiences symptoms associated with schizophrenia (e.g., delusions, hallucinations, and disorganized thinking) in addition to symptoms during a psychotic period that meet the criteria for either a major depressive disorder or bipolar disorder.

For information on recovery from and treatment of schizoaffective disorder:

Anti-Depressant Medication

Go To: Medications – Medications to Treat Mental Illness, p. 80

Anti-Psychotic Medication

Go To: Medications – Medications to Treat Mental Illness, p. 83

Cognitive Behavioral Therapy (CBT)

Go To: Treatment and Supports, p. 18

Mood Disorders

Go To: Diagnoses – Specific Mental Diagnoses – Bipolar and Related Disorders, p. 48

Mood Stabilizer Medication

Go To: Medications – Medications to Treat Mental Illness, p. 86

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, an inability to make decisions, or a lack of emotional expression. The hallucinations are mostly auditory with individuals hearing voices that say negative things. Delusions are often paranoid in nature. People with schizophrenia can have difficulty with reality testing and may display inappropriate affect or mood.

For information on recovery from and treatment of schizophrenia:

Anti-Psychotic Medication

Go To: Medications – Medications to Treatment Mental Illness, p. 83

Cognitive Behavioral Therapy (CBT)

Go To: Treatment and Supports, p. 18

Illness Management and Recovery (IMR)

Go To: Treatment and Supports – Evidence-Based Practices, p. 22

Self-Help Groups

Go To: Treatment and Supports, p. 33

Substance-Related and Addictive Disorders

A substance-related disorder encompasses the use of legal, non-prescription drugs (e.g., alcohol, nicotine) or illegal drugs (e.g., opioids, hallucinogens), and prescription medications (for their side effects).

Common substances of abuse include alcohol, benzodiazepines, cocaine/crack, marijuana, methamphetamine, and opioids (including heroin and “pain pills” such as Percocet or Oxycontin).

While each affects the user differently, all of these substances produce intense activation of brain reward centers, and abuse occurs when the individual continues to use the substance despite significant problems. The treatment philosophy of substance-related disorders is the same regardless of the drug(s) of choice, but there may be some treatment variations based on which drug(s) a person uses or abuses. This category is further subdivided into substance-induced disorders and substance-use disorders. Gambling disorders are also included in this category in that the behaviors also activate reward centers.

Substance-Induced Disorders

Substance Intoxication

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.

Substance Withdrawal

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

Other Substance-Induced Mental Disorders

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 or psychotic symptoms. The treatment is cessation of the substance being used.

Substance Use Disorders

Individuals with substance use disorders experience a range of symptoms and socio-legal difficulties that persist with continued use of the substance. With repeated exposure to the substance, an individual's brain circuitry is altered and these changes may persist after the withdrawal of the offending substance. DSM-5 uses 11 criteria to determine the presence and severity of the substance use disorder. The number of the criteria met will determine whether the substance use disorder is "mild," "moderate," or "severe." These criteria fall into the following four groups:

Impaired Control

Criteria for impaired control include taking a substance more often, in higher quantities, or over a longer period of time than intended.

Individuals may also spend a lot of energy to obtain the substance, experience cravings, and adjust their daily activities to accommodate their drug use.

Pharmacologic Criteria

These criteria were formerly associated with the term substance dependence. They include using more of the substance to achieve the desired effect (tolerance) and experiencing withdrawal symptoms upon the cessation of the drug of abuse. These symptoms can be relieved by continued use of the substance.

Risky Use

In this category, the individual continues to use substances when doing so has caused significant negative consequences in the past (e.g., drinking while driving).

Social Impairment

Using substances can interfere with expected role performance at work, school, or home. The individual may withdraw from normal activities or avoid important family or social events to continue their substance use.

For more information on:
Medications to Treat Substance Use Disorders

*Go To: Medications –
Medications to Treat Substance
Use Disorders, p. 90*

Substance Use Treatment

*Go To: Treatment and
Supports, p. 35*

Personality Disorders

Personality disorders are defined by DSM-5 as “an enduring pattern of inner experience and behavior that deviates 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 leads to distress or impairment.” In prior DSMs, personality disorders were listed on a separate axis (Axis II disorders), which inadvertently suggested there were fundamental differences in their etiology or treatment. As that is not the case, personality disorders (as well as medical conditions) are simply listed among all other disorders. They are grouped into three clusters (A, B, and C) based on some overlap in symptoms. This section is not a comprehensive review of the 10 specific personality disorders. Discussed below are personality disorders from Cluster B, which are more likely to be encountered in criminal justice settings.

Anti-Social Personality Disorder (ASPD)

An individual with anti-social personality disorder displays a pervasive pattern of disregard for the rights of others and a failure

to abide by lawful behavior without remorse for his/her behavior. Symptoms may include deceitfulness, impulsivity, and aggressiveness. To be diagnosed with anti-social personality disorder, an individual must have met criteria for a conduct disorder by the age of 15. Some symptoms relating to ASPD can be reduced through use of medication.

For information on recovery from and treatment of anti-social personality disorder:

Antidepressant Medication

Go To: Medications – Medications to Treat Mental Illness, p. 80

Mood Stabilizer Medication

Go To: Medications – Medications Used to Treat Mental Illness, p. 86

Anti-Psychotic Medication

Go To: Medications – Medications to Treat Mental Illness, p. 83

Cognitive Behavioral Therapy (CBT)

Go To: Treatment and Supports, p. 18

Borderline Personality Disorder

A person with borderline personality disorder displays a pattern of unstable interpersonal relationships and emotional dysregulation, or reactions to a situation out of the socially acceptable range of emotions. Symptoms may include 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 often engage in self-mutilating behavior, such as cutting and burning. They also make suicidal gestures that can be lethal. Some symptoms relating to the disorder can be reduced through the use of medication.

For information on recovery from and treatment of borderline personality disorder:

Anti-Depressant Medication

Go To: Medications – Medications to Treat Mental Illness, p. 80

Mood Stabilizer Medication

*Go To: Medications – Medications used to
Treat Mental Illness, p. 86*

Antipsychotic Medication

*Go To: Medications – Medications to Treat
Mental Illness, p. 83*

Cognitive Behavioral Therapy (CBT)

Go To: Treatment and Supports, p. 18

Dialectical Behavioral Therapy (DBT)

*Go To: Treatment and Supports –
Cognitive Behavioral Therapy, p. 18*

Narcissistic Personality Disorder

A person with narcissistic personality disorder displays a pervasive pattern of grandiose thoughts, behavior, and a need for admiration. He or she has expectations of others, such as feeling entitled to special treatment not based on achievements. The individual may be preoccupied with ideas of unlimited success, power, and love and

believe that only people of high status can understand him/her. He or she often lacks empathy towards others and acts in an exploitative manner. Some symptoms of the disorder can be reduced through medication.

For information on recovery from and treatment of narcissistic personality disorder:

Antidepressant Medication

Go To: Medications – Medications to Treat Mental Illness, p. 80

Mood Stabilizer Medication

Go To Medications – Medications Used to Treat Mental Illness, p. 86

Antipsychotic Medication

Go To: Medications – Medications to Treat Mental Illness, p. 83

Cognitive Behavioral Therapy (CBT)

Go To: Treatment and Supports, p. 18

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. 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. Also, people with mental illness often suffer from more medical problems and complications than people without psychiatric diagnoses. Additionally, medical problems can prevent people from taking certain psychiatric medications that might otherwise be helpful in reducing symptoms. Finally, the medications used to treat mental illness can themselves predispose a person to medical problems or even cause them.

Provisional and Other Disorder Diagnoses

Clinicians are directed to use the term “provisional” when they want to indicate some degree of

uncertainty in the diagnosis – the clinician may not have sufficient information to make a diagnosis or the diagnosis may depend on the duration of the illness, which has not yet been met.

DSM-5 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 the reason that the person doesn't meet criteria and modify their diagnosis with an “other specified” or “unspecified” disorder notation.

Other Components of a Diagnosis

Psychosocial and Environmental Problems

Psychosocial and environmental problems may impact a person's mental illness or may be consequences of psychiatric symptoms. These may include problems related to an individual's:

- Primary support system
- Social environment
- Education

- Occupation
- Housing
- Finances
- Access to health care services
- Interaction with the legal system²¹

These psychosocial and environmental factors are now covered through an expanded set of codes that allow clinicians to indicate other conditions that may be a focus of clinical attention or affect diagnosis, course, prognosis, or treatment of a mental disorder.

Global Measure of Disability

The DSM-5 eliminated Axis V, which represented the clinician's judgment of the individual's overall level of functioning. While acknowledging the importance of this assessment, at the time of publication there was not a generally accepted method of measuring this dimension. DSM-5 lists the World Health Organization Disability Assessment Schedule (WHODAS 2.0) as a possible measure of disability; however, it is not recommended for use until it has been studied further.

Cultural Formulation

Our culture shapes the expression and experience of the symptoms and behaviors that are criteria for diagnosis. The DSM-5 defines culture as “systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations.” The boundaries between “normal” and “abnormal” vary across cultures. To better understand the impact of culture on diagnoses, the DSM-5 suggests how to assess and formulate the impact of culture on our understanding and describing the illness experience.

Medications^c

Medications to Treat Mental Illness

Anti-Anxiety

Anti-anxiety medication may reduce or relieve symptoms of anxiety disorder. Antidepressant medication is often prescribed to treat these symptoms as well.

Benzodiazepines

Benzodiazepines are fast-acting medications that help reduce symptoms of an individual's anxiety. Side effects may include drowsiness, loss of coordination, fatigue, and confusion. Caution is taken when prescribing benzodiazepines to justice-involved people with co-occurring disorders because they are habit-forming and have a "street value." Common medications include alprazolam (Xanax),

^c Unless otherwise cited, the source for information in this section on medications is from: National Institute of Mental Health. (2008). *Medications*. Bethesda, MD: Author.

clonazepam (Klonopin), lorazepam (Ativan), and diazepam (Valium).

Non-Benzodiazepines

These medications, while not originally intended to treat anxiety, are effective at reducing many symptoms. They are often better long-term medication options than benzodiazepines, as they are not habit forming and have lower street value. They are also used to treat people with substance use disorders and in settings that prohibit benzodiazepines, such as jails and prisons. Common medications include buspirone (Buspar), selective serotonin reuptake inhibitors, and propranolol (Inderal).

Antidepressants

Many people with major depression are prescribed antidepressant medication as part of their recovery process. Antidepressant medications are not stimulants but reduce the symptoms of the depression. Side effects

may include dry mouth, constipation, reduced sexual functioning, blurred vision, dizziness, drowsiness, anxiety or agitation, sleeping problems, or an elevated pulse.

Selective Serotonin Reuptake Inhibitors (SSRI)

Selective serotonin reuptake inhibitors are antidepressants that are as effective as tricyclic antidepressants in treating the symptoms of depression but have fewer side effects. Common SSRI medications include fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), and escitalopram (Lexapro).

Serotonin and Norepinephrine Reuptake Inhibitors (SNRI)

Serotonin and norepinephrine reuptake inhibitors are a type of antidepressant with similar effectiveness and low side effect profile to SSRIs. Common SNRIs

include venlafaxine (Effexor) and duloxetine (Cymbalta).

Tricyclic Antidepressants (TCA)

Tricyclic anti-depressants were some of the first medications developed for the treatment of major depression.

An individual with major depression who is taking tricyclic antidepressant medication may experience more unpleasant side effects than if taking more recently developed antidepressant medications.

Other Antidepressants

A number of recently developed antidepressants do not fall into the category of serotonin and norepinephrine reuptake inhibitors (SSRI, SNRI), or tricyclic antidepressants (TCA). Many of these medications, which include bupropion (Wellbutrin), mirtazapine (Remeron), and desvenlafaxine (Pristiq), have different side effects than other classes of antidepressants.

Antipsychotics²²

Antipsychotic medication, first developed in the 1950s, may help reduce an individual's psychotic symptoms.

First Generation (Typical)

Antipsychotics

First developed in the 1950s, typical antipsychotic medications are effective in reducing a person's psychotic symptoms but also have many side effects. These side effects include muscle stiffness, tremors, and a permanent movement disorder called tardive dyskinesia. Common medications in this class include chlorpromazine (Thorazine), fluphenazine (Prolixin), perphenazine (Trilafon), and haloperidol (Haldol).

Second Generation (Atypical) Anti-Psychotics

Atypical anti-psychotic medications were introduced in the 1990s. An individual taking atypical

antipsychotic medication may experience fewer but different side effects than if taking typical antipsychotic medication. Side effects include weight gain, reduced sexual function, problems with menstruation, skin sensitivity, and drowsiness. Clozapine (Clozaril) was the first atypical anti-psychotic medication. Because of the need for constant blood tests related to potential side effects of the medication, many clinicians do not prescribe it unless all other options have proven unsuccessful. Common atypical antipsychotic medications include olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), aripiprazole (Abilify), ziprasidone (Geodon), lurasidone (Latuda), and paliperidone (Invega).

Long-Acting (Decanoate) Antipsychotics

Three antipsychotic medications – Risperidone, Prolixin, and Haldol – are available in long-acting injectable form. These medications can be administered every two to four weeks and are often used when adherence to a daily medication regimen has not been possible.

Cognition Enhancers

These medications work to delay the progression of dementia but cannot reverse any cognitive impairment that has already occurred. For example, they will not help people retrieve lost memories but may help reduce further memory loss. There are two main groups: acetylcholinesterase inhibitors and glutamate antagonists. The former includes medications such as donepezil (Aricept) and rivastigmine (Exelon), which increase the amount of acetylcholine in the brain. This chemical helps nerve cells communicate with one another. Common

side effects include nausea and vomiting, headaches, and bad dreams. Stopping these medications abruptly can cause memory loss to worsen.

Glutamate Antagonists such as memantine (Namenda), block the effects of glutamate in the brain. These medications have been shown to bring about an improvement in the activities of day-to-day living and to slow the progression of the decline in social functioning. Common side effects include dizziness, headaches, and constipation.

Mood Stabilizers²³

Mood stabilizer medication may be used in the treatment of mental illnesses such as bipolar disorder and borderline personality disorder. Except for lithium, most mood stabilizers are either anticonvulsant medications or second generation anti-psychotic medications. These medications can also be used to treat depression when more traditional antidepressant medication has not been effective.

Anticonvulsants

An individual with bipolar disorder may take an anticonvulsant medication as part of treatment to reduce the manic symptoms of the illness. Side effects of anticonvulsants may include headaches, double vision, dizziness, anxiety, confusion, and liver dysfunction. Common medications in this class include valproic acid (Depakote), carbamazepine (Tegretol), topiramate (Topamax), oxcarbazepine (Trileptal), and lamotrigine (Lamictal).

Lithium

Lithium may be used by an individual with bipolar disorder to even out the episodes of manic and depressive symptoms. Possible side effects of lithium include hand tremors, weight gain, and changes in kidney function. Trade names for lithium include Eskalith, Lithobid, Lithonate, and Lithotabs.

Medications to Treat Attention-Deficit/ Hyperactivity Disorder (ADHD)

Medications used to treat Attention-Deficit/Hyperactivity Disorder help reduce the impulsivity, distractibility, and poor time management associated with this diagnosis. They are generally divided into stimulants and non-stimulants.

Stimulants

Common stimulants include amphetamine/dextroamphetamine (Adderal), dextroamphetamine (Dexedrine), lisdexamfetamine (Vyvanse), and methylphenidate (Concerta, Metadate, Methylin, and Ritalin). These are all available in short-acting, intermediate-acting, and long-acting forms. A methylphenidate patch (Daytrana) is also available. Side effects of these medications can include irritability, anxiety, decrease in sleep and appetite, and verbal/physical tics. They also have a high potential for abuse and “recreational” use.

Non-stimulants

Other medications have been shown to be effective in treating some of the symptoms of ADHD. These include atomoxetine (Strattera), bupropion (Wellbutrin), clonidine (Kapvay), and guanfacine (Intuniv). Many of these were originally designed for other purposes and each has a unique side effect profile.

Medications to Treat Side Effects

Many of the medications prescribed to reduce the symptoms of an individual's mental illness cause significant side effects such as tremors, dizziness, or vision problems. Some side effects are temporary, but others may cause long-term physical impairment if left untreated. Medications to reduce side effects are sometimes prescribed to improve adherence to the primary medication. For example, an individual with schizophrenia may take medication for tremors caused by anti-psychotic medications. Common side effect medications include benztropine (Cogentin), trihexyphenidyl (Artane), and diphenhydramine (Benadryl).

Medications to Treat Insomnia

Many people with mental illness have trouble sleeping. As sleep is an important function needed to maintain mental and physical health, medications are often used to treat insomnia. Many of these medications are not meant to be taken long-term and can become habit forming. In other cases, sleepiness is a side effect of the medication, in which case a lower dose is prescribed. Common medications include zolpidem (Ambien), eszopiclone (Lunesta), trazadone (Desyrel, Oleptro), diphenhydramine (Benadryl), olanzapine (Zyprexa), quetiapine (Seroquel), mirtazapine (Remeron), and the various benzodiazepines.

Medications to Treat Substance Use^{24, 25}

Substance use disorders have three phases – acute intoxication or overdose, withdrawal/detoxification, and long-term recovery. Not all substance use disorders require medication for each phase, but in some cases, medication is essential to prevent medical complications or death. In other cases, medications can help to reduce both the physical and

emotional discomfort associated with stopping drug use and cravings for the drug(s), thus diminishing the likelihood of relapse.

Acute Intoxication or Overdose

This occurs when a person is under the influence of a substance and is experiencing its effects. For the most part, medication is given only when a person has overdosed on a drug(s) as part of acute medical intervention required to prevent complications or death. For example, naloxone (Narcan) is an opioid receptor antagonist used during emergency situations for opioid overdose.

Withdrawal/Detoxification

When people stop using drugs or alcohol, they can experience withdrawal symptoms that can be quite uncomfortable and, in some cases, can cause medical complications and death. Not all substances require medications to help a person get through the acute withdrawal and detoxification phases of recovery, but they are usually given when a person is coming off of alcohol, benzodiazapines, or opioids.

Alcohol Withdrawal

Benzodiazepines (such as Ativan, Librium, or Klonopin) are used in gradually smaller doses to help prevent alcohol withdrawal, which can cause seizures, permanent dementia, or delirium tremens (DTs) (which can be fatal). In addition, people in alcohol withdrawal should receive high doses of thiamine and folate, vitamins that are depleted during alcohol withdrawal and needed to safely survive the withdrawal phase.

Benzodiazepine Withdrawal

As with alcohol withdrawal, benzodiazepine withdrawal can be fatal and requires a gradual tapering of any medication in this class to avoid complication. No other medications or vitamins are required.

Opioid Withdrawal

While withdrawal from opioids is not typically fatal, it can be

so uncomfortable that a person will opt for relapse to avoid the symptoms. Thus, in some cases, medication is given to help reduce the physical and psychological discomfort. Medications used include clonidine (Catapres), a blood pressure medication that has been found to reduce some of the physiologic symptoms of withdrawal, as well as opioid agonists, such as buprenorphine (Suboxone or Subutex) and methadone.

Long-Term Recovery

After a person has come through the physical detoxification from substances, he or she enters the lifelong recovery phase of treatment. Many medications are used to help keep people sober and in recovery.

Acamprosate

Acamprosate (Campral) is used to reduce cravings for alcohol.

Antagonists

Antagonist medications block the effects of a drug. These medications are used in the treatment of both opiate and alcohol abuse. A common antagonist medication is naltrexone (Depade or ReVia).

Aversion Therapy

Aversion therapy medications produce acute withdrawal symptoms should an individual consume the abused drug. A common medication in this category is disulfiram (Antabuse), which produces nausea in an individual who has ingested alcohol.

Opiate Agonist Treatment

Opiate agonists stabilize cravings for the abused drug by working on the “opioid receptor” in the brain that provides the positive sensations associated with opioid use. Medications may be full or

partial agonists. A partial agonist also provides a ceiling effect similar to antagonist medications. Buprenorphine (Suboxone or Subutex) is a partial agonist that is as effective as full agonists in treating addiction to heroin.^{26, 27} Methadone is a full agonist.

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	Benzotropine	Side Effect
Dalmane	Flurazepam	Sleep
Depakene	Valproic Acid	Mood Stabilizer
Depakote	Valproic Acid	Mood Stabilizer

Common Medications *continued*

Trade Name	Generic Name	Type of Medication
Desyrel	Trazodone	Antidepressant Sleep
Effexor	Venlafaxine	Antidepressant
Elavil	Amitriptyline	Antidepressant
Eskalith	Lithium	Mood Stabilizer
Fanapt	Iloperidone	Antipsychotic
Gabitril	Tiagabine	Mood Stabilizer
Geodon	Ziprasidone	Antipsychotic
Halcion	Triazolam	Sleep
Haldol	Haloperidol	Antipsychotic
Invega	Paliperidone	Antipsychotic
Klonopin	Clonazepam	Anti-Anxiety
Lamictal	Lamotrigine	Mood Stabilizer
Latuda	Lurasidone	Antipsychotic
Lexapro	Escitalopram	Antidepressant
Librium	Chlordiazepoxide	Anti-Anxiety
Lithobid	Lithium	Mood Stabilizer

Continued over

Common Medications *continued*

Trade Name	Generic Name	Type of Medication
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

Common Medications *continued*

Trade Name	Generic Name	Type of Medication
Restoril	Temazepam	Sleep
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

Frequently Asked Questions

What is a serious mental illness?

The definition of serious mental illness (SMI), as established by the Substance Abuse and Mental Health Services Administration (SAMHSA), is “having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV), and resulted in functional impairment that substantially interfered with or limited one or more major life activities.”²⁸

The percent of people with serious mental illness is only a portion of the total number of people with mental illness. For the general population of the United States, it is estimated that approximately 26 percent experienced a mental illness in the past 12 months. During that same time period, 5.7 percent experienced a serious mental illness.²⁹

What are co-occurring disorders?

The term co-occurring disorders (COD) refers to co-occurring substance-related and mental disorders.

Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders. From a treatment perspective, both disorders are primary. Although the disorders may impact each other, neither are merely symptoms of the other. Approximately 15 percent of men and 31 percent of women in jail have serious mental illnesses.³⁰ It is estimated that each year more than 1.1 million people diagnosed with mental illnesses are arrested in the United States.^{30, 31} Roughly three-quarters of these individuals are expected to also experience co-occurring substance use disorders.³²

It is important that treatment of co-occurring disorders be tailored to the individual, with a focus on treatment engagement, continuity of care, and access to a comprehensive package of services that may include housing, vocational support, and childcare. Integrated treatment of co-occurring disorders, where mental health and substance use treatment takes place in the same service setting with cross-trained staff, is an approach that has been identified as an evidence-based practice (EBP) by the Center for Mental Health Services (CMHS).

Access to treatment is an important issue when considering co-occurring disorders. Many people do not receive treatment and those who do may receive it in an emergency setting, from a primary care physician, or in the criminal justice system rather than from a behavioral health provider.³³

What is the difference between dual diagnosis and co-occurring disorders?

Like the term co-occurring disorders, the terms dual diagnosis and dual disorders consider both the mental illness and substance use disorder as primary. Similar terms identify a primary disorder. MICD (mentally ill chemically dependent), CAMI (chemically abusing mentally ill), and MICA (mentally ill chemical abuser) are examples of terms that identify as primary either the mental illness or the substance use disorder.

How does trauma impact mental illness?

Violence and trauma, whether physical or psychological, can cause psychological damage that impacts an individual's physical health, mental health, and use of substances. More often than not, adults with trauma histories have a lifetime

experience of repeated and severe abuse. Trauma can be looked at in this way:

When an individual is bombarded with repeated traumas that constitute threats to his or her personal integrity and world view, that individual comes to question even the most fundamental assumptions about the world. In the wake of trauma, that person must construct a new theory of how the world works and how people behave.³⁴

Without adaptation, mental health and substance abuse treatment can retraumatize people with trauma histories, as can the criminal justice system. Without a trauma-informed system of care, an individual whose trauma-related symptoms may not be apparent or are misunderstood could go without the treatment necessary for recovery.

Within the criminal justice, mental health, and substance abuse systems, it is important to incorporate trauma-specific services, trauma-informed services, and the principles of trauma-informed service systems.

How is homelessness defined?

According to the U.S. Department of Housing and Urban Development (HUD), the federal definition of homelessness includes:

- an individual who lacks a fixed, regular, and adequate nighttime residence; and
- an individual who has a primary nighttime residence that is—
 - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
 - an institution that provides a temporary residence for individuals intended to be institutionalized; or
 - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.³⁵

The definition explicitly excludes “any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a state law.”³⁶

A separate definition addresses chronic homelessness. According to HUD, a person experiencing chronic homelessness is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.”³⁷

Resources

Judges' Criminal Justice/Mental Health Leadership Initiative

Coordinated by

Policy Research Associates

www.prainc.com

Tel: (518) 439-7415

Council of State Governments Justice Center

<https://csgjusticecenter.org>

Tel: (212) 482-2320

Advocacy

Advocacy Handbook of the Council of State Governments

https://issuu.com/csgjustice/docs/cp_advocacy_handbook

Judge David L. Bazelon Center for Mental Health Law

<http://www.bazelon.org>

National Alliance for the Mentally Ill

<http://www.nami.org>

Assertive Community Treatment

Assertive Community Treatment Association
<http://www.actassociation.org>

CMHS Assertive Community Treatment
Implementation Resource Guide
<https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4344>

Evidence-Based Practices

Evidence-Based Practices
Resource Center
<https://www.samhsa.gov/ebp-resource-center>

Homelessness and Housing

Corporation for Supportive Housing
<http://www.csh.org>

National Alliance to End Homelessness
<http://www.endhomelessness.org>

U.S. Department of Housing and Urban
Development

<http://www.hud.gov>

U.S. Interagency Council on Homelessness

<https://www.usich.gov/>

Judicial

Conference of Chief Justices

<https://ccj.ncsc.org/>

National Center for State Courts

<http://www.ncsc.org>

National Judicial College

<http://www.judges.org>

Medicaid and Medicare

Centers for Medicare and Medicaid Services

<https://www.cms.gov/>

Mental Illness and Mental Health Treatment

Substance Abuse and Mental Health Services
Administration

<https://www.samhsa.gov/>

National Institute of Mental Health

<http://www.nimh.nih.gov>

Substance Abuse

Substance Abuse and Mental Health Services
Administration

<https://www.samhsa.gov/>

National Institute on Drug Abuse

<https://www.drugabuse.gov/>

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