BJA MENTAL HEALTH COURTS PROGRAM

Navigating the Mental Health Maze

A Guide for Court Practitioners

BJA Bureau of Justice Assistance

Criminal Justice | Mental Health
CONSENSUS PROJECT
coordinated by the Council of State Governments

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About the Bureau of Justice Assistance (BJA)

The Bureau of Justice Assistance, a component of the Office of Justice Programs, U.S. Department of Justice, supports innovative programs that strengthen the nation's criminal justice system. Its primary mission is to provide leadership and a range of assistance to local criminal justice strategies to make America's communities safer. BJA accomplishes this mission by providing funding, training, technical assistance, and information to state and community criminal justice programs and by emphasizing the coordination of federal, state, and local efforts. BJA's specific goals are to help communities reduce and prevent crime, violence, and drug abuse and to improve the functioning of the criminal justice system. **www.ojp.usdoj.gov/BJA/**

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The Office of Justice Programs, US. Department of Justice, was created in 1984 to provide federal leadership in developing the nation's capacity to prevent and control crime, administer justice, and assist crime victims. OJP carries out this mission by forming partnerships with other federal, state, and local agencies, as well as national and community-based organizations. OJP is dedicated to comprehensive approaches that empower communities to address crime, break the cycle of substance abuse and crime, combat family violence, address youth crime, hold offenders accountable, protect and support crime victims, enhance law enforcement initiatives, and support advancements in adjudication. OJP also works to reduce crime in Indian Country, enhance technology's use within the criminal and juvenile justice systems, and support state and local efforts through technical assistance and training. **www.ojp.usdoj.gov**

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The Council of State Governments (CSG) is a nonprofit, nonpartisan organization that serves all three branches of state government. Founded in 1933, CSG has a long history of providing state leaders with the resources to develop and implement effective public policy and programs. Owing to its regional structure and its constituency—which includes state legislators, judges, and executive branch officials—CSG is a unique organization. Comparable associations operate only on a national level and target one branch of state government exclusively.

The development of this guide was overseen by staff of the Criminal Justice Program of CSG's Eastern Office, which also coordinates the Criminal Justice/Mental Health Consensus Project.

About the Criminal Justice/Mental Health Consensus Project

Coordinated by the Council of State Governments (CSG), the Criminal Justice/Mental Health Consensus Project is an unprecedented national effort to improve the response to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. The landmark Consensus Project Report, which was authored by CSG and representatives of leading criminal justice and mental health organizations, was released in June 2002. Since then, the Consensus Project has continued to promote practical, flexible approaches to this issue through presentations, technical assistance, and information dissemination. This includes providing technical assistance to the Bureau of Justice Assistance Mental Health Courts Program.

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A Guide for Court Practitioners

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Introduction

INDIVIDUALS WITH MENTAL ILLNESSES ARE familiar faces in courtrooms across the country. The U.S. Department of Justice estimates that the prevalence of mental illness in state prison and jails is three to four times that in the general population, and all of these inmates pass through the nation's court systems.[1] When they do, some act strangely, muttering to themselves or to an invisible companion; others are distant, hardly aware of the proceedings taking place before them. And some appear to be no different than any other defendants, their symptoms undetectable during the rapid court process. Most have been booked on low-level crimes, which usually amount to the public manifestation of their untreated mental illnesses.

Except for when questions of legal competency are raised, many defendants with mental illnesses cycle through court systems receiving only minimal attention to their conditions. Many will serve short sentences in jail, where they often decompensate further, and will be released with little or no linkage to community treatment and other supports. Not surprisingly, many will be back before the court in short order.

Recognizing this growing problem, some court systems are attempting to stop, or at least slow down, the "revolving door" effect by identifying defendants with mental illnesses and linking them to essential community treatment and supports. Court systems have pursued this goal in various ways, including through diversion programs, dedicated mental health probation caseloads, adaptations to traditional court processes, and mental health courts—specialized dockets dedicated to certain offenders with mental illnesses.

In trying to respond to defendants with mental illnesses, whether through the vehicle of a specialized mental health court or through another method, court officials quickly become aware that these defendants have complicated needs that can only be met through collaboration with mental health treatment providers and administrators. They also recognized that effective collaboration requires a basic understanding about how mental illnesses are diagnosed, how they are treated, and how court processes and mental health services can be coordinated. This guide is intended to provide that information. Readers may include judges, prosecutors, defense attorneys, pretrial services staff, probation officers, courtroom clerks, court reporters, and others in the court who have contact with defendants with mental illnesses.*

*__Mental health professionals__ should consider consulting a similar publication from the TAPA Center for Jail Diversion: *Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers Need to Know*, which is available at: www.gainsctr.com/pdfs/tapa/Massaro.pdf.

This guide does *not* intend to suggest that court practitioners become diagnosticians or assume responsibility for developing treatment plans or overseeing mental health services in their communities. They must rely on their partners in the mental health system to fulfill these roles. Nevertheless, for court officials and mental health partners to work together effectively, they must share some basic understanding of the needs of their common clientele. Toward this end, this guide provides *non–mental health professionals* with a basic overview of mental illnesses, their diagnosis, and their treatment. The core ideas included in each part of the guide are summarized below:

- **Part I – The mental health "system"** discusses the shift from large institutions to a community-based system of care, generally comprised of a fragmented network of providers that are organized differently in each state. This part also explains the relationship between the decrease in state hospital populations and the corresponding increase in people with mental illnesses in the criminal justice system, as well as the diverse funding streams that support mental health services.
- **Part II – Mental illnesses and their symptoms** explains the current understanding of mental illnesses as genuine neurobiological diseases of the brain that can be managed at levels of effectiveness comparable, or superior, to the treatment of physical illnesses. The four main types of symptoms of mental illness: anxiety, disturbances in perception and thinking, disturbances of mood, and disturbances of cognition are also discussed, as is the difficulty in identifying some defendants with mental illnesses whose symptoms may not be immediately obvious.

mental health courts program publications

The Council of State Governments (CSG) published this guide as part of its technical assistance to the Mental Health Courts Program of the Bureau of Justice Assistance. It is intended for all court practitioners, whether or not they participate in a specialized mental health docket. Readers interested specifically in mental health courts should consult the three other documents published in conjunction with this guide:

- *What is a Mental Health Court?*
- *A Guide to Mental Health Court Design and Implementation*
- *A Guide to Collecting Mental Health Court Outcome Data*

These documents are available online at: www.consensusproject.org/mhcourts.

- **Part III – How mental illnesses are diagnosed** describes how clinician's evaluate the nature and severity of symptoms to diagnose mental disorders, how the *The Diagnostic and Statistical Manual* (DSM-IV) classifies these disorders, and the multiple sources of information used to make a diagnosis. This section also addresses the typical diagnoses of people with mental illnesses who come before the court, such as schizophrenia, bipolar or manic depressive disorder, major depression and anxiety disorders, personality disorders, and co-occurring substance use disorders.
- **Part IV – Guiding principles for quality care** outlines principles such as consumer (i.e., client) centeredness, responsiveness to individual needs, recovery, cultural competency, and evidence-based practices that should underlie all mental health treatment. The following evidence-based practices are explained: Assertive Community Treatment, psychotropic medications, integrated services for co-occurring mental illness and substance abuse disorders, supported employment, family psychoeducation, and illness self-management.
- **Part V – Treatment and support needs for individuals with mental illnesses** details the range of coordinated, high-quality, community-based services needed to address the extensive mental health and social welfare needs of individuals with mental illnesses. These include: housing and residential care, entitlement programs, case management, medical care, supportive counseling, education and employment programs, crisis intervention, and hospitalization. As this section explains, the goal of treatment is not to eliminate all symptoms, but rather to reduce symptoms so they minimally affect functioning.
- **Part VI – How to coordinate treatment and court-based services** discusses the processes and issues with which courts must contend to gather sufficient information about the mental health status and treatment needs of defendants and options for how those needs can be met, including: mental health screening, mental health assessment, providing services, overcoming structural barriers, advocacy role of the court, and confidentiality.

The Mental Health "System"

THE PUBLIC MENTAL HEALTH SYSTEM HAS changed dramatically over the past 40 years. Once based exclusively on custodial care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for people with mental illnesses. In 1955, state mental hospital populations peaked at a combined 559,000 people; in 1999 this number totaled fewer than 80,000.[2] There are many reasons for this change: fiscal imperatives, political realignment, philosophical shifts, and medical advances, in no particular order, have all played a part. These forces and others have converged to create a reality that few could have envisioned when the federal Community Mental Health Centers Act was signed into law in 1964. Though a comprehensive discussion of the current mental health delivery system in the United States is beyond the scope of this guide, the following provides useful background for criminal justice officials seeking to understand the context in which mental services are provided.[3]

The term mental health "system" is a misnomer for what is actually a fragmented network of programs, services, and funding streams. Indeed, no rational organization chart can possibly be drawn to accurately depict the administration and delivery of mental health services in this country. To begin with, as the following table explains, mental health treatment is actually provided by an array of practitioners in myriad settings, many of which are not traditionally associated with mental illness. Unfortunately, the activities of these entities are rarely coordinated.

sectors of mental health service provision[4]

Sector	Providers	Location	Percentage of all U.S. Citizens Receiving Care
Specialty mental health	Psychiatrists, psychologists, psychiatric nurses, psychiatric social workers	Most care is provided in outpatient settings. Acute care is usually provided in special psychiatric units of general hospitals or beds scattered throughout general hospitals, and in some state or county mental hospitals. Some public sector facilities coordinate a wide range of outpatient, intensive case management, partial hospitalization, and inpatient services.	**Adults -** 6 percent **Children -** 8 percent
General medical/ primary care	Internists, pediatricians, nurse practitioners	Office-based practice, clinics, acute medical/surgical hospitals, nursing homes	**Adults –** 6 percent of adults (initial point of contact for many) **Children –** 3 percent
Human services	School-based counseling, vocational rehabilitation, criminal justice-based services, religious counselors	Schools, jails, prisons, public housing facilities, religious institutions	**Adults –** 5 percent **Children –** 17 percent (most frequently in school settings)
Voluntary support network	Self-help groups, peer counselors	Drop-in centers, 12-step group meetings	**Adults –** 3 percent

For the purposes of court practitioners, the most relevant of these sectors are the specialty mental health care system and the voluntary support networks; it is in these areas where defendants with mental illnesses will generally receive services when they are under supervision of the court.

Despite the significant reduction in state hospital populations, states retain principal responsibility for the administration of mental health services.[5] In most states,

this responsibility resides in a mental health authority, which may be a cabinet-level agency or, more likely, an agency subsumed in a larger department responsible for health or human services. Some state mental health agencies administer the delivery of services through locally based, state run providers, which are staffed by state employees. In other states, services are provided by local for-profit and not-for-profit agencies, which are either overseen directly by the state or monitored at the county level. This diversity has allowed states to develop service mechanisms based on their unique politics and priorities, but it also leads to significant disparities in the types of services provided and levels of funding.[6]

As a means to limit costs and target services, most states have defined a priority population, which usually focuses on the most serious illnesses such as schizophrenia, bipolar disorder, and severe depression. This can cause significant difficulties for court-involved consumers, many of whom pose high public safety risks or cause the most disturbances in correctional settings, but are low priorities from a diagnostic point of view. Recent efforts have been undertaken in some states to expand the priority definitions to include people with co-occurring disorders, children, or even criminal justice involved individuals. But expansions in priority populations without concomitant funding increases often do no more than stretch further an already overextended system.

the role of deinstitutionalization in the overrepresentation of people with mental illnesses in the criminal justice system

The significant reduction in the population of state mental hospitals during the past 40 years has corresponded to a steady rise in prison and jail populations. Some suggest that this correlation represents a phenomenon of "transinstitutionalization," implying that the very same people who were in mental health institutions are now incarcerated. While there is little doubt that deinstitutionalization—and the associated inadequate funding of community-based mental health services—has played a role in the overrepresentation of people with mental illnesses in the criminal justice system, the relationship is not as simple as many contend. In fact, no study has proven a transition of people with mental illnesses from state hospitals to jails and prisons. While the total number of people with mental illnesses incarcerated has increased along with the general rise in correctional populations, there is no evidence that the percentage of people in prison or jail who have a mental illness is any greater than it was when the Community Mental Health Centers Act was passed.[7]

Even more complicated than the arrangement of service delivery is the manner in which it is funded. To provide the full spectrum of services envisioned in this guide, a local provider agency, whether it is state or privately run, must weave together funds derived from a dizzying array of sources, each with different guidelines, fiscal years, and stated purposes. Some funding comes to agencies on a per capita basis, some on a "fee- for-service" or reimbursement basis. Some services are paid for regardless of who accesses them, while most require clients to qualify for programs by demonstrated poverty or disability. The text box to the right outlines the major sources of funding for mental health services.

Further complicating the funding picture is the fact that many of the needs of people with serious mental illnesses are not directly related to their conditions. These include substance abuse treatment, affordable housing, and income supports, all of which are the purview of agencies outside of the mental health "system."

As will be discussed throughout this guide, the professionals in the mental health system know much about how to meet the needs of consumers. But the considerable fragmentation of services and funding often makes it difficult for consumers to access these services. Furthermore, providers bypass, overlook, or turn away far too many potential clients, many of whom are too disabled, fearful, or deluded to make and keep appointments at community mental health centers. These systemic shortcomings are at the heart of the significant overrepresentation of people with mental illnesses in the criminal justice system. It is in this context that court officials must consider their efforts to effectively respond to the diverse needs of defendants with mental illnesses.

Court officials interested in a more comprehensive discussion of the mental health service delivery system should consult the following resources (full citations appear in the references section):[8]

- Mental Health: A Report of the Surgeon General (especially chapter six) – www.surgeongeneral.gov/library/mentalhealth/
- Achieving the Promise: Transforming Mental Health Care in America: Final Report (The Final Report of the President's New Freedom Commision on Mental Health) – www.mentalhealthcommission.gov/reports/reports.htm
- The Criminal Justice / Mental Health Consensus Project (especially chapter one and chapter seven) – www.consensusproject.org

funding for mental health services

Local support – In many communities, local tax levies provide some support for community mental health agencies. The level of local support varies widely, and because some agencies serve several towns, one town may provide substantial support while its neighbor contributes meagerly.

County support – In a number of states, mental health services are financed and managed at the county level. In these states, general funds are typically provided to counties in block grants based on formulas that may include population, anticipated need, and historic contribution.

State support – State general revenue funds are traditionally the largest funding source for mental health services. But for a variety of reasons, the share of state funds has been falling for a decade, whether measured as the percentage of state budgets or as the portion of the total mental health budget in a given state. At the same time, the amount of state funding needed to provide the required "match" for federal Medicaid funds has continued to rise, as states have increased their reliance on Medicaid for many services.

Federal block grants – Each state receives a share of the Mental Health Block Grant, which is administered through the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration. These Block Grant funds typically comprise approximately 1.5 percent to 3 percent of a state mental health system's budget. States also receive Substance Abuse Block Grants, which make up a higher proportion of the budget for substance abuse services. Even in systems where mental health and substance abuse services are administered together, however, the two Block Grant programs are subject to rules that prevent their blending.

Medicaid – This joint state / federal program based on need provides an increasing percentage of funding mental health services, but with many restrictions. First, many people who rely upon public mental health services do not qualify for Medicaid. Second, only certain services are eligible for Medicaid reimbursement, which means some important rehabilitative services cannot be financed through this funding stream and that states tend to shift away from those services because of the inability to draw down federal funds. Third, Medicaid regulations prohibit reimbursement for hospitalization of adults aged 21 to 64 in large psychiatric institutions considered "institutions for mental diseases" (IMDs). Furthermore, states cannot receive waivers for the IMD exclusion, which would allow flexibility in using Medicaid dollars for an array of community services. These waivers are predicated on offsets in institutional care, which obviously can't be realized when Medicaid does not cover institutional care for mental illnesses in the first place.

Medicare – While Medicare, a federal funding program for the elderly, is a major funder of mental health services, its contributions are restricted by limits on the number of inpatient days and outpatient visits, and higher copayments for mental health as opposed to physical health.

Other federal programs – Support for mental health services also comes through programs administered by other agencies in the federal government. These include housing programs funded through the Department of Housing and Urban Development, vocational rehabilitation programs administered by the Department of Education, and the Temporary Assistance for Needy Families program, overseen by the Department of Health and Human Services. In addition, qualifying veterans receive mental health services through programs operated by the Veterans Health Administration of the Department of Veterans Affairs. In most states, these programs are operated independently of the state-administered public mental health system. It is often the case that if an individual receives services through a VA program, he or she may not be deemed eligible for non-VA services.

Understanding Mental Illness and Its Symptoms

SERIOUS, LONG-TERM, DISABLING MENTAL ILLNESSES INCLUDE schizophrenia, severe depression, bipolar disorder, and some severe anxiety and personality disorders. Each of these illnesses may co-occur with substance use disorders and is often associated with homelessness and poverty.

Most people, including mental health professionals, once believed that poor parenting, bad genes, or some combination of the two caused mental disorders. Many believed that the symptoms of mental illness were volitional, largely under the control of the person with the illness, while others attributed the symptoms to moral weakness. The prevailing notion was to blame the individual, his or her family, or both. Depending on the time and place, treatment consisted either of trying to talk individuals out of these disorders (through analysis) or of excluding them from society altogether, relegating them to long-term stays in remote state institutions where their care was primarily custodial.

Over the past five decades, advances in science and technology have led to a fundamental paradigm shift in the understanding of the causes of these disorders. Accumulating research evidence suggests that mental illnesses are genuine neurobiological diseases of the brain. Just as in the case of diabetes, where no amount of willpower can make a diseased pancreas secrete appropriate amounts of insulin to control blood sugars, the functioning of the brain is essentially outside the direct control of the individual.

That treatment "works" for mental illnesses is indisputable. The concept of *brain plasticity* suggests that the functions and even the structure of the brain can be altered by treatment and environmental changes. In fact, research indicates that mental illnesses can be managed at levels of effectiveness comparable, or superior, to the treatment of physical illnesses.[9] While the current state of knowledge has its limits, medications and therapeutic supports have been developed that control psychiatric symptoms effectively and enable many individuals with serious mental disorders to lead successful and productive lives.

BIOPSYCHOSOCIAL DISEASE MODEL

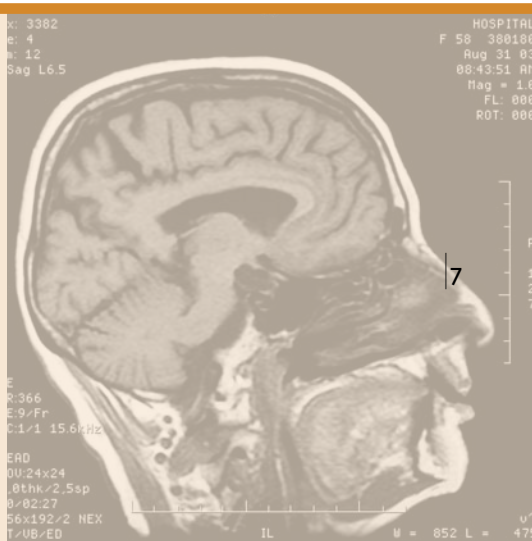
The precise causes of mental disorders are complex and still not well understood. Like physical illnesses, they are believed to be determined by an interplay of biological, psychological, and social factors. No single gene is likely to cause a particular mental illness; rather, the interaction of multiple genes and environmental stressors increases the risk of mental disorders.

Smoking, bad dietary habits, and lack of exercise may predispose a person to coronary artery disease, although some people with these very same risk factors show no evidence of the disease. The same is true for mental illness. A number of identical twin studies have found only one twin to be affected by mental disorder. That said, for almost all psychiatric conditions, a genetic link has been demonstrated.

Beyond genetics, social factors such as economic and environmental disadvantage are associated with higher rates of mental illness. Living in a crowded homeless

neurobiology of mental illness

Within the complex architecture of the brain, communication between neurons involves electrical signals that travel down brain cell axons and across the space that separates cells, called *synapses*. Chemicals called *neurotransmitters*, such as norepinephrine, serotonin, and dopamine, help the neurons to communicate. Scientists now believe that the symptoms of mental illness are due to imbalances in these neurotransmitters. Thus, rebalancing this delicate chemistry is the initial target of a new generation of medications as well as various psychotherapies.



shelter, a violent inner-city neighborhood, or an unhealthy family structure can all influence the way an individual thinks, feels, and behaves. The biopsychosocial model of disease suggests that changes in any or all of these domains may be used to remediate an individual's illness. The most successful treatment interventions address a combination of these factors.

SYMPTOMS OF MENTAL ILLNESS AND TYPES OF DISORDERS*

Defendants with mental illnesses are not necessarily easy to identify. Quiet, passive, and nonproblematic defendants may have treatment needs that are not obvious at first glance. Some people with serious mental illnesses suffer from *anosognosia,* meaning they have no insight into their own illnesses. One study estimates that approximately half of all individuals with schizophrenia and 40 percent of those with bipolar disorder simply do not appreciate the need for treatment.[11] This lack of insight helps to explain why some people refuse treatment and medication and also underscores the need for careful pretrial screening and assessment by a mental health professional. Others may accept their need for treatment but face substantial economic or geographic barriers to care.

The symptoms of mental illness generally cluster in four domains: anxiety, disturbances in perception and thinking, disturbances of mood, and disturbances of cognition. While all people with serious, long-term disorders have some symptoms and characteristics in common, they also have unique strengths and talents that define them as individuals, beyond their illness or status with the court.

*Published in 1999, *Mental Health: A Report of the Surgeon General* was a seminal effort by the federal government to synthesize what was known about mental illness and to correct myths and misinformation.[10] The report's detailed review of mental health science and policy is an excellent resource for the curious court practitioner. Its conceptualization of symptoms guides this overview.

diverse people, diverse terminology

Many different terms are used to describe people involved with the mental health system and the criminal justice system. In this report, we have chosen to use the following terms:

- **Individual or person with a mental illness –** someone with a mental illness
- **Consumer –** someone receiving mental health treatment
- **Defendant –** someone appearing in court
- **Inmate –** someone who is detained or incarcerated in jail or prison

Anxiety

Feelings of fear or dread, trembling restlessness, rapid heart rate, sweating, shortness of breath, and lightheadedness are commonly associated with anxiety and are symptoms that nearly everyone experiences to some extent. For most people, most of the time, these feelings are transitory. Some anxiety is even adaptive, functioning as an important precursor to avoiding or confronting a threat. But excessive, unregulated anxiety can be debilitating and can interfere with the ability to function.

Anxiety disorders include *social phobia* (fear of appearing or speaking in front of groups), *panic disorder* (recurrent panic attacks lasting a few hours, causing great fear, and making it hard to breathe), *obsessive-compulsive disorder* (recurrent, unwanted thoughts [*obsessions*] and/or repetitive behaviors [*compulsions*] that cannot be controlled), and *posttraumatic stress disorders* (a reaction to trauma involving recurrent nightmares, anxiety, depression, and the experience of reliving the traumatic event).

Disturbances in perception and thinking

Disturbances in perception and thinking are the most flagrant and serious symptoms of mental illness and are often associated with psychosis. The two most common forms of psychosis are *hallucinations* and *delusions*. *Hallucinations* are subjective perceptions in the absence of outside stimuli; essentially, perceiving things that do not actually exist. These can involve any sensory modality—they can be auditory (hearing voices or sounds), visual (seeing images), olfactory (smelling odors), tactile (feeling touched by something), or gustatory (tasting something).

In addition to hallucinations being frightening for the defendant, they interfere with concentration and the ability to participate in one's own defense. Some hallucinations, such as *command hallucinations,* may instruct the person to harm himself or others, clearly suggesting a risk of dangerousness upon release. With medication, many hallucinations dissipate entirely. Even when they cannot be eliminated, medication may weaken them to the point that they can be ignored and functioning is improved.

Delusions are false beliefs that are held despite overwhelming evidence to the contrary. A common delusion, often observed in court settings, is that of *paranoia*. Individuals with paranoia may be convinced that one or more people intend to harm them, which may result in their refusal to participate in their own defense, silence in response to questions, or desperate efforts to avoid imagined persecutors. *Delusions of grandeur* are beliefs that one possesses supernatural powers or skills. These delusions

may lead some individuals to take unwarranted risks because they believe they can manage any situation without risk of harm.

Other psychotic symptoms are less obvious and may include disorganized or illogical thoughts, bizarre or disorganized behavior, and difficulty following rules or instructions. Even a simple command, such as "Lie down and put your hands behind your head," may not be understood. Psychotic symptoms may also be accompanied by *agitation* (restlessness), *blunt affect* (flattening of moods), *anhedonia* (the inability to experience pleasure), and loss of motivation or initiative.

Obviously, these symptoms can make it difficult for a defendant to participate in the court process. But because psychotic symptoms reflect difficulties in processing and interpreting stimuli in the central nervous system, they do tend to respond to specific medications (*anti-psychotic medications*).

Schizophrenia is one of the most common psychotic disorders and can be one of the most destructive in terms of its effect on a person's life. The symptoms of schizophrenia typically fall into two categories: positive (the experience of something in consciousness that would not normally be present) and negative (the absence of thoughts and behavior that would normally be expected) symptoms. The disorder has several specific types depending on the other symptoms experienced.

Disturbances in mood

Disturbances in mood are among the most common symptoms seen in court defendants and may take the form of emotional highs or lows or significant fluctuations in mood.

Depression often appears as apathy, hopelessness, poor self-esteem, feelings of helplessness, and suicidal thinking. Instead of just feeling "down," an individual may not be able to work or function at home, may feel suicidal, may lose his or her appetite, and may feel fatigued. Other symptoms can include loss of interest; changes

positive and negative symptoms[12]

Positive symptoms reflect an "excess of normal functions" and include: hallucinations, delusions, disorganized speech, and grossly disorganized or catatonic behavior.

Negative symptoms reflect a "diminution or loss of normal functions" and include: social withdrawal, lack of interest, restriction in emotional expression, and decreased speech or interest.

in sleep, appetite, and weight; feelings of worthlessness; loss of concentration; and recurrent thoughts of death. Periods of sustained depression inhibit an individual's capacity to enjoy life or experience pleasure. Left untreated, it can prove fatal.

On the other end of the mood spectrum, *mania* is characterized by grandiosity, racing thoughts, poor impulse control, or pressured speech. When mood is overly elevated, a person may have difficulty shutting down his exuberance and handling his day-to-day responsibilities. Sleep cycles are disturbed, or the person may not feel the need to sleep for days at a time. Symptoms may include inflated self-esteem or grandiosity, more talkativeness than usual, *flight of ideas* (racing thoughts), distractibility, increased goal-directed activity, and excessive involvement in pleasurable activities with a high potential for painful consequences (such as sexual indiscretions, gambling, substance use, and buying sprees).

Both of these disturbances are often associated with changes in appetite, sleep, energy, concentration, and memory. Antidepressant medication, mood stabilizers, and psychotherapy or some combination are commonly used to treat these disturbances and their physiological effects on the body. A person with *bipolar disorder* typically cycles between episodes of mania and depression.

Disturbances of cognition

Cognition refers to the ability to organize, process, and recall information. Cognitive functions affect an individual's ability to speak, pay attention, concentrate, and remember. Some cognitive deficits can be so profound that a person may be unable to perform simple functions such as preparing meals, dressing, and bathing.

When these disturbances result from progressive deterioration of functioning or occur late in life, they may be indicative of alcoholism, Alzheimer's disease, or other late-life dementias. Accurate diagnosis is critical, since similar symptoms may result from severe depression or other serious mental disorders. Examples of these disorders include *amnesia* (memory loss) and *aphasia* (inability to understand or use language).

How Mental Disorders Are Diagnosed

ANXIETY, ANGER, AND DESPAIR ARE normal reactions to the stressful experience of being arrested. Even when exaggerated, these feelings are not necessarily symptoms of a diagnosable mental disorder. Only through a clinician's careful evaluation of the nature and severity of symptoms can a mental disorder be diagnosed.

The Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association is considered the definitive text on the differential diagnosis and treatment of mental disorders in both children and adults.[13] It defines a *mental disorder* as:

> ...a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and

distinction between mental health and mental illness

Mental illness and mental health actually exist on a continuum, with the distinction between the two based on the:

- Nature and severity of symptoms;
- Duration of symptoms;
- Extent to which symptoms interfere with one's ability to carry out daily routines, succeed at work or school, and form and keep meaningful interpersonal relationships.

> that is associated with present distress (e.g., a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event.

The DSM-IV goes on to specify that deviant behavior and conflicts between an individual and society are *not* mental disorders. Thus, the fact that someone has become involved in the criminal justice system is not, by itself, evidence of a mental disorder.

LINK BETWEEN DIAGNOSIS AND TREATMENT

Reliable diagnosis requires a thorough and careful assessment by a trained mental health professional, usually a *psychologist* (who has a master's or doctoral degree in psychology) or a *psychiatrist* (a medical doctor who specializes in psychiatry). Multiple sources of information are used to assess a recognizable pattern of symptoms

classification system of DSM-IV

The DSM-IV uses five different axes to organize and communicate clinical information:

- **Axis I** is where all mental disorders are listed, with the exception of Axis II disorders.
- **Axis II** is used to record all personality disorders and mental retardation.
- **Axis III** is used to record general medical conditions.
- **Axis IV** is where the person's psychosocial and environmental problems are listed.
- **Axis V** is where the clinician records a numerical assessment of the individual's overall level of functioning.

Frequently, clinicians will discuss the relative contributions of Axis I versus Axis II disorders to an individual's presenting behaviors, thoughts, and mood abnormalities. This clinical distinction is critical to the development of effective treatment plans.

that constitute a *syndrome*. Once a syndrome is recognized, the clinician determines whether it meets the explicit criteria for a particular disorder as described in the DSM-IV.* The importance of accurate evaluation cannot be overemphasized, because the diagnosis should always guide the treatment decisions that follow.

*While technical in nature, the DSM-IV is recommended to court personnel as a useful reference that outlines the symptoms associated with various diagnoses.

MENTAL ILLNESS AND PERSONALITY

Some personality traits so consistently impede an individual's functioning that they meet DSM-IV criteria for a diagnosable *personality disorder*. The typical features of personality disorders include disturbed self-image, troubled relationships with others, inappropriate emotional expression, and inadequate impulse control. People with personality disorders are often perceived to be odd and eccentric, overly dramatic and emotional, or anxious and fearful in their interactions with others and their view of the world. Axis II disorders often co-occur with Axis I disorders, particularly mood disorders, and with addictive disorders.

Personality disorders are listed on Axis II in the classification scheme and include *paranoid personality disorder, borderline personality disorder, antisocial personality disorder,* and *narcissistic personality disorder,* among others. Antisocial personality disorder is frequently diagnosed in people served in criminal justice settings, in part because the diagnostic criteria include criminal activity. However, many court-based initiatives exclude people with this diagnosis from the target populations for diversion or other specialized responses.

Axis II disorders are typically very challenging to treat because the person suffering from the personality disorder usually does not appreciate the symptoms

sources of information used to make a diagnosis

- A consumer's self-report of his or her symptoms, their intensity, and their duration;
- Data derived from a mental status exam by a clinician;
- Information derived from a systematic observation of behavior, and assessment of functional capacity;
- Information from police reports and prior records of arrest and detention;
- Reports from the individual's family, significant others, law enforcement and court officials (including probation officers, case workers, and advocates).

as unusual or problematic. Rather, the desire for change belongs to the individual's family and friends, who are concerned about the symptoms. The personality disorder itself can be a large part of why the person's motivation for change is weak.

"SERIOUS" AND "SEVERE AND PERSISTENT" MENTAL ILLNESS

In any given year, about 22 percent of the U.S. adult population has a diagnosable mental disorder, but not all of these individuals require treatment.[14] Some disorders resolve with time, while others do not produce sufficient disability to warrant treatment. Court practitioners are likely to encounter individuals with a broad range of symptoms and disabilities.

Mental disorders requiring court accommodation usually fall within the broad categories of *serious* and *severe and persistent mental illness,* which differ based on criteria related to diagnosis, disability, and duration. About one in 20 people in the U.S. has a *serious* mental disorder, defined as a mental disorder lasting for at least a year with significant functional impairment, and about half of this group is profoundly impaired and, therefore, meets criteria for *severe and persistent* mental illness.[15] While the same general criteria are used to determine eligibility for state-supported public mental health services, definitions vary in restrictiveness state-by-state. A state's definition of *severe and persistent* mental illness will affect access to public mental health services and, therefore, needs to be understood by court personnel.

"serious" and "severe and persistent" mental disorders

The specific diagnoses that are considered **serious** or **severe and persistent** are:

- Schizophrenia;
- Schizoaffective disorder;
- Bipolar or manic-depressive disorder;
- Severe forms of major depression and anxiety disorders;
- Some personality disorders (e.g., schizoid, schizotypal, borderline).

CO-OCCURRING DISORDERS

Addictive disorders

Although substance use disorders are included within DSM-IV and have very specific criteria, addictive and nonaddictive disorders have separate treatment interventions, administrative and clinical structures, and funding mechanisms, and, therefore, are often not considered together in strategic planning initiatives.

This separation does not serve people with mental disorders well since most have co-occurring mental and addictive disorders. In criminal justice settings, three out of four people meeting criteria for a serious mental illness simultaneously meet criteria for a substance use disorder.[16] Research has demonstrated consistently that *integrated treatment,* where both conditions are addressed concurrently, is the most effective response to the needs of dually diagnosed individuals.[17]

Importantly, because the symptoms of addictive disorders can mimic those of a psychiatric disorder, substance abuse must be ruled out as the primary cause for disturbances in mood, thinking, or behavior. When addictive drugs produce psychiatric symptoms, it is considered a *substance-induced psychiatric condition*. For example, acute and prolonged use of cocaine can cause paranoia, which would be diagnosed as a substance-induced delusional disorder rather than a serious mental illness. The appropriate treatment for this condition is prolonged abstinence from cocaine.

Developmental disabilities

Developmental disabilities (once called mental retardation) are intellectual deficits that usually first appear in infancy or early childhood. Mental retardation and pervasive developmental disorders are also found within DSM-IV, but they are not the focus of this document. Co-occurring developmental disabilities and mental illnesses are challenging to treat. Competency to stand trial must be assessed in all individuals with developmental disabilities. People who are diagnosed with both disorders also require special consideration both in terms of treatment and any punitive options used to encourage compliance with court orders.

Guiding Principles of Quality Care

IN PRACTICE, PROVIDING COMPREHENSIVE, INTEGRATED CARE TO people who struggle with complex and co-occurring mental disorders is a daunting task. Limited fiscal resources are best expended on programs and practices with proven abilities to improve mental health functioning and reduce subsequent criminal behavior. Mental health programs to which defendants have access should demonstrate their fidelity to principles of effective treatment. These include:

- Consumer centeredness
- Individual treatment planning
- Recovery
- Cultural competency
- Evidence-based practices

CONSUMER CENTEREDNESS

As the language conventions used to refer to different cultural and ethnic groups have changed, defendants and their families may also be sensitive about the terms used to describe people with mental illnesses. In the mental health system, *consumer*

is the term most frequently used to characterize a person who is receiving mental health services.

In recent years, consumer advocacy groups have expressed a preference for "people-first" language that avoids labeling the person as diseased (e.g., a mentally ill person) and instead focuses on the fact that those struggling with mental illness are people first (e.g., a person with mental illness).

The mental health field has slowly recognized the benefits of consumer participation in planning, delivering, and evaluating mental health services. "Nothing about us, without us," has been the cry of an increasingly vocal consumer movement in this country. Ignoring consumer preferences in treatment planning often leads to ineffective treatment plans with low levels of compliance. As a result, consumers have begun to play an important role in managing funding for services, treatment, and supports.[18] Full consumer approval in the court process is not warranted, but soliciting defendant input and offering choices among treatment options can improve both short-term compliance and long-term outcomes.

INDIVIDUALIZED TREATMENT PLANNING

As their diagnoses, disabilities, demographics, and criminal charges differ, every defendant with a mental illness who appears before the bench also brings a unique set of strengths, resources, and limitations. This heterogeneity requires court decisions about treatment and supervision to be tailored to individual circumstances

using people-first language

Use **a person with depression** rather than *a depressive*	Use **a person with schizophrenia** rather than *a schizophrenic*	Use **a person who uses heroin** rather than *an addict*

These terms acknowledge that everyone has qualities and strengths in addition to a stigmatizing illness.

and to avoid a "one-size-fits-all" approach. Understanding and addressing an individual's unique characteristics and circumstances will result in the most effective interventions.

Although high-quality treatment depends on the ability to respond to individual needs, in an open court process such as a mental health court, responding differently to defendants with apparently similar circumstances can open the door to accusations of disparity or bias. To incorporate individualized treatment planning into court case processing, it may be necessary to explicitly state that all defendants will receive sanctions and rewards tailored to their own circumstances.

RECOVERY

Consumers, families, and professionals used to believe that serious and severe mental disorders were virtual life sentences, that mental disorders always had a downhill course, and that people were incapable of recovering sufficiently to enjoy life and return to meaningful activities. Both research and practical experience have proven this thinking to be erroneous. Despite disabling mental illnesses, many people have the potential to recover given appropriate treatment, supports, and hope.

Belief in the capacity of people to change and heal is central to effective court programs. Without incorporating the goal of recovery, courts are left only with punishment and sanctions to encourage compliance. Although the period of court-monitored supervision is relatively brief, it can catalyze long-term treatment and recovery.

recovery

The concept of **recovery** is defined as "the process in which people are able to live, work, learn, and participate fully in their own communities."[19] Recovery entails either a reduction or elimination of symptoms.

CULTURAL COMPETENCY

Because of their racial, ethnic and cultural status, some people of color have more limited access to general health care and to mental health services than non-minority populations.[20] In addition to race, cultural variation exists in terms of religion, sexual orientation, and factors associated with socioeconomic status. These differences vary across jurisdictions, and understanding the cultural diversity in a given locale is an important early step in developing culturally sensitive responses.

Racial disparities are even more pronounced among people with mental disorders who become entangled in the criminal justice system. In 2000, although nonwhites constituted approximately 25 percent of the general U.S. population, they represented the majority of people incarcerated in prisons (65%) and jails (56%).[21] The extent to which people of color are overrepresented in the criminal justice system gradually increases from the point of arrest through long-term incarceration in prison.

The field of mental health has developed a *cultural competence* paradigm to reduce racial, cultural, and socioeconomic disparities in access to quality mental health services.[22] Cultural competence must also be addressed in general health services, law enforcement, court services, and corrections. For example, courts should involve peer counselors, interpreters, and bilingual friends and family to ensure that proceedings are linguistically and culturally sensitive.

racial and ethnic characteristics of people in jail and prison

Race/ethnicity	Jail	Prison
White	44%	35%
Black	39	44
Hispanic	15	19
Other	2	2

SOURCE: Harrison, P. and A. Beck (2004). *Prisoners in 2003*. Washington, D.C.: Bureau of Justice Statistics; and Harrison, P. and J. Karberg (2004). *Prison and Jail Inmates at Mid-Year 2003*. Washington, D.C.: Bureau of Justice Statistics.

EVIDENCE-BASED PRACTICES

Mental health courts are emerging at a time when the entire field of medicine, including mental health, is moving toward the implementation of *evidence-based practices* (EBPs) in the delivery of care. To qualify as an EBP, empirical research must demonstrate that a specific practice increases the likelihood of positive outcomes. A corollary goal of these efforts is to allocate scarce mental health resources accordingly so as to gain maximum value for consumers and their families, as well as the community at large.[23] As a result, providers are being challenged to demonstrate both quality and effectiveness in the care they deliver.

Basing mental health treatment on EBPs improves both mental health and public safety. Defendants should have access to a wide array of effective treatments that match their particular needs to appropriate care. While not all community-based services for people with mental illnesses qualify as EBPs, and EBPs have not been established for every condition or disorder, several EBPs have particular relevance for court consideration. Evidence-based practices for people with serious mental illnesses include:

- Assertive Community Treatment (ACT) – Treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for case management and treatment needs their clients.

cultural competency

Consensus panels convened by the Substance Abuse and Mental Health Services Administration (SAMHSA) have defined **cultural competency** as:

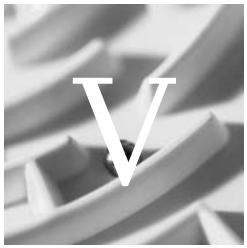
> An acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work toward better meeting the needs of minority populations.

evidence-based practices

Evidence-based practices are mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes.[24]

Knowledge about which treatments are most effective should help shape court-ordered treatment conditions.

- Psychotropic medications – Medications designed to reduce anxiety, depression, or psychosis by acting on the chemistry of the brain.
- Integrated services for co-occurring mental illness and substance use disorders – Practices through which providers trained in both substance abuse and mental health services develop a single treatment plan addressing both sets of conditions and interact consistently to reassess and treat the client.
- Supported employment – A practice that matches and trains people with serious mental disabilities to jobs where their specific skills and abilities make them valuable assets to employers.
- Family psychoeducation – The provision of information and education to families, significant others, and the consumer regarding mental disorders and their treatment to use to enhance involvement of significant others who may be essential in assisting a client to maintain treatment and to recover.
- Illness self-management[25] – Teaching consumers skills and techniques to minimize the interference of psychiatric symptoms in their daily activities.



Meeting the Comprehensive Needs of People with Serious Mental Illnesses

DEFENDANTS WITH SERIOUS MENTAL ILLNESSES REQUIRE access to a range of coordinated, high-quality, community-based services designed to address their extensive mental health and social welfare needs. The precise combination of services provided for any one defendant should be guided by thoughtful assessment of his or her individual needs. Unfortunately, the availability of sufficient resources for many essential services varies by jurisdiction. Court officials need to be familiar with the local resources available in their community and to identify gaps in these resources that can be filled through ongoing advocacy efforts.

essential community services

The array of services in any community should include:

- Psychotropic medication
- Integrated substance abuse treatment
- Housing and residential care
- Entitlement programs
- Assertive Community Treatment (ACT) teams and case management
- Medical care
- Supportive therapy
- Rehabilitation, job programs, education, and employment counseling
- Family support
- Consumer self-help
- Crisis services
- Hospitalization

PSYCHOTROPIC MEDICATION

One of the first goals of treatment is to address the disturbances of thinking and mood that are, in part, a product of underlying neurochemical imbalances of the brain. Some of the common classes of medications used to achieve this goal include:

- Antidepressants and mood stabilizers
- Anti-anxiety medications
- Antipsychotic medications

A brief overview of specific medications in these three categories can be found in Appendix A.[26]

A psychiatrist prescribes medication that is known, based on empirical data, to control the symptoms of a particular disorder. In the initial stages of treatment, the consumer needs to be monitored on a regular basis to assure compliance with the prescribed medications, to determine if the medications are working, and to identify any adverse side effects. Finding the right medication(s) at the correct dose may take some time. Depending on the nature of the symptoms, people with serious mental disorders may need to take several different types of medication simultaneously.

When a consumer does not respond to medication, the initial dosage may be increased; if there is still no response, another medication may be tried to achieve symptom remission. It is important to note that these drugs do not cure mental illness, but rather help to control or lessen symptoms. Furthermore, in the same way that insulin is used to treat chronic diabetes, most people will need to take these medications for the rest of their lives to avert or lessen the risk of relapse and hospitalization.

Over the past decade, a second generation of psychotropic medications has been developed. Often referred to as *atypical* (as opposed to *typical* medications), these drugs offer two distinct advantages: a more tolerable side effect profile and greater effectiveness in treating consumers who did not respond to the earlier generation of drugs. Helping consumers adhere to and find the means to pay for complex medication regimens is still a formidable challenge. Success depends on developing a trusting relationship between the consumer and clinician and on securing sources of financial support.

At the systems level, government and third-party payers struggle to contain costs by limiting access to expensive medications that show no greater effectiveness than less expensive drugs, and policy makers are seeking methods to assure appropriate

prescribing practices. *Formularies* are lists of medications covered by specific insurance or benefit plans, as part of a cost-containment strategy. Based on cost, some states, insurance plans, or detention facilities have limited the number and type of medications listed on the formulary. Others have developed algorithms that direct providers to use certain medications on a priority basis.

At the defendant level, a central challenge to court-based work is to identify mechanisms for ensuring access to needed medications. Treatment plans need to address the following questions:

- From whom will the defendant obtain medication?
- How will the defendant pay for medication?
- Who will monitor compliance with medication?

INTEGRATED SUBSTANCE ABUSE TREATMENT

Given the large number of people who are dually diagnosed, substance abuse treatment is a critical element in a comprehensive system of care. Research conducted over the last decade has shown that the most successful models of treatment for people with co-occurring disorders provide integrated mental health and substance abuse services.

Historically, the mental health and substance abuse treatment systems have been administratively, financially, and clinically distinct. Those with co-occurring disorders have been excluded from service (e.g., "You cannot be in this addictions program if you are taking psychotropic medications"), have had their two sets of disorders treated sequentially (referred to as *ping-pong therapy*), or have had their disorders treated in parallel efforts without communication between mental health and addiction providers. These approaches have frustrated consumers, family members, and providers because they have produced few positive clinical outcomes.

Integration requires providers to develop a single treatment plan addressing both sets of conditions and outlining the continued formal interaction and cooperation of all providers in the ongoing reassessment and treatment of the consumer. In many cases, integration requires modifications to traditional approaches to care. Successful programs involve family and natural supports, provide intensive case management (as described in subsequent sections), use motivational interventions, and take a long-term treatment perspective consistent with recovery principles.[27] For people with serious mental illnesses and co-occurring substance use disorders, integrated care has sufficient research support to qualify as an EBP.

Despite the solid evidence that integrated care is required for positive outcomes, not all consumers with co-occurring disorders have access to it. A recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that 61 percent of those with co-occurring serious mental illness and substance use disorders do not receive treatment for either illness and that 34 percent receive only mental health treatment.[28]

Courts should determine whether local providers have the capacity and resources for integrated care. If they do not, the court may have a role in bringing mental health and addiction providers together to discuss the options, although the court should not be burdened with figuring out how to achieve the necessary clinical integration.

HOUSING AND RESIDENTIAL CARE

Without stable shelter, it is difficult to imagine how anyone, particularly someone with a psychiatric problem, can live successfully in the community. Unfortunately, people with serious mental illnesses and/or substance abuse problems are at increased risk for homelessness, and their problems finding and maintaining stable housing are often compounded by their histories of involvement with the criminal justice system.

The affordable housing crisis in the United States is particularly overwhelming for people with multiple disabilities, who have difficulty competing for the scarce available units. In addition, federal "one strike and you're out" policies may ban a person from renting a federally subsidized apartment if any member of the family has a criminal record. Even without federal restrictions, landlords may be unwilling to rent a room or apartment to someone with a criminal record.

A lack of stable housing makes participation in court and treatment programs extremely difficult. Individuals who are homeless are more likely to enter the criminal justice system and more likely to return to it repeatedly, and mental illness increases this likelihood even further. People with mental illnesses who are homeless are more than twice as likely to be arrested and jailed as other homeless individuals.[29]

Defendants with mental illnesses should be prioritized for community public housing placements, because their residential stability is both a clinical and a public safety concern. Several programs to improve housing options have succeeded in helping these consumers attain stability. Such *supportive housing* programs typically couple housing with an appropriate level of professional and peer support to allow a person with mental illness to live independently in the community. Supports may include crisis services, mental health and substance abuse treatment, and employment assistance.[30]

ENTITLEMENT PROGRAMS

Services that provide treatment for mental health, substance abuse, and health problems, in addition to food stamps and the money needed to pay for housing and basic necessities, are often accessed through federal entitlement programs. One of the most important of these programs is *Supplemental Security Income* (SSI), which is designed to provide income support to the aged, blind, and disabled. In most states, if someone qualifies for SSI, he or she is automatically eligible for Medicaid, which opens up most doors to healthcare.

Disabled persons who have significant work histories but are no longer able to sustain gainful employment can get income support through the *Social Security Disability Insurance* program (SSDI). Obtaining SSDI for two years automatically makes an individual eligible for Medicare.

Prior to arrest, many people with mental illnesses rely on these government programs to survive. If they lose these benefits while incarcerated, their access to treatment, housing, and other supports is much more difficult, leading to a downward spiral that can culminate in rearrest. Recent clarification of SSI and SSDI guidelines may increase the number of inmates who retain or who gain access to these benefit programs.[31]

The application process for these programs can be cumbersome and requires assistance from knowledgeable case managers. Not all court participants will be eligible for federal entitlement programs, so it is essential for court and mental health officials to understand state and local benefits in order for them to oversee successful community integration. Furthermore, having access to these benefits does not guarantee that all a person's social needs will be met. In 2002, not one of the 2,702 identified national housing market areas included an efficiency or one-bedroom unit that was affordable for people with disabilities on SSI.[32]

CASE MANAGEMENT AND ACT TEAMS

Accessing and coordinating all of the services needed by an individual with serious mental illness is a challenge requiring expertise, varied skills, and long hours. Various *case management* models are employed with different objectives. Coordinating and brokering services are functions that can be provided from within or outside the court setting. Staff responsible for this function must have the ability to engage defendants in planning, possess detailed knowledge of the services available in the local community, and be able to coordinate many disparate agencies, programs, and providers.

People with more serious mental disorders may have difficulty moving between multiple programs and providers. To meet their needs, multidisciplinary *Assertive Community Treatment (ACT) teams,* including a psychiatrist, substance abuse counselors, case managers, nurses, vocational specialists, peer counselors, and others, provide 24-hour case management services. ACT qualifies as an EBP because research has shown that ACT teams improve the continuity of care, reduce the use of inpatient treatment services, and extend community tenure.[33]

However, ACT is labor-intensive, relatively expensive (though not when considering other cost-offsets), and generally available to only the most impaired individuals in the community. ACT is particularly well suited to the most seriously impaired defendants who repeatedly appear before the bench.

Other models of case management embrace a number of different practices and orientations, all intended to coordinate care. Unlike ACT, these models do not have the capacity to deliver medication and treatment services. Courts need to understand both the form and intensity of case management services available in their community and adapt existing models to ensure coordination between the criminal justice and mental health systems.

Many people with mental illnesses are reluctant to seek treatment, and others, because of their symptoms or prior negative experiences with the mental health treatment system, avoid it at all costs. The fear of hospitalization or incarceration may also deter people from seeking the treatment they need. Unfortunately, these same individuals are often among those most in need of services. For this reason, outreach is essential to engage people in treatment, allowing for the time required to build trust. Often, rapport-building entails meeting people on their own turf: in parks, on streets, or in shelters, with initial contacts focused on meeting their basic needs for food, clothing, and shelter. ACT is one model that can provide this level of service.

MEDICAL CARE

Good health care (including dental care) is essential to everyone's well being, and this is no less true for people with significant mental disorders. Unfortunately, their psychiatric problems, difficulty accessing regular medical care, and lack of health insurance cause many people with mental illnesses to neglect their own health and self-care. Health care, when received at all, takes place in emergency rooms rather than doctors' offices or preventive health care settings. Because some psychotropic medications are associated with weight gain, increased risk for diabetes, and other adverse side effects, ongoing health care is an essential part of the constellation of services provided to defendants with mental illnesses.

SUPPORTIVE THERAPY

Supportive therapy or counseling is intended to provide an individual with the coping skills necessary to live with a long-term disabling illness. Therapists may assist with practical problems, such as finding housing or employment; provide guidance about relationship issues; suggest strategies for managing intractable symptoms, such as hearing voices; and may even serve as a sounding board for court-related issues. Because many people with serous mental illnesses are lonely and estranged from their families and friends, supportive therapy can provide much needed encouragement and consistent support.

REHABILITATION, JOB PROGRAMS, EDUCATION, AND EMPLOYMENT

We are often defined by our roles as workers; the question "What do you do?" is one of the most common asked in any social situation. For most people with serious mental illnesses, it is a difficult one to answer. Because the onset of these disorders typically occurs when people are in their late teens or early adult years, educational and vocational trajectories are often halted abruptly. When resumes (and self-esteem) are blemished by unexplained gaps, due to illness, hospitalization, or incarceration, competitive employment is very difficult to secure. Unemployment is common among this group, with rates estimated as high as 90 percent.[34]

Rehabilitation and job programs seek to redress these problems by offering training in the vocational and interpersonal skills needed to obtain and retain employment. One evidence-based practice in the rehabilitation field is *supported employment*.[35] Essentially, an employment specialist is added to the community mental health treatment team; this person helps the consumer find appropriate competitive employment and provides on-the-job support. Supported employment programs in some jurisdictions have helped 60 to 80 percent of participants with serious mental illnesses to secure a job.[36]

CONSUMER SELF-HELP

People with similar illnesses tend to come together for mutual support; this is a particularly valuable resource for individuals with mental disorders, who are often isolated and alone. Self-help programs can range from informal gatherings to drop-in centers to offshoots of outpatient programs that are facilitated by paid staff. Research suggests that these programs provide valuable information and support to their participants.[37]

FAMILY SUPPORT

When someone is diagnosed with a chronic illness, such as diabetes or heart disease, the patient and his family are typically given information and guidance about the illness and its management. Unfortunately, similar efforts are not always made when someone is diagnosed with a serious mental illness. Families, especially mothers, were once blamed for causing mental illness. With advances in our understanding of the neurobiology of mental illnesses, some of the blame and shame has been lifted, but it is still stressful and stigmatizing for families to cope with psychiatric disabilities, particularly when the person with a mental illness has also become entangled with the criminal justice system.

Families and friends are instrumental in the recovery of their loved ones and are needed to serve as advocates for improved systems of mental health care. A number of national and local organizations provide self-help groups, information, and support to the families of people with mental illnesses.*

These services generally include structured courses to educate families about mental disorders. Family education and support has been shown to lead to improved patient outcomes.[38] One model, called *family psychoeducation,* has a sufficiently compelling research base to be considered an EBP.[39] The principles of family education are considered so integral to quality care that they have also been incorporated into practice guidelines for professionals.[40]

* **These organizations include** NAMI, the National Mental Health Association (NMHA), and the Depression-Bipolar Support Alliance (DBSA), among many others.

CRISIS SERVICES

The course of serious mental illness is often cyclical, characterized by periods of relative well being interrupted by periods of deterioration or *relapse.* Relapse is sometimes caused by the failure to adhere to a prescribed regimen of medication; at other times, it occurs during periods of stress. Relapse can also occur spontaneously, without any obvious precipitating event. When relapse occurs, the individual needs immediate attention.

Crisis services, therefore, are a vital component of a system of care. Many communities have developed telephone, mobile, or residential crisis programs to serve as less costly and less restrictive alternatives to inpatient hospitalization. Multidisciplinary teams provide 24-hour evaluation and treatment services, as well as respite and support for families and residential care providers. These programs aim to stabilize consumers as rapidly as possible and to divert them from emergency rooms, jails, and hospitals.

Some crisis programs also offer temporary housing during the period of stabilization. While the evidence base for crisis housing is comprised primarily of uncontrolled studies, communities having access to crisis housing resources report that they are effective in promoting stability and avoiding the use of inpatient or custodial settings.

HOSPITALIZATION

As discussed in part I, psychiatric hospitals were once total institutions that managed almost every aspect of the lives of their residents. Patients with serious and severe mental illnesses were typically hospitalized in remote locations, far from their home communities, for long periods of custodial care. Despite the shift during the past 40 years to community-based treatment system, state, municipal, and private hospitals still play an important role. When people are acutely ill and a danger to themselves or others, they are often stabilized in a community hospital close to home over the course of several weeks, followed by continuing care on an outpatient basis.

REALISTIC EXPECTATIONS

In summary, although a range of services may be required to stabilize a defendant with a mental illness, not all defendants will need all of these services, and not every community will be able to provide them. But even in the best-case scenario of a defendant who is appropriately assessed and linked to high-quality care, progress in recovery can be slow. The goals of treatment are not to eliminate all symptoms, but rather to reduce symptoms so they minimally affect functioning. Even with excellent care, some defendants may still be reluctant to share information or engage in their defense; they may relapse and require more intensive services for some period of time. *Cure* is not always possible, nor is it necessarily the objective of court interventions. However, thoughtful court release plans and willing, capable community providers can reduce the likelihood of rearrest among defendants with mental illnesses.[41]

Coordinating Treatment and Court-based Services

LEARNING ABOUT THE PROCESS BY WHICH mental health professionals diagnose and treat mental illnesses does not imply that courts can, or should, become diagnosticians or treatment providers. Instead, informed partnerships between court practitioners and mental health providers should enable each group of professionals to focus on their respective areas of expertise while improving access to treatment for defendants with mental illnesses.

For this collaboration to be effective, the court will need information and options: information about the mental health status and treatment needs of the defendant and options for how these treatment needs can be met in the community. In the context of a busy court docket with multiple competing priorities, collecting, interpreting, and presenting this information requires significant coordination among a number of court personnel. Staff capacity and sophistication will vary widely across jurisdictions, and the imperatives of speedy processing will present challenges. Each jurisdiction will need to develop its own procedures for bringing mental health information and treatment options to the bench in a timely fashion, as well as mechanisms for regular reviews and updates.

In some communities, this has meant the development of a specialized docket, or mental health court. In others, court-based diversion programs that do not entail a separate docket have been established, and in still others, strategies have been put in place to ensure that the traditional court process is informed by relevant information about a defendant's mental health needs without the development of a new program.

Approaches to collecting information, designing alternatives to incarceration, and monitoring compliance within these alternative strategies vary considerably.

As mentioned previously, this guide is one component of technical assistance under the Bureau of Justice Assistance Mental Health Courts Program, and one of its companion pieces deals in-depth with the operation of specialized mental health dockets: *A Guide to Mental Health Court Design and Implementation*. That guide suggests strategies for issues such as:

- Determining whether a mental health court is appropriate for a particular jurisdiction
- Identifying the target population for a mental health court
- Receiving referrals, gathering information, and evaluating clients
- Setting the terms of participation, such as treatment and supervision requirements
- Coordinating the various members of the court team
- Supervising defendants, rewarding adherence to treatment plans, responding to violations, and setting benchmarks for completion
- Sustaining the mental health court over time
- Helping participants transition to community-based care after their period of judicial supervision is completed

Communities interested in developing a mental health court should consult that guide, which includes examples of how specific jurisdictions have addressed the issues above, as well as the considerable other literature that has emerged about specialized mental health dockets. But whether a community decides to launch a mental health court or not, it will need to contend with the following processes and issues inherent to the coordination of court and treatment services:

- Mental health screening
- Mental health assessment
- Providing services
- Overcoming structural barriers
- Advocacy role of the court
- Confidentiality

MENTAL HEALTH SCREENING

Although not responsible for diagnosing or treating defendants with mental illnesses, court staff do play a role in identifying defendants who exhibit signs or symptoms of these disorders, screening them, and referring those with positive screens to mental health practitioners for a thorough evaluation.

Given the high rates of mental illness in the criminal justice system, screening for mental illness should occur at each point of contact. For example, determining the presence of a mental illness should be one the first essential actions of defense counsel upon appointment. Jail, pretrial services, and court staff should also pursue early identification of mental illness among their clientele.

People working in the criminal justice system must be on alert for defendants who appear to have unusual moods, thoughts, or behaviors that may indicate the presence of mental illness. In addition to observing behavior upon arrest, while detained, or in court, criminal justice staff should also administer a short screening form to collect information on past psychiatric services, medications, and current psychiatric symptoms.

indicators that mental health factors may affect an individuals' court participation[1]

Key mental health indicators that suggest potential difficulties in court processing include:

- Delusions, hallucinations, severe depression, paranoia, or mania (i.e., hyperactivity and agitation) that is obvious to others, is disruptive to status hearings, or prevents constructive interaction with court staff
- Presence of suicidal thoughts or other dangerous behavior
- Inability to handle stress in group settings
- Impaired cognitive functioning (including difficulties in attention, concentration, memory, and abstract thinking that impair an individual's ability to communicate his needs)
- Inability to interact effectively with court staff without excessive anxiety, agitation, or aggressive behavior (in some cases, anxiety and agitation can result from withdrawal from alcohol, cocaine, methamphetamine, or other drugs)
- History of failure to respond to or adhere to psychotropic medication
- The presence of a co-occurring personality disorder, for example, borderline personality disorders with associated suicidal and manipulative behaviors, and antisocial personality disorders with associated features of sociopathy, such as callousness towards others and an inability to develop reciprocal interpersonal relationships

ASSESSING CLINICAL AND SUPPORT NEEDS

Multiple assessments are needed to identify defendants who need more intensive mental health services and to sort out diagnoses, duration, and disability. As previously mentioned, these assessments require a mental health professional to examine health records, observe behavior, and administer mental status exams. Proper assessment also requires careful attention and adequate time to rule out medical conditions or substance use that could account for abnormal mood, behavior, or thinking.

Once a defendant with a mental illness is identified and determined eligible for a mental health court, diversion program, or other alternative response, appropriate conditions of release or supervision must be customized to respond to individual needs. Specific conditions of release and the intensity of community corrections supervision should be proportionate to the severity of the criminal offense and should not be made more punitive because of a person's psychiatric condition. In many ways, this process is an accelerated version of re-entry planning from jail or prison. Court personnel must assess both clinical and support needs quickly and match these needs to known community resources. Some courts have adapted jail re-entry strategies, such as the APIC (Assess, Plan, Identify, Coordinate) model, for this purpose.[42]

the APIC model

Assess the clinical and social needs and public safety risks of the individual. Gather information, catalog needs, consider cultural issues, engage individual in self-assessment, and ensure access to and means to pay for services.

Plan for the treatment and services required to address the individual's needs. Address critical period following release from jail, as well as long-term needs, seek family input, address housing needs, arrange integrated treatment for people with co-occurring disorders, and ensure access to medications as needed.

Identify programs responsible for services. Specify appropriate referrals in the treatment plan, forward treatment summaries to the provider, and ensure the treatment plan reflects the individual's level of disability, motivation for change, and availability of community resources.

Coordinate the transition plan to ensure implementation and to avoid gaps in care. Utilize case management services, make referral and placement decisions cooperatively, provide consumers with specific contact information for providers, and follow up with consumers who miss scheduled appointments.

PROVIDING SERVICES

While some courts have secured funds to provide mental health services under their own auspices, most do not, because such costs are usually prohibitive and court-operated services often duplicate existing community mental health services. Because people with serious mental illnesses are likely to require care long after court sanctions have ended, they are better served by linkages with community-based providers, who are able to follow consumers regardless of their court status. One exception to this practice is court-based case management. Court-based case managers perform essential planning and monitoring functions of court-ordered treatment and support. Coordinating and brokering required services with community providers is a critical component of successful treatment and transition planning.

CONFIDENTIALITY

In 1996, Congress passed the *Health Insurance Portability and Accountability Act* (HIPPA) to regulate and protect the sharing of all health (including mental health) information. These regulations weren't intended as a barrier to communication, but rather a set of guidelines within which to work. Court personnel and treatment providers should jointly assume responsibility for discussing and clarifying issues of confidentiality and information sharing.

The limits of confidentiality and the nature of communication between treatment providers and the court system need to be discussed with each defendant. Court personnel and treatment providers should make clear the potential benefits and consequences of releasing health information to the courts prior to his or her signing Release of Information forms. If the defendant is put on probation or parole, the officer should receive complete information about all treatment referrals, and this exchange of information should be explained to the defendant.

STRUCTURAL BARRIERS TO ACCESSING EFFECTIVE MENTAL HEALTH CARE IN THE COMMUNITY

The fragmentation of community mental health care is one of the main reasons why people with mental illnesses are overrepresented in the criminal justice system.

With the paucity of funds allocated to mental health services, communities often cannot provide the broad range of mental health services and supports required to

treat mental illnesses successfully. Without these services, many people with mental illnesses become involved in the criminal justice system, where their treatment needs remain undiminished.

The quality and availability of mental health programs varies greatly, depending on community values and state and local economies. Even within a single community, the services available to a particular individual depend on timing, personal resources, and program eligibility criteria. Too often, community mental health resources are in short supply. Similarly, the high costs of prescription drugs and the limitations of state formularies sometimes make it impossible for an indigent person with a mental health disorder to access and adhere to a regimen of prescribed medications.

In addition to these resource limitations, the motivation and willingness of mental health providers to participate in court-based initiatives vary widely. Just as society (and the courts) tend to stigmatize and discriminate against people with mental illnesses, the mental health system often discriminates against people with criminal justice involvement. Community mental health agencies are often reluctant to provide services to people who have been arrested and incarcerated, both because of their self-perceived lack of competence in serving this group and because of stereotypical concerns about criminal behavior.

Knowing the types of services available to defendants is a critical step in overcoming the structural barriers to accessing treatment. This information is best attained through the establishment of community partnerships with key stakeholders invited to regular meetings. These meetings can help to identify community mental health and addiction services and providers, clarify the program capacity and target populations, and elaborate the eligibility criteria for services.

Assessing the quality and effectiveness of services is a more elaborate process. It begins with courts officials and treatment providers sharing their expectations, both at the system and client level. But only through ongoing communication and monitoring of outcomes can court officials keep abreast of the impact of the services that individuals under court supervision receive.

Strategies for addressing these systemic deficiencies are beyond the scope of this guide, yet they are presented here because they set the context within which new approaches to working with defendants with mental illnesses will be implemented. While mental health courts or other court-based initiatives cannot change the systems of health, mental health and social services single-handedly, they can work collaboratively with the mental health system to improve access to quality treatment and to advocate for more expansive community resources.

ADVOCACY ROLE OF THE COURT

The Council of State Governments' Criminal Justice/Mental Health Consensus Project identified the obligation to "build awareness of the need for high quality, comprehensive [mental health] services and of the impact of stigma and discriminatory policies on access to them."[44] Growing appreciation of this need is evidenced by the efforts of some courts to divert greater numbers of defendants with mental illnesses to community care.

Some communities have established committees to oversee issues at the intersection of the criminal justice and mental health systems. These groups, often chaired by judges, can be powerful vehicles for identifying and addressing service gaps, provided they have broad representation and buy-in from key agency personnel across the criminal justice and mental health systems. Some problems will be beyond the groups' ability to affect immediately, but the groups' work can become the basis for a broad strategic advocacy effort to improve care. The testimony of a well-informed judge can carry the day in budget hearings and may lead to increased state and federal funding and support. A small program that achieves desired mental health and public safety outcomes may require sustained advocacy in order to serve a broader range of court participants. By highlighting the inadequacy of current funding for services, the courts can also play a vital role in shaping public opinion.

Armed with a better understanding of mental illnesses and the people who have them, court personnel can assist in building the necessary bridges to community services. A few success stories can catalyze a change in attitudes and support for these underserved defendants. Over time, courts can build upon these successes and translate a small effort into a more successful systemic response.

Conclusion

THE CRIMINAL JUSTICE SYSTEM WAS never intended to process, house, and supervise individuals with complex neurobiological illnesses, although many people with mental disorders have ended up there simply because they have no other place to go. Each of these individuals has, in essence, become a casualty of a failed mental health system.

Likewise, court practitioners were never intended to require comprehensive knowledge of mental illness and its treatment to successfully fulfill their responsibilities. But the prevalence of people with mental illnesses in the criminal justice system has made that knowledge increasingly indispensable. To that end, this guide can help court practitioners begin to educate themselves about mental illnesses and how to treat such illnesses. But its real value may be in spurring dialogue between court officials, others in the criminal justice system, and their counterparts in the mental health and substance abuse treatment arenas. It is only through consistent collaboration that representatives of these systems can educate each other and effectively serve their shared clientele.

The experience of numerous jurisdictions, backed by research, attests to the power of collaboration between the courts and the mental health system. Whether it is through a mental health court, a post-booking diversion program, or another mechanism, when defendants with untreated mental illnesses are stabilized and receive community-based care, their quality of life improves, and they are far less likely to commit subsequent crimes and return before the court. The expansion of these efforts offers the potential for reversing the overrepresentation of people with mental illness in the criminal justice system. More importantly, it holds great promise for people with mental illnesses, their families, and their communities.

Appendix A Common Medications Used In Treating Mental Illnesses

Antianxiety Medications

Type of Drug	Brand Name	Generic Name	Average Dosage Range (mg/day)	Possible Side Effects
Benzodiazepines	Ativan	Lorazepam	2–10	Drowsiness, loss of coordination, fatigue, mental slowing, and confusion **All benzodiazepines have the potential for addiction**
	Compazine	Prochlorperazine	15–150	
	Klonopin	Clonazepam	0.5–16	
	Librium	Chlordiazepoxide	5–100	
	Valium	Diazepam	2–40	
	Xanax	Alprazolam	0.75–4	
Non-Benzodiazepine	Buspar	Buspirone	15–60	Dizziness, nausea, headache, fatigue, nervousness, light-headedness, and excitement
	Atarax (Vistaril)	Hydroxyzine hydrochloride	200–400	Sleepiness, dizziness, and dry mouth

Mood Stabilizing Medications

Type of Drug	Brand Name	Chemical Name	Average Dosage Range (mg/day)	Possible Side Effects
Lithium	Eskalith Eskalith Controlled Release	lithium carbonate	900–3600	Tremors, dry mouth, muscle weakness, fluid buildup, diarrhea, nausea, vomiting, mental confusion, lack of coordination, drowsiness
Anticonvulsants	Tegretol	carbamazepine	100–2000	Nausea, vomiting, indigestion, tremors, drowsiness, weight gain, elevated liver enzymes, skin rashes, sun sensitivity, headaches, dizziness, nausea, tiredness, blurred or double vision
	Depakene Depakote	valproic acid	125–2000	
	Lamictal	lamotrigine	25–500	

Traditional Antipsychotic Medications

Type of Drug	Brand Name	Chemical Name	Average Dosage Range (mg/day)	Possible Side Effects
	Clozaril	clozapine	200–900	Dry mouth, drowsiness, blurred vision, constipation, urinary retention, nose bleeds, dizziness
	Geodon	ziprasidone	60–120	
	Haldol	haloperidol	1–40	
	Loxitane	loxapine	4–250	
	Mellaril	thioridazine	50–600	
	Moban	molindone	15–250	
	Navane	thiothixene	6–60	
	Prolixin	fluphenazine	1–40	
	Risperdal	risperidone	1–8	
	Serentil	mesoridazine	25–300	
	Seroquel	quetiapine	150–750	
	Stelazine	trifluoperazine	4–60	
	Thorazine	chlorpromazine	50–1250	
	Trilafon	perphenazine	8–64	
	Zyprexa	olanzapine	5–20	

Medications for Extrapyramidal Side Effects of Traditional Antipsychotics

Type of Drug	Brand Name	Chemical Name	Average Dosage Range (mg/day)	Possible Side Effects
Anticholinergic	Artane	trihexyphenidyl	5–15	Dry mouth, constipation, blurry vision, drowsiness, urinary retention, memory loss
	Benadryl	diphenhydramine	50–300	
	Cogentin	benztropine	0.5–8	
	Kemadrin	procyclidine	5–20	
Dopamine agonist	Symmetrel	amatadine	100–400	Increase in "present" symptoms
Benzodiazepines	Ativan	lorazepam	2–10	Drowsiness, psychomotor impairment, memory loss, **psychological and physiological dependence**
	Compazine	prochlorperazine	15–150	
	Klonopin	clonazepam	0.5–16	
	Librium	chlordiazepoxide	5–100	
	Valium	diazepam	2–40	
	Xanax	alprazolam	0.75–4	

Appendix B Glossary[45]

a

Addictive disorder—The illness characterized by physical dependence on a substance of abuse as demonstrated by the inability to cease use without experiencing withdrawal symptoms. The term is used interchangeably with the term substance dependence.[46]

Agitation—Excessive motor activity that accompanies and is associated with a feeling of inner tension. The activity is usually nonproductive and repetitious and consists of such behavior as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.[47]

Amnesia—Loss of memory. Types of amnesia include anterograde (loss of memory of events that occur after the onset of the condition) and retrograde (loss of memory of events that occurred before the onset of condition).[48]

Anhedonia—The inability to experience pleasure in activities that would normally be enjoyable.

Anosognosia—A condition characterized by a lack of insight into one's own illness.

Antipsychotic medications—Antipsychotic medications, otherwise known as neuroleptics, are mainly used in the treatment of disorders where there is an element of psychosis. Antipsychotics can be split into two types: typical antipsychotics and atypical antipsychotics. Both types work by altering the level of chemicals (called neurotransmitters) in the brain. These chemicals are the ones that are involved in transmitting impulses down the nerves in the brain. They tend to work at junctions between nerve fibers (called synapses). At these junctions the level of neurotransmitters is crucial in deciding whether an impulse carries on or is stopped. Scientists believe that psychosis is caused by chemical imbalances in the brain.[49]

Antisocial personality disorder—A psychiatric condition characterized by chronic behavior that manipulates, exploits, or violates the rights of others. The behavior is often criminal. Many specialty courts exclude antisocial personality disorders from their target populations.[50]

Anxiety disorders—Anxiety disorders cause intense feelings of anxiety and tension when there is no real danger. The symptoms cause significant distress and interfere with daily activities. Sufferers of anxiety disorders usually take extreme measures to avoid situations that provoke anxiety. The physical signs of anxiety are restlessness, irritability, disturbed sleep, muscle aches and pains, gastrointestinal distress, and difficulty concentrating. Types of anxiety disorders include phobias, panic disorder, obsessive-compulsive disorder, and posttraumatic stress disorder.[51]

Aphasia—An impairment in the understanding or transmission of ideas by language in any of its forms—reading, writing, or speaking—that is due

to injury or disease of the brain centers involved in language.[52]

Assertive Community Treatment (ACT) (sometimes referred to as Program of Assertive Community Treatment [PACT])—A team-based approach to the provision of treatment, rehabilitation, and support services. ACT/PACT models of treatment are built around a self-contained multidisciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of patients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all patient services using a highly integrated approach to care.

Assessment—An examination, more comprehensive than a screening, performed by a mental health professional after a positive screen. It usually includes a review of the medical screening, behavior observations, an inquiry into any mental health history, and an assessment of suicide potential.

b

Biopsychosocial disease model—A model that describes the belief that mental and physical disorders are determined by an interplay of biological, psychological, and social factors. No single gene is likely to cause a particular mental illness; rather, the interaction of multiple genes and environmental stressors increases the risk of mental disorders.

Bipolar disorder—A mental disorder characterized by alternating periods of excitability and depression. During manic periods, the person may be overly impulsive and energetic, with an exaggerated sense of self. The depressed phase brings overwhelming feelings of anxiety, low self-worth, and suicidal thoughts.[53]

Blunt affect—A state of being in which moods are flat; the person appears rather vacant and without intense emotion states.

Borderline personality disorder—People with this disorder present instability in their perceptions of themselves and have difficulty maintaining stable relationships. Their moods may also be inconsistent, but never neutral—their sense of reality is always seen in "black and white." Adults with borderline personality disorder often seek caretaking by manipulating others, and often find themselves feeling empty, angry, and abandoned, which may lead to desperate and impulsive behavior.[54]

Brain plasticity—A concept suggesting that the functions, and even the structure, of the brain can be altered by treatment and environmental changes, which suggests that recovery from mental illness is possible.

c

Case management—A range of services provided to assist and support patients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human needs; linkages and training for consumers in the use of basic community resources; and monitoring of overall service delivery. This service is usually provided by staff whose primary function is case management.[55]

Cognitive disorder—A disorder of thinking; significant impairment of cognition or memory that represents a marked deterioration from a previous level of functioning.

Community mental health system—The system intended to provide public mental health services directly to those in need of assistance in communities where they reside. Development of the community mental health system can be traced to enactment of the Community Mental Health Centers Act of 1964. Intended to provide a community-based alternative to institutional care for many people with mental illnesses, implementation of the community mental health system rested on expansion of outpatient services in the community, particularly in federally funded community mental health centers. In many jurisdictions, the community mental health system has yet to meet the expectations of its designers or those who work within it, primarily because funding did not materialize to provide needed services.[56]

Compulsion—Repetitive ritualistic behavior, such as hand washing or ordering or a mental act such as praying or repeating words silently, that aims to prevent or reduce distress or prevent some dreaded event or situation. The person feels driven to perform such actions in response to an obsession or according to rules that must be applied rigidly, even though the person recognizes the behaviors to be excessive or unreasonable.[57]

Consumer—In the mental health system, "consumer" is the term most frequently applied to a person who receives mental health services. The term is sometimes used more generically to refer to anyone who has a diagnosis of mental illness. Not all persons with mental illness accept this terminology, however. Some may prefer to be known simply as clients of the facilities where they receive services. People who feel they have been abused by the system or who reject traditional mental health services may prefer a term such as "survivor."

Co-occurring disorder—Refers to co-occurring substance use (abuse or dependence) and mental disorders. An individual may have one or more mental disorders as well as one or more substance use disorders. A diagnosis of co-occurring disorders can be made when at least one disorder of each type can be independently established.[58]

Cultural competence—Comprehension of and responsiveness to cultural concerns of ethic and racial groups, including their histories, traditions, beliefs, and value systems. Cultural competence is one means toward helping mental health service systems and professionals create better services and ensure their adequate utilization by diverse populations. Cultural competence entails a set of behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations.[59]

d

Delusion—A false belief based on incorrect conclusions about external reality that is firmly sustained despite what almost everyone else believes and despite obvious evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion). Delusions are subdivided according to their content. Some of the more common types are as follows: bizarre; delusional jealousy; grandiose; delusion of reference; persecutory; somatic; thought broadcasting; thought insertion.[60]

Depression—Feeling sad, blue, unhappy, miserable, or down in the dumps. Most people feel this way at one time or another for short periods. But true clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for an extended time.[61]

Developmental disability—A substantial handicap in mental or physical functioning, with onset before the age of 18 and of indefinite duration. Examples are autism, cerebral palsy, and mental retardation.[62]

DSM-IV—An official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when discussing mental health problems.[63]

Evaluation—A face-to-face interview of the consumer and a review of all reasonably available health care records and collateral information. Evaluation includes a diagnostic formulation and, at a minimum, an initial treatment plan.

Evidence-based practices (EPBs)—Interventions and treatment approaches that have been proven effective through a rigorous scientific process.

f

Family psychoeducation—Activities to provide information and education to families and significant others regarding mental disorders and their treatment. This activity acknowledges the importance of involving significant others who may be essential in assisting a client to maintain treatment and to recover. Family psychoeducation models include courses taught by mental health professionals, as well as those taught by family members themselves. Family psychoeducation qualifies as an EBP.

Flight of ideas—A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.[64]

Formularies—A standard list of the most commonly used medications and preparations used within an institution or covered by an insurance plan. To contain costs, some states, insurance plans, and institutions have limited the number and type of medications listed on their formularies.

h

Hallucination—Abnormal auditory (hearing), olfactory (smelling), visual (seeing), gustatory (tasting), or kinesthetic (feeling) perceptions that are common symptoms of schizophrenia; most common are the hallucinations that involve hearing voices or seeing objects that do not actually exist.[65]

Health Insurance Portability and Accountability Act (HIPPA)—Legislation intended to provide portability of employer-sponsored insurance from one job to another in order to prevent what has become known as "job lock," or the inability to change jobs because of the fear of losing health insurance. This act also makes it illegal to exclude people from coverage because of preexisting conditions and offers some tax deductions to

self-employed people who pay their own health insurance premiums. In addition, the act directs the federal government to standardize billing codes and to develop privacy standards related to individually identifiable health care information.

i

Illness self-management—A growing trend within the mental health field in which clients educate themselves to recognize symptoms of their illness, as well as factors that exacerbate or ameliorate them. By managing those factors and taking remedial steps when symptoms become acute, some find they are able to avoid more intrusive interventions by professionals. Those consumers who are successful in managing their illness often gain confidence in their ability to achieve recovery.

Integrated treatment—Generally refers to providing an array of services through a single agency or entity. Often requires discretionary or blended funding to cover the cost of multiple services. A terms most frequently used in the mental health field when referring to services for co-occurring mental illness and substance abuse disorders.[66]

m

Mania—An episode usually seen in the course of bipolar disorder characterized by a marked increase in energy, extreme elation, impulsivity, irritability, rapid speech, nervousness, distractibility and/or poor judgment. During manic episodes, some people also experience hallucinations or delusions.[67]

Medicare—Federal health insurance program primarily for older Americans and people who retire early due to disability.

Mental illness—Term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[68]

Mood disorder—A category of mental health problems including a disturbance in mood, usually profound sadness or apathy, euphoria, or irritability, such as the disorder depression.[69]

n

Narcissistic personality disorder—Persons with this personality disorder have severely overly inflated feelings of self-worth, grandiosity, and superiority over others.[70]

o

Obsessive compulsive disorder—An anxiety disorder in which a person has an unreasonable thought, fear, or worry that he or she tries to manage through ritualized activity. Frequently occurring disturbing thoughts or images are called obsessions, and the rituals performed to try to prevent or dispel them are called compulsions. People with obsessive-compulsive personality disorder often become uncomfortable in situations that are beyond their control and have difficulty maintaining positive, healthy interpersonal relationships as a result.[71]

Obsession—Persistent, unwanted, unpleasant, and intrusive thoughts, images, or impulses that repeatedly well up in the mind of the obsessive-compulsive disorder sufferer and cause a high degree of anxiety. Some examples of obsessions include fear of being contaminated with germs, repeated doubts (checking the stove or a locked door), aggressive impulses, or sexual images.[72]

p

Panic disorder—A stress-related, brief feeling of intense fear and impending doom or death accompanied by intense physiological symptoms such as rapid breathing and pulse, sweaty palms, smothering sensations, shortness of breath, choking sensations, and dizziness. Panic attacks can happen very frequently and leave the individual emotionally drained. Sufferers often live in fear of having another panic attack and develop avoidance (phobic) behaviors. Sufferers often consult physicians repeatedly, thinking they are having a heart attack or asthma attack.[73]

Paranoid personality disorder—People with this disorder are often cold, distant, and unable to form close, interpersonal relationships. Often overly suspicious of their surroundings, people with paranoid personality disorder generally cannot see their role in conflict situations and often project their feelings of paranoia as anger toward others.[74]

Personality disorder—Psychological disorders in which maladaptive personality patterns cause personal distress or inability to get along with others. These inflexible ways of interacting often remain constant despite aging, different environments, and medication and often cause serious difficulties for the disordered individual.[75]

Pharmacological intervention—Treatment that uses one or more medications such as antidepressants, antipsychotics, anti-anxiety medications, or others.

Posttraumatic stress disorder (PTSD)—An anxiety disorder in which symptoms develop following a psychologically distressing event that is outside the normal range of human experiences (military combat, sexual assault, natural disasters, severe auto accidents). The essential features of PTSD include increased arousal, re-experiencing of a traumatic event, and avoidance of stimuli associated with the traumatic event. The symptoms include continued flashbacks, nightmares, and intense distress when exposed to an object or situation that is related to the traumatic event.[76]

Psychiatric symptomatology—The array of symptoms that a person with a mental illness may display.

Psychotic symptoms—Hallucinations and delusions are the most common types of psychotic symptoms demonstrated. Symptoms are divided into two classes: positive symptoms and negative symptoms. Positive symptoms generally involve the experience of something in consciousness that would not normally be present, such as hallucinations and delusions. Negative symptoms reflect the absence of thoughts and behaviors that would otherwise be expected, as in social withdrawal. Psychotic symptoms can occur in a wide variety of mental disorders. They are most characteristically associated with schizophrenia, but can also occur in severe mood disorders.[77]

Psychiatrist—Licensed physicians who have earned the M.D. degree, have residency experience, and take boards in psychiatry. Training focuses on psychopharmacology (or medication management of mental health issues) and the

other medical therapies, diagnosis, and psychotherapy or psychoanalysis. Specialties include forensic psychiatry, child and adolescent psychiatry, and geriatric psychiatry.[78]

Psychologist—Licensed mental health professionals who have earned a doctoral degree in psychology (either a Ph.D. or a Psy.D. [Doctor of Psychology]) and have received extensive clinical training. They are trained in research, assessment, and the application of different psychological therapies. Clinical psychologists are concerned with the study, diagnosis, treatment, and prevention of mental and emotional disorders and disabilities.[79]

Psychotropic medications—Prescription drugs that address psychiatric symptoms, usually given to reduce anxiety, depression, or other consequences of mental illness such as hallucinations, delusions, or bizarre thinking.

r

Recovery—Most people with mental illness see recovery as a process tied closely to the experience of gaining a new and valued sense of self and purpose, although some may see it as the end state of that process. Many treatment approaches today are defined as "recovery-oriented," meaning that they provide consumers with tools that will enable them to gain a combination of self-esteem and self-reliance, in turn allowing them to become increasingly or fully independent of the mental health system.

Relapse—The recurrence of a disease after apparent recovery, or the return of symptoms after remission.[80]

s

Schizophrenia—Schizophrenia is a mental illness characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self. The array of symptoms, while wide ranging, frequently includes psychotic manifestations, such as hearing internal voices or experiencing other sensations not connected to an obvious source (hallucinations) and assigning unusual significance or meaning to normal events or holding fixed false personal beliefs (delusions).[81]

Serious mental disorder—A term defined by federal regulations that generally applies to mental disorders that interfere with some functioning.[82]

Severe and persistent mental disorder—A term that applies to more seriously affected individuals and that incorporates the concepts of chronicity or recurrence, often used to describe consumers with high levels of need.

Social phobia—Persistent anxiety regarding social or performance situations due to a fear of embarrassment. Social phobias can drive sufferers to drop out of school, avoid making friends, or lose their jobs. Public speaking, meeting new people, going to parties, and going to school or work can provoke feelings of anxiety in sufferers of social phobia.[83]

Social Security Disability Income (SSDI)—Individuals who have worked are "insured" by the Social Security taxes (FICA) that are withheld from their earnings to replace part of a person's earnings upon retirement or disability or to support survivors when a worker dies. If insured workers (and, in some cases, their dependents or survivors) become disabled, they may become eligible for

SSDI benefits. The amount received is dependent upon how many years an individual has worked, and the individual must apply to determine if she is eligible for benefits.

Supplemental Security Income (SSI)—The SSI Program was established in 1974 as a mechanism for incorporating various state programs into one federal program. SSI is a program that provides direct federal payments to aged, blind, and disabled people who have limited income and resources.

Supported employment—An evidence-based practice for people with severe developmental, mental, or physical disabilities that matches them with and trains them for jobs where their specific skills and abilities make them valuable assets to employers.

Supportive housing—A system of professional and/or peer supports that allows a person with mental illness to live independently in the community. Such supports may include regular staff contact and assistance as needed with household chores, as well as the availability of crisis services or other services designed to prevent relapse, such as those focusing on mental health, substance abuse, and employment.

Supportive therapy—Interventions focused on providing individuals with the coping skills necessary to live with a long-term, disabling illness. Therapists may assist with practical problems, provide guidance with relationship issues, and suggest strategies for managing symptoms.

Syndrome—A grouping of signs and symptoms that occur together and that suggest a common underlying origin, course, familial pattern, or treatment selection.[84]

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About the Mental Health Courts Program

The Bureau of Justice Assistance administers the Mental Health Courts Program (MHCP), which has awarded grants to 37 mental health court projects nationwide since 2002. The MHCP funds projects that seek to improve the response to adult and juvenile offenders with mental illnesses through continuing judicial supervision and the coordinated delivery of mental health and related services. **www.ojp.usdoj.gov/BJA/grant/mentalhealth.html**

The program also provides technical assistance, coordinated by the Council of State Governments (CSG), to grantee courts and other jurisdictions. As part of its technical assistance effort CSG has developed four publications to aid communities considering or implementing a mental health court:

THIS GUIDE:

Navigating the Mental Health Maze: A Guide for Court Practitioners offers a basic overview of mental illnesses, including their symptoms, diagnosis, and treatment, and discusses the coordination of treatment and court-based services.

OTHER GUIDES IN THE SERIES:

What Is a Mental Health Court? introduces the mental health court concept, including the reasons why communities establish such courts, how they differ from drug courts, recent research, and concerns that these courts have raised.

A Guide to Mental Health Court Design and Implementation provides detailed guidance on issues such as determining whether to establish a mental health court, selecting the target population, ensuring confidentiality, and sustaining the court. Examples from existing mental health courts illustrate key points.

A Guide to Collecting Mental Health Court Outcome Data provides practical strategies to both well-established and newly operating courts for deciding which data to collect; obtaining, evaluating, and comparing the data; and overcoming common challenges.

The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice strategies to make America's communities safer.

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The Criminal Justice / Mental Health Consensus Project is an unprecedented national effort to improve the response to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system.