59 Evidence Based Practices and Treatment for Individuals in the Criminal Legal System

IMJusticeBH@ucf.edu
https://www.gmuace.org/major-projects/nimh/

contact.NCHATS@msu.edu
https://nchats.org/

Disclosures (Funding)

The National Institute of Mental Health (P50MH127512, MPIs Johnson, Weinstock, Ahmedani)

The National Institute of Mental Health (MH118680, MPIs Taxman and Johnson).

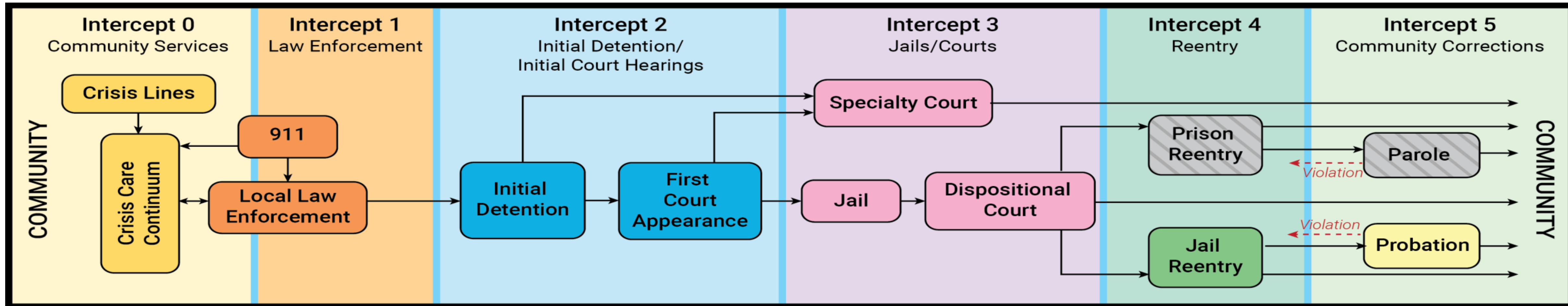
All opinions are those of the research team and not of the funding agency.

What are Evidence Based Policies and Practices (EBPPs) or Treatments (EBPTs)?

Evidence-Based: A policy, practice, and treatments where there is sufficient research evidence that a positive effect can occur

Evidence-Influenced: A policy, practice, and treatments where clinical guidance and/or some research can substantiate that a positive effect can occur

Justice Involvement Phases Where Individuals Can Receive Care



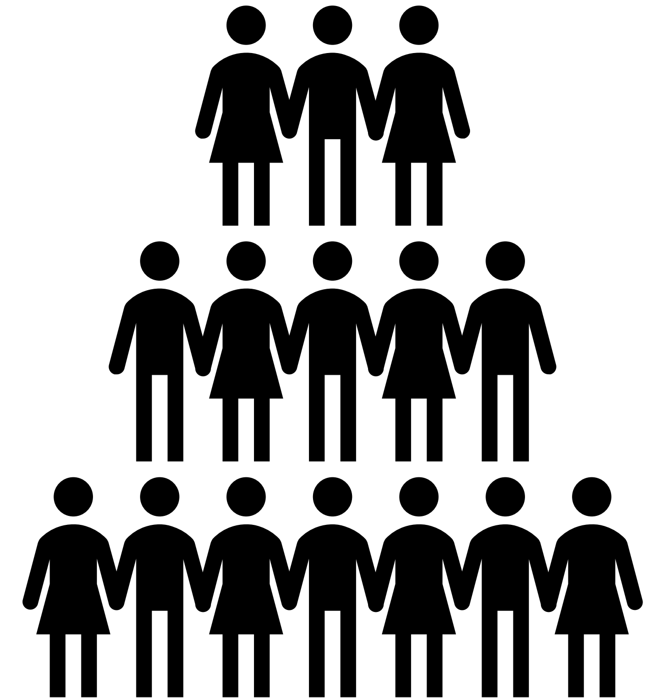
E A C H Y E A R

- 911 calls: **240** million
- Police contacts: **53** million
- Arrest & jail detention (3-7 days): **10.9** million
- Jail sentence: ~ 1 million
- Probation: 5.8 million
- Prison: ~2.2. million
- Parole: 1.3 million

****Intercepts = potential places to intervene**

Setting the Stage: Most Individuals are Arrested for Misdemeanor Offenses

- Over 9 million cases occur a year for minor offenses
- Typically, cases require court attention and
  - defendants often lack lawyers
  - judges process cases in a matter of minutes
  - nearly everyone pleads guilty
  - individuals end up with a criminal record
  - expunging the records are difficult
- Account for **over 25%** of the daily jail population (Zeng, 2019)
- Over 1 million arrests each year are for drug possession



(Nataspoff, 2018)

Why avoid using the criminal justice system?

- Justice-involvement ***increases*** further justice-involvement, poor labor market (employment) participation, and poor educational outcomes.

- The sheer volume of arrests processing through the system results in:
  - managerial justice
  - managing through plea bargaining
  - reduced attention to individuals with more serious offenses
  - inability to provide needed behavioral health services to those in need

Nataspoff, A. (2018); Mueller-Smith,M. & Schnepel, K.T. (2021); Doleac, J., & Harvey, A. (2021)

Why avoid using the criminal justice system?

- There are **benefits to reducing justice-involvement**
- In a recent study, non-prosecution of arrestees for misdemeanor events over a 2-year period resulted in:
  - 58% reduction in prosecution of further criminal complaints compared to processing for misdemeanor offenses ($p<.001$)
  - 60% reduction in *new* misdemeanor charges ($p<.001$)
  - 8% reduction in new felony charges (not statistically significant)
  - Reductions occur for violent, disorderly conduct/theft, and motor vehicle criminal complaints
  - Reductions are more pronounced for first-time individuals
  - Non-prosecution leads to overall reductions in future criminal complaints, prosecutions, and acquiring a criminal record

Agan,A., Doleac, J., & Harvey, A. (2021)

Avoiding Criminal Convictions is Beneficial

- Diversion of individuals charged for the ***first-time with felony offense*** reduces probability of:
  - Any future conviction by approximately **45%**
  - Total future convictions by **75%**

- Diversion ***increases quarterly employment rates*** by 49%
  - ***Total earnings*** over the ten-year follow-up period grew by $85,365

Mueller-Smith,M. & Schnepel, K.T. (2021),

Avoiding Criminal Convictions is Beneficial

More benefits of diversion:

- ***Changes the life-course trajectory*** of individuals, especially pronounced for young black men.
- ***Reduction in stigma*** associated with a felony conviction plays a key role in generating these benefits.

Mueller-Smith, M. & Schnepel, K.T. (2021),

More information on these practices/treatments and evidence that they improve mental health can be found at:

Johnson, J.E., Ramezani, N., Viglione, J., Hailemariam, M., & Taxman, F. S. (2024). Recommended mental health practices for individuals interacting with U.S. police, court, jail, probation, and parole systems. *Psychiatric Services*, 75(3): 246-257.

https://pubmed.ncbi.nlm.nih.gov/37933131/

- Mental health treatment required by the court — 42%
- Problem solving court — 41.6%
- Integrated mental health and substance use services; integrated dual disorder programs — 40.6%
- Crisis call-in centers — 40.3%
- Coordination between jail and community mental health services at transitions into or out of jail (e.g., hand-off) — 38.3%
- Diversion from criminal justice action to mental health treatment — 36.7%
- Trauma-informed care, settings, or services — 36.6%
- Crisis Intervention Teams (co-responding police efforts) — 35.9%
- Building an alliance with patients, taking preferences into account in mental health treatment planning — 35.8%
- Mental health peer navigators, peer advocacy, or peer support — 34.2%
- Critical Time Intervention -OR- Case management for mental illness — 32.1%
- Therapeutic Walk-in or crisis center — 31.2%
- Family or caregiver education and support about the patient's mental illness — 31.1%
- Supported employment for individuals with mental health conditions — 30.6%
- Medicaid eligibility continuity — 29.3%
- Permanent supportive housing for individuals with mental health conditions — 29.2%
- Use of standardized, validated mental health screening tool — 28%
- Assertive community treatment (ACT), Forensice assertive community treatment (FACT), or Forensic Intensice Case Management (FICM) for mental illness — 27.2%

I.M. JusticeBH

Evidence-based Practices (EBPs)

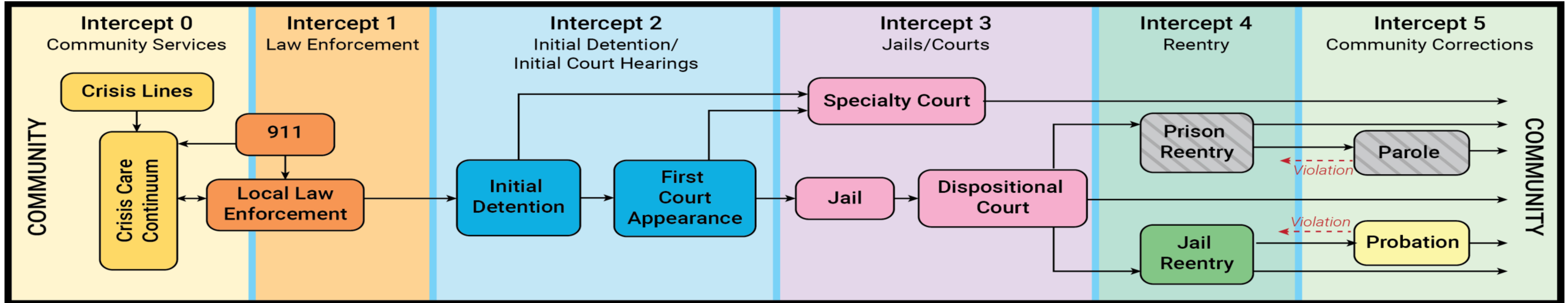
Offered in CLS or in community

27-42% of counties offer each approach

Medicaid Eligibility contributes to offering EBPs and SUD treatment

Johnson, et al 2024

What Evidence-Based Practices are available for Justice-Involved Populations (in and out of your county)?

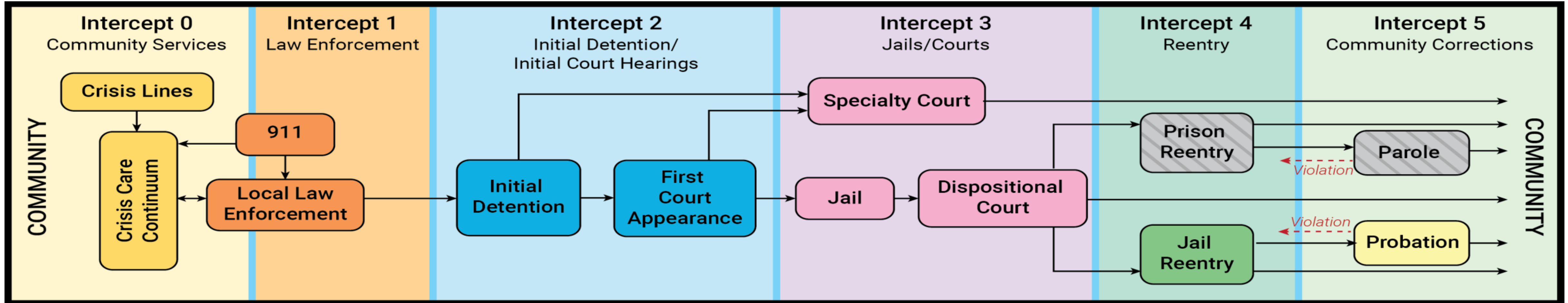


© 2016 Policy Research Associates, Inc.

- Pre-arrest diversion to mental health treatment including 24/7 drop-off centers
- Diversion from jail and/or prison
- Mental Health Courts
- Permanent supportive housing for individuals with mental health conditions
- Coordination between jail and community mental health services at transitions in or out of jail
- Trauma-informed care, settings, or services

- Building an alliance with patients
- Crisis call-in centers
- Critical Time Intervention/case management
- Family caregiver education/support
- Supported employment
- Eligibility continuity with Medicaid

What Evidence-Based Practices are available for Justice-Involved Populations (in and out of your county)?



Integrated Services

- (Forensic) Assertive Community Treatment
- Integrated MH and SUD services/programs
- MH peer navigators/support
- MH training for correctional staff

Diversion or Deflection

Definition:

Replace formal justice processing with access to treatment services and programs; Emphasis on getting individuals into treatment

Key Components:

1. Direct access to screening, assessment, and treatment
2. Offers crisis "beds"
3. Allows police to drop individuals off at a therapeutic center/walk-in instead of jail
4. Prosecutors/judges do not press charges in lieu of going to treatment
5. Provides clinical services
6. Uses peer navigators to support/assist individuals
7. Provides medications

Findings:

1. Increases access to clinical care
2. One site suggests a reduction in fatal overdoses and in property crime arrests; not replicated
3. Reduces further involvement in the justice system; reduces criminalization and recidivism
4. Increases employment and income
5. More pronounced impact for Black men

; Labriola, et al., (2023); Mueller-Smith,M. & Schnepel, K.T. (2021), Agan, A, Doleac, J., & Harvey, A. (2021)

Mental Health Courts

Definition:
Problem-solving courts that are devoted to attending to the needs of individuals with mental health issues

10 Key Problem-Solving Principles Apply

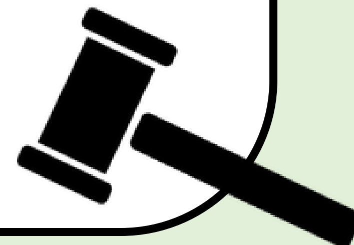
NADCP Standards **PLUS**

- Screen for mental health needs
- Provide mental health treatment
- Provide medications
- Engage in medication management efforts

https://www.nadcp.org/standards/adult-drug-court-best-practice-standards

Findings:

- Small to moderate impact on reducing recidivism (Lowder, et al., 2017; Fox, et al, 2021)
- More engagement in treatment if services are part of the court process
- Common implementation challenges regarding problem solving courts



Permanent Supportive Housing for individuals with mental health conditions (homelessness)

Definition:
Provides housing before addressing health or behavioral health needs. Individual does not need to be "treatment ready" to receive housing.

Key Components:

- **Housing First** provides permanent housing without requiring clients to be treatment ready, and health, mental health, and supportive services
- Permanent housing
- Medical services (nurse on premise)
- Mental health services

Findings:

- Reduced homelessness
- Increased housing stability
- Decreased ER visits and hospitalization
- Stronger client satisfaction

(National Academies of Sciences, Engineering, and Medicine 2018; Peng, et al., 2020)

Integrated Mental Health and Substance Use Disorder Services/Programs

Key Components

Clinical care consists of treating mental health and substance use disorders simultaneously with

- Same clinician
- Same program
- Integrated therapy that addresses both disorders
- Various types of treatment including Interpersonal Therapy, Cognitive Behavioral Therapy, Motivational Interviewing
- Emphasis on reduction of harm due to SUD and attention to preventing mental health conditions of anxiety and depression
- Case management to address supports for housing, employment, family issues
- Medication management

Findings:

- Does not impact client-level outcomes of treatment retention, death, substance use, global functioning (non-CJ clients)
- Studied varied MH outcomes like depression and anxiety
- Few explored substance use behaviors

Hunt, G. E., Siegfried, N., Morley, K., Brooke-Sumner, C., & Cleary, M. (2019) ;
Hides, L., Quinn, C., Stoyanov, S., Kavanagh, D., & Baker, A. (2019).

(Forensic) Assertive Community Treatment

Definition:

Assertive community treatment includes the provision of services by a multidisciplinary team, and referral to outside services and resources.

- Variation of case management
- Forensic—geared towards individuals in the legal system

Findings:

- A moderate reduction (37%) in homelessness
- Small impact on improved psychiatric symptom(s) severity
- Small impact on treatment retention (but no impact on initiation)
- No difference in hospitalization outcomes

Key Features:

- Cognitive behavioral interventions and skill development addressing criminogenic risk and need
- Coordination with criminal justice entities, including law enforcement, pretrial services, courts, jails, and community corrections
- Legal advocacy and assistance navigating the criminal justice system
- Application assistance with enrollment in or reinstatement of Social Security (SS) benefits, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, or other benefits after incarceration
- Medication education and management
- Supportive housing
- Skill development in activities of daily living
- Occupational, vocational, and educational skill development
- Opportunities to participate in pro-social activities and interpersonal skill
- Peer Navigators

SAMSHA (2021). Forensic Assertive Community Treatment (FACT) A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-fact-br.pdf

Vanderplasschen, W., Rapp, R. C., De Maeyer, J., & Van Den Noortgate, W. (2019)

Supported Employment

Definition:
Employment opportunities to assist in choosing, acquiring, and maintaining employment. Places individuals with mental illness in employment positions with intense assistance on the job. Focus on competitive employment that pays competitive wages and not reserved for any populations

Findings:

- Higher rates of competitive employment, fewer days to the first job, longer retention, higher wages (Marshal et al., 2014).
- Significantly increases levels of employment and increased lengths of employment (Kinoshita et al., 2013).
- Criminal justice involvement often results in individuals taking longer to actively engage in services (Frounfelker et al., 2010; Frounfelker, Teachout, Bond, & Drake, 2011).
- Reductions in recidivism varies (DCJS, 2015).
- Common implementation challenges are access, system issues, negative beliefs and attitudes of employers, funding restrictions, and poor leadership. (Mueser & McGurk, 2014).

Key Principles:

- Competitive employment.
- Type of employment based on consumer interest or desire.
- Rapid job searches (no assessments, training, or counseling).
- Integration of rehabilitation and mental health services.
- Time-unlimited and individualized support.
- Systematic job development.
- Can include ”soft” skills and other approaches to improve “on-the-job” performance.
- Personalized benefits counseling.

Domain Name	Domain Categories			
Facilitator Identity	Licensed Clinician	Certified Peer	Other Peer	
Facilitator Lived Experience	Direct	Indirect	Remote	
Linkage Client	Person in Need	Concerned Significant Other	Extended Network	
Facilitator-Client Relationship	Rigid/ Directive	Collaborative	Permissive/ Flexible	
Linkage Activity	Case Management	Targeted Navigation	Ad Hoc Support	
Linkage Method	In Person	Digital Synchronous (Human)	Digital Asynchronous (Automated)	
Linkage Connectivity	Integrated	Warm Handoff (Assertive Linkage)	Referral (Passive Linkage)	
Linkage Target	MOUD Services	Co-Occurring Treatment	Ancillary Services	Recovery Supports

Linkage Facilitators Typology

Varies by type of framework

Can involve formal or informal models

States started with certification

Results vary depending on the type of model used

Often use peers

Hogue, et al., 2024

Co-Responder Models

Definition:
Integration of police and social worker teams to respond to calls and/or incidents for MH individuals

Key Components:

- 24/7 operations
- Social worker are considered legitimate response
- Social workers are engaged

Behavioral Health Findings:

- Improved and more immediate responses to crisis situations
- More accurate on-scene needs assessments
- Increased ability to follow-up with individuals post-crisis
- Decrease in psychiatric hospitalizations

Criminal Justice Findings:

- Decreased likelihood officers will use force or lethal force
- Reduction in officer and citizen injuries
- Improved police understanding of crisis behavior and appropriate responses
- Decrease in arrests and jail admissions for those in behavioral health crisis
- Fewer repeat calls for service, SWAT call-outs, reduction in civil lawsuits, and reduction in time spent on mental health calls
- Improved police-community relationships

Krider, Huerter, Gaherty, & Moore, 2020;
El-Mallakh, Kiran, & El-Mallakh (2014)

Mental Health Peer Navigators/Support

Definition:
Someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. Supports others experiencing similar challenges with non--clinical, strengths---based support (Davidson, et al., 1999).

Key Components:
- Inspires hope that people can and do recover; walk with people on their recovery journeys;
- Dispels myths about what it means to have a mental health condition or substance use disorder;
- Provide self--help education and link people to tools and resources;
- Support people in identifying their goals, hopes, and dreams, and creating a roadmap.

Findings:

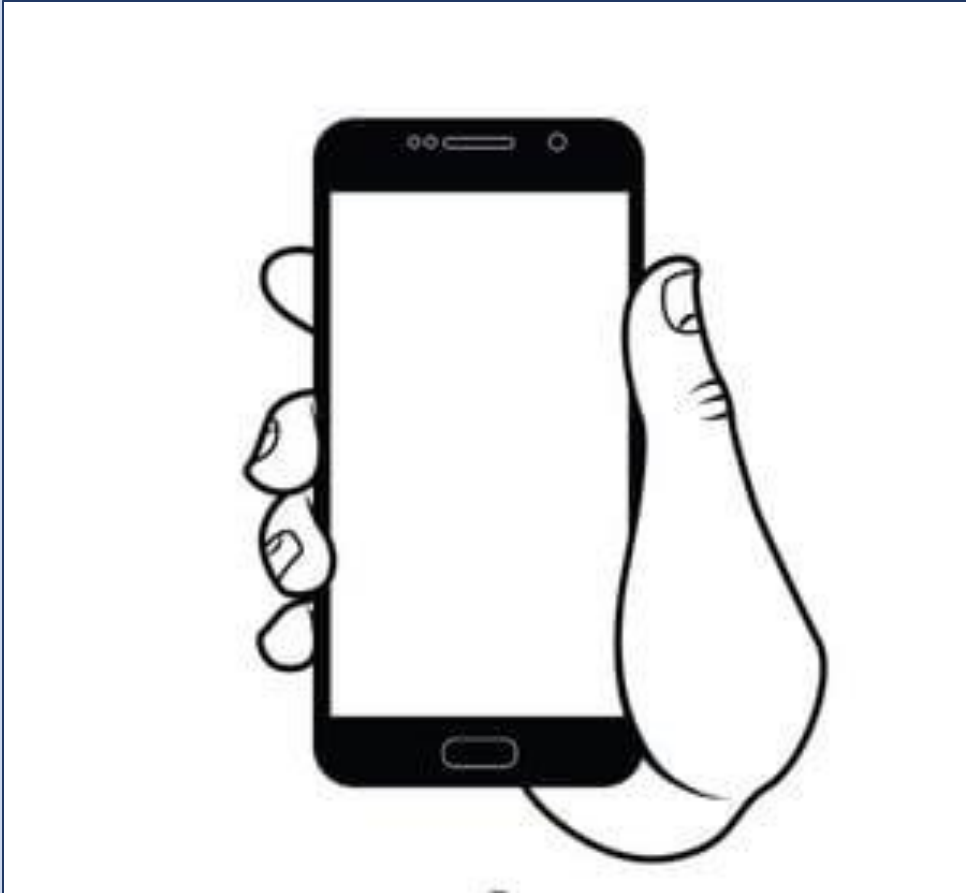
MH Literature:

- Increased self-esteem and confidence, sense of hope, empathy
- Increased sense of control and ability to make changes (Davidson, et al 2012)
- Improved empowerment scopes (Resnick & Rosenheck, 2008)
- Increased sense that treatment is responsive and meets needs (Davidson, et al. 2012
- Increased engagement in self-care (Davidson, et al 2012
- Increased social supports and social functioning
- Decreased symptoms
- Reduced hospitalization
- Decreased substance use and depression

Criminal Justice Literature:

- Insufficient evidence regarding recidivism

Crisis Call-In Centers



Definition:
Call centers to request services or to address crisis status.

Key Components:

- 24/7 Centers
- Part of emergency response
- Can target for outreach or wrap around services
- Volunteer or staff based (too few studies to assess outcomes)

Findings:

- Few studies examine effectiveness of operations
- Most studies focus on proximal measures which include status at the end of the call
- Few studies examine distal measures of effectiveness, and if so, do so for a week after the call.
- Impact on suicide reduction, mental health crises, etc. unknown

Hoffberg, A. S., Stearns-Yoder, K. A., & Brenner, L. A. (2020)

Critical Time Intervention or Case Management

Definition:
A time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition.

Findings:

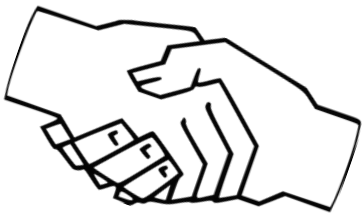
- Most studies used veterans or individuals with housing stability
- Reductions in homelessness
- More likely to engage with treatment services
- Community case management after jail associated with lower probability of rearrest

Key Components:

- Addresses a period of transition
- Time-limited
- Phased approach
- Decreasing intensity over time
- Community-based
- Small caseloads
- Harm reduction approach
- Weekly team supervision
- Regular full caseload review

https://www.criticaltime.org/cti-model/

Lennon MC, McAllister W, Kuang L, et al. 2005;
Draine J, Herman DB. 2007



Building an Alliance with Patients

Definition:
A working alliance is the trust between the client and clinician/criminal justice staff. The alliance is built on trust, care, and support; Client feels they have voice in the process.

Findings:

- Contributes to reduced substance use and technical violations
- Improves relationship among individual involved in the justice system and justice staff
- Often more effective in reducing symptoms than many evidence-based treatments

Key Components:

- Shared decision making which empowers the individual
- Trust between staff and individual exists, facilitated through open, honest, transparent decisions
- Staff are clear on the desired behavior(s), and the consequences if these are or are not achieved
- Staff are empathetic
- Staff listen to the individual and promote the individual to have choices
- Staff work with the individual to examine the costs and benefits for decisions

Taxman & Ainsworth, 2009; Blasko, et al., 2016

Coordination between Jail and Community Mental Health Services In or Out of Jail

Definition:

- Jail and/or community mental health sets up mental health appointments prior to person's release
- Emphasis on getting individuals into mental health treatment in the community

Findings:

Lack of adequate transition can result in:

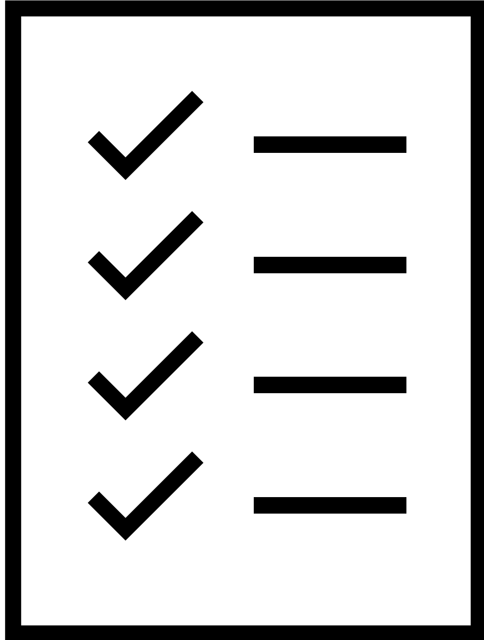
- Compromise in public safety
- Psychiatric symptoms
- Hospitalization
- Substance use relapse
- Suicide
- Homelessness
- Rearrest

(Osher et al., 2003)

Key Components:

- MOU between agencies to share information
- 3-way conversations with individual, service provider and CJ staff
- Proactive processes to refer and initiate services in jail and in the community—seamless transition
- Use of same standardized instruments
- Similar treatment providers in jail and the community

Mental Health and Jail Cross-Training



Definition:
Training that involves individuals from different organizations, typically to share information and develop a consensus around goals; often used for new initiatives to develop teams.

Key Components:

- Focused on increasing awareness (10% uptake).
- Build strategic knowledge to address implementation issues such as quality improvement processes, learning organizations, process improvements, etc.
- Build procedural knowledge regarding how to implement and integrate into existing processes
- Emphasis on applications instead of knowledge acquisition

Findings:

- Most trainings have small effects on actual behavior and/or actions of participants.
- Trainings are likely to increase knowledge.
- More effective trainings focus on building strategic knowledge with an emphasis on partnership building and skill development.

Taxman, Henderson, Farrell, & Young, 2014

Family Caregiver Education/Support

Definition:
Support for family members to learn about the mental health and criminal justice systems, mental illnesses, resources for help, what to expect, and assistance navigating criminal justice issues

Findings:

- Increased understanding on how to build family resilience (Shaver & Huser, 2019)
- Social support can protect against depression (Johnson et al., 2011; Kobak, Sudler, & Gambler, 1991; Patten et al., 1997)
- Education about mental illness, medications, communication has strong research support for reducing mental health symptoms, hospitalizations, and crises in individuals with bipolar disorder or schizophrenia generally (not just justice-involved)

Key Components:

- Recognizes that families can have a significant impact on their relative's mental health recovery and functioning; Helps reduce burden and stress for family members.
- Education about schizophrenia (or bipolar disorder)
- Education about medications
- Specific strategies for responding to symptoms
- Assistance with crisis intervention
- Problem-solving training
- Emotional support
- Structured communication practice in the family

See https://div12.org/treatment/family-psychoeducation-for-schizophrenia/ and https://div12.org/treatment/family-focused-therapy-fft-for-bipolar-disorder/

Supporting Policies

- Eligibility through Medicaid
- Continuity of Medicaid coverage
- HIPAA forms to share information
- Standardized Screening Instruments, Referral Strategies, Treatment Placement
- Performance Measures: Use of Cascade of Care to Monitor Screening, Referrals, Initiation and Engagement in Care
- Step up and down policies to address behavioral health functionality

Evidence-Based Mental Health Treatments

for justice-involved populations:

25 recommendations

Evidenced Based Treatments (EBPTs)

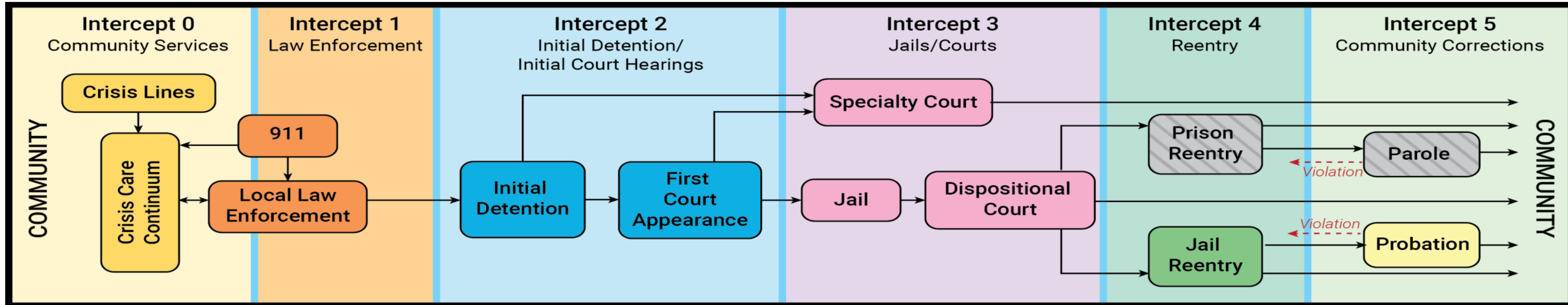
Diagnosis-specific treatments tha improve mental health

Each is offered to people involved in criminal or legal systems **in the community or in custody** in 23-40% of counties

Treatment	%
Mood stabilizes for bipolar disorder or mania	39.7%
Cognitive behavioral therapy (CBT) for depression or Behavioral Activations for depression	37.9%
Cognitive-behavioral therapy (CBT) for PTSD or cognitive processing therapy for PTSD	36%
Education about bipolar disorder and its treatment (>1 session)	35.8%
SSRIs or tricyclic antidepressants for anxiety	35.7%
Cognitive behavior therapy (CBT) for suicide prevention	34.6%
Cognitive behavioral therapy (CBT) for psychosis	34.4%
Exposure therapies or cognitive-behavioral therapy (CBT) for anxiety	34.2%
SSRIs or tricyclic antidepressants for PTSD	32.8%
Selective serotonin reuptake inhibitors for depression	30.4%
Family Education about schizophrenia or psychosis	30%
The Safety Planning Intervention for suicide prevention	30%
Family Education about bipolar disorder or family treatment for bipolar disorder	29.3%
Dialectical behavioral therapy (DBT) for borderline personality disorder or suicide prevention	28.8%
Seeking Safety for PTSD	27.9%
First generation antipsychotic medications	27.9%
Second generation antipsychotic medications	26.9%
Any group or individual counseling for insomnia	26.8%
Interpersonal Psychotherapy (IPT) for depression	24.1%
Any group or individual counseling for physical pain	22.8%
Prolonged exposure for PTSD	22.5%

Johnson, et al (2024)

Reminder: Justice Involvement Phases where Individuals Can Receive Care



© 2016 Policy Research Associates, Inc.

E A C H Y E A R

- 911 calls: **240** million
- Police contacts: **53** million
- Arrest & jail detention (3-7 days): **10.9** million
- Jail sentence: ~ 1 million
- Probation: 5.8 million
- Prison: ~2.2. million
- Parole: 1.3 million

****Intercepts = potential places to intervene**

Interventions Addressing Suicidal Thoughts or Behaviors

Gold standard definition of a suicide attempt is anything one does with non-zero intent to die. All attempts should be taken seriously.

Preparatory suicide behaviors include writing notes, collecting materials for a suicide attempt, starting and then changing one's mind.

1. The Safety Planning Intervention for Suicidal Thoughts or Behaviors

WORKS WITH THE PATIENT TO IDENTIFY TRIGGERS FOR SUICIDE CRISES AND THEN TO CREATE A WRITTEN SAFETY PLAN IDENTIFYING:

Warning signs

Internal coping strategies

People and social settings that can be a distraction

People to ask for help

Professionals or agencies to contact

Ways to make the environment safe

2. Dialectical Behavior Therapy (DBT) for Suicidal Thoughts or Behaviors

Targets the issue causing distress and teaches skills to deal with them without having to resort to self-defeating behaviors.

- Emphasizes four basic sets of skills: mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation

3. Cognitive-Behavioral Therapy for Suicide Prevention

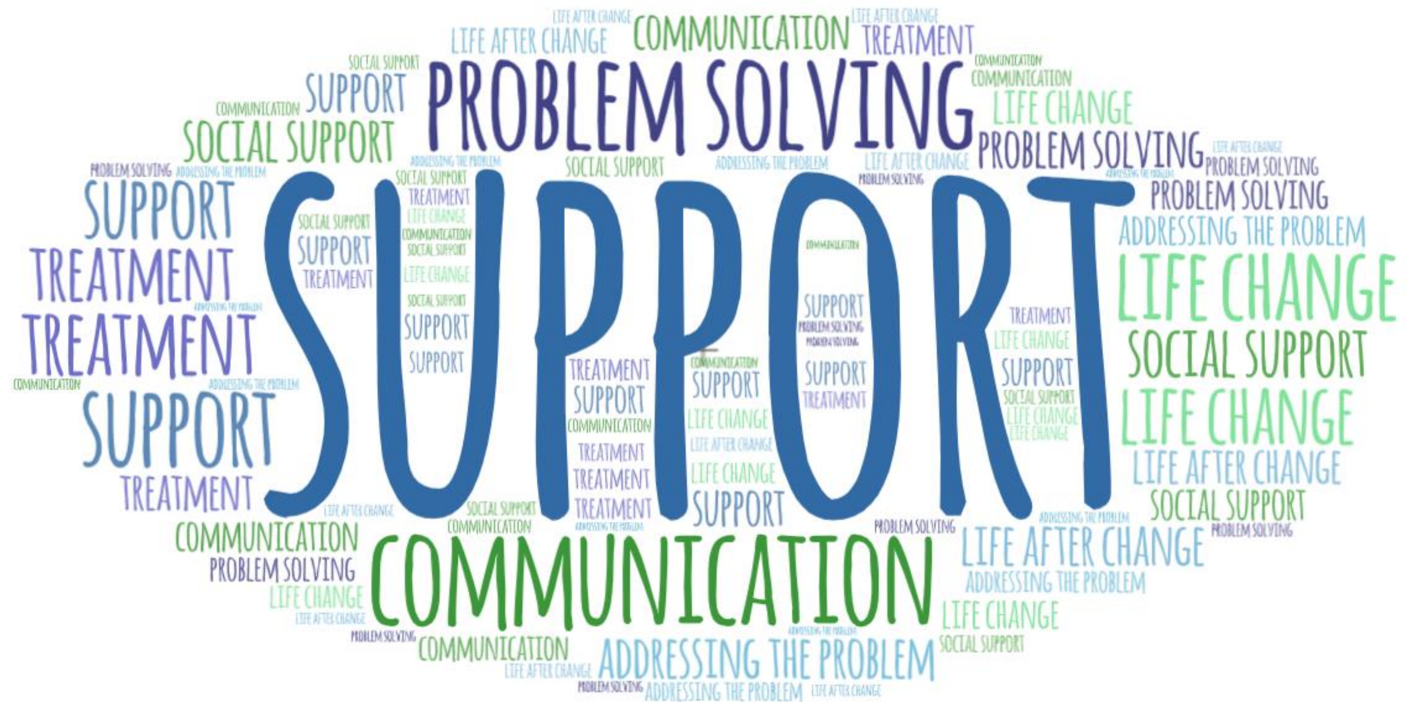
Teaches patients skills to use alternative ways of thinking and behaving during episodes of suicidal crises and assists them in building a network of mental health services and social supports to prevent future suicide attempts.

Treatments for Depression

Major depressive disorder is characterized by a persistent feeling of sadness or loss of interest and a range of behavioral and physical symptoms. These may include changes in sleep, appetite, energy level, concentration, or self-esteem. Depression can also be associated with thoughts of suicide.

4. Interpersonal Psychotherapy (IPT) for Depression

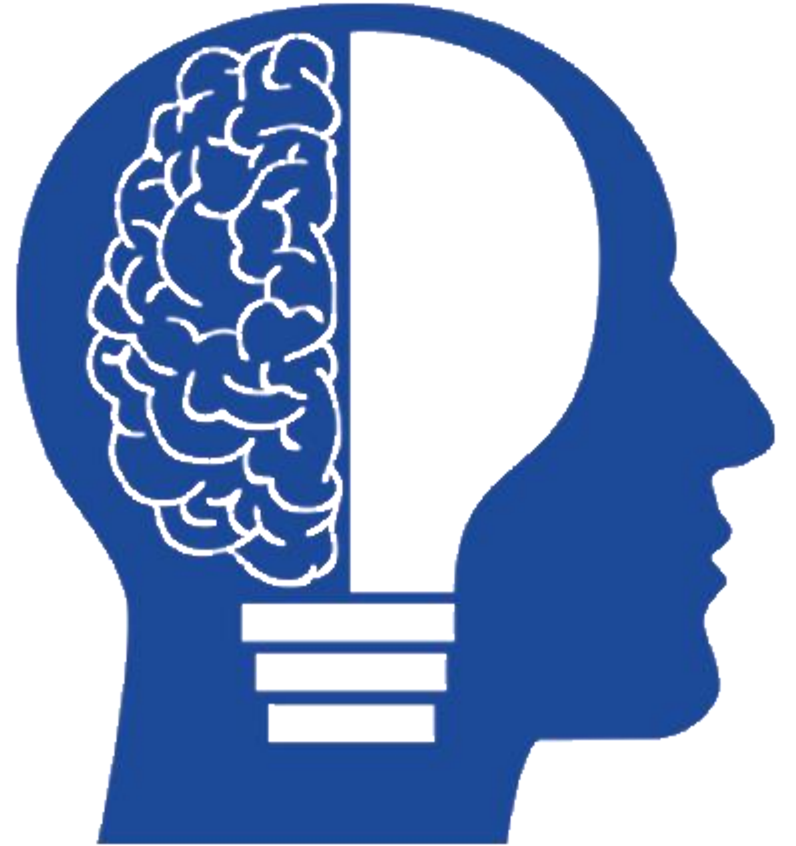
Treatment that ties the current depressive episode to a life change, grief, conflict with an important other, or isolation, and then works to address the problem by improving social support, communication, and adjustment to life after the change



See Johnson et al. (2019). *J Consulting and Clinical Psychology*, 87(4), 392-406. **https://pmc.ncbi.nlm.nih.gov/articles/PMC6482450/**

5. Cognitive-Behavioral Therapy (CBT) or Behavioral Activation for Depression

Treatments that work to increase pleasant activities and/or change thinking to reduce depression



6. Selective Serotonin Reuptake Inhibitors (SSRIs) for Depression

A class of medications often used as a first-line pharmacotherapy for depression:

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)
- Citalopram (Celexa)
- Volazodone (Viibrid)
- Vortioxetine (Brintellix)

Treatments for Bipolar Disorder or Mania

- Bipolar disorder/mania are characterized by changes from the person's normal state that last at least 4-7 days that include at least 3 of the following:
- Abnormally upbeat, jumpy or wired
- Increased activity, energy or agitation
- Exaggerated sense of well-being and self-confidence (euphoria)
- Decreased need for sleep
- Unusual talkativeness
- Racing thoughts
- Distractibility
- Increased risk-taking— for example, going on buying sprees, taking sexual risks or making foolish investments

7. Mood Stabilizers for Bipolar Disorder or Mania

- Medications that help to reduce mood swings and prevent manic and depressive episodes:
  - Lithium (Carbolith, Duralith, Lithane)
  - Divalproex (Valprioc Acid, Valproate)
  - Carbamazepine (Tegretol)
  - Lamotrigine (Lamictal)

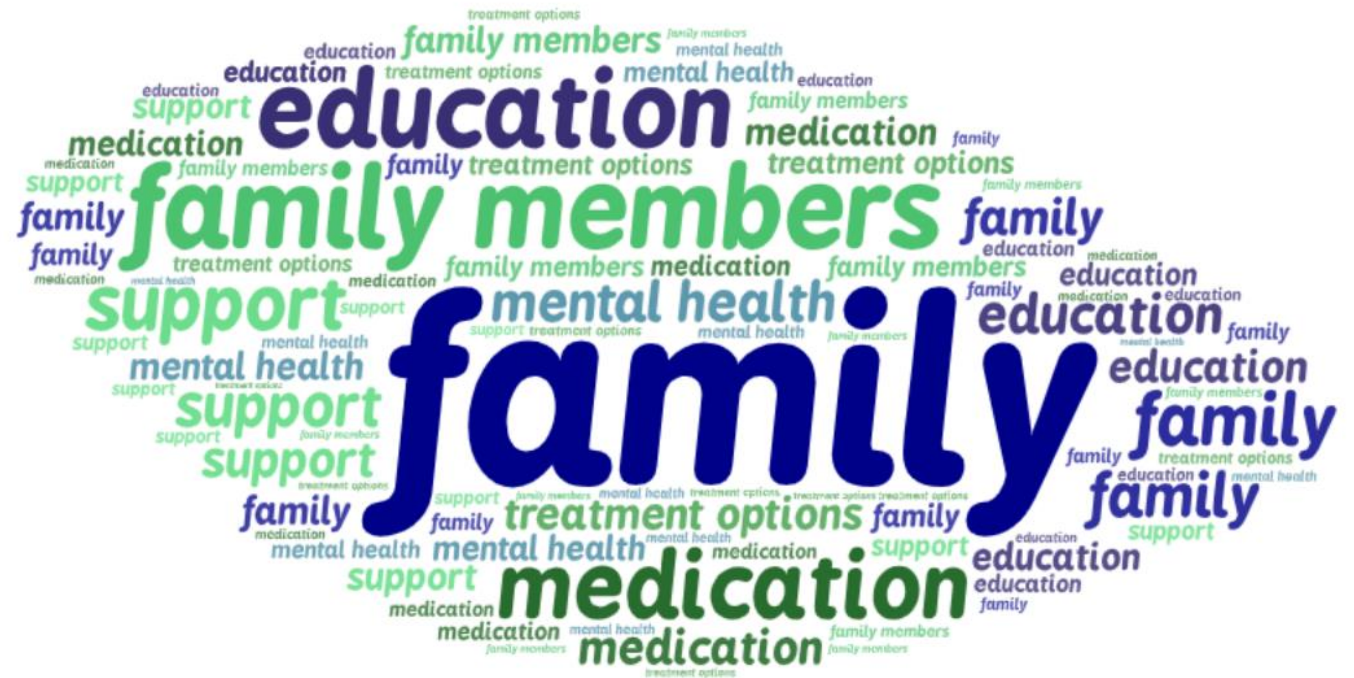
8. Education about Bipolar Disorder or Mania

PROVIDING PATIENTS WITH INFORMATION ABOUT BIPOLAR DISORDER AND ITS TREATMENT TO IMPROVE ADHERENCE TO PHARMACOLOGICAL TREATMENT BY HELPING PATIENTS UNDERSTAND THE BIOLOGICAL ROOTS OF THE DISORDER AND THE RATIONALE FOR PHARMACOLOGICAL TREATMENTS.

- Patients are also taught the early warning signs for episodes, and common triggers for symptoms.
- Psychoeducation interventions are typically—but not always—held in group format. The best tested approach consists of 21 group sessions

9. Family Education about Bipolar Disorder or Mania

- Meeting with family members for at least 1-2 sessions (often more) to educate them about bipolar disorder, treatment options, and how best to support the client's mental health and functioning.
- Often includes the importance of adherence to psychiatric medications



Treatments for Schizophrenia or Psychosis

Psychosis includes hallucinations (hearing, seeing, feeling, tasting things that others don’t; often voices whispering or talking) and/or delusions (an unshakeable belief in things that are not true, despite evidence to the contrary; for example, extreme paranoia)

10. Cognitive-Behavioral Therapy (CBT) for Schizophrenia or Psychosis

- CBT for schizophrenia involves establishing a collaborative therapeutic relationship, developing a shared understanding of the problem, setting goals, and teaching the person techniques or strategies to reduce or manage their symptoms.
    - Specific CBT approaches used in treating schizophrenia include cognitive restructuring, behavioral experiments / reality testing, self-monitoring and coping skills training.

11. Family Education about Schizophrenia or Psychosis

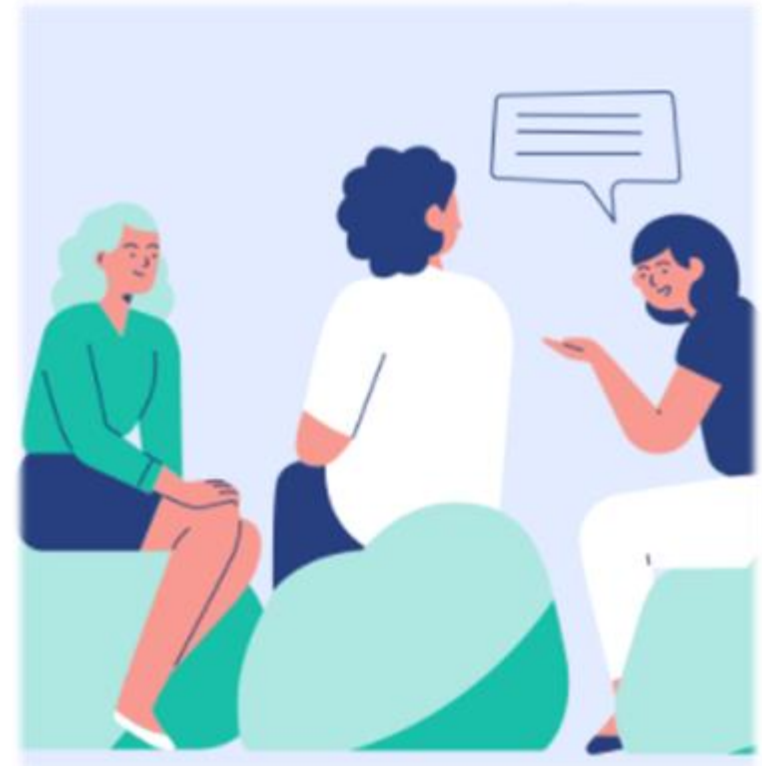
Provision of family education about schizophrenia or psychosis, including assistance with crisis intervention, problem solving training, emotional support, and communication skills training.

Patient-centered goals: reduced relapse, fewer hospitalizations, and improved outcomes for the person with schizophrenia

Family-centered goals: reduce distress of dealing with a family member's mental illness, improve patient-family relations, and decrease the burden of mental illness on family members

12. Social Skills Training for Schizophrenia or Psychosis

- Uses the principles of behavior therapy to teach communication skills, assertiveness skills, and other skills related to disease management and independent living.
  - Conducted in small groups that are ideally led by two co-therapists.
  - Skills are broken down into several discrete steps. After reviewing the steps of the skill, the therapist models the skill by demonstrating a role play. Participants then do role-plays to learn and practice the skill.



13. First Generation Antipsychotics for Psychosis

Medications used to treat acute psychosis and to manage chronic psychotic disorders by blocking dopamine receptors in the brain to prevent signaling:

- Phenothiazines (chlorpromazine, Fluphenazine, Mesoridazine, Perphenazine, Thioridazine, Trifluoperazine)
- Haloperidol
- Loxapine
- Molindone
- Thiothixene

14. Second Generation Antipsychotics for Psychosis

Medications used to treat acute psychosis and to manage chronic psychotic disorders that disrupt dopamine signaling but also affect serotonin levels:

- Aripiprazole
- Clozapine
- Olanzapine
- Quetiapine
- Resperidone
- Ziprasidone

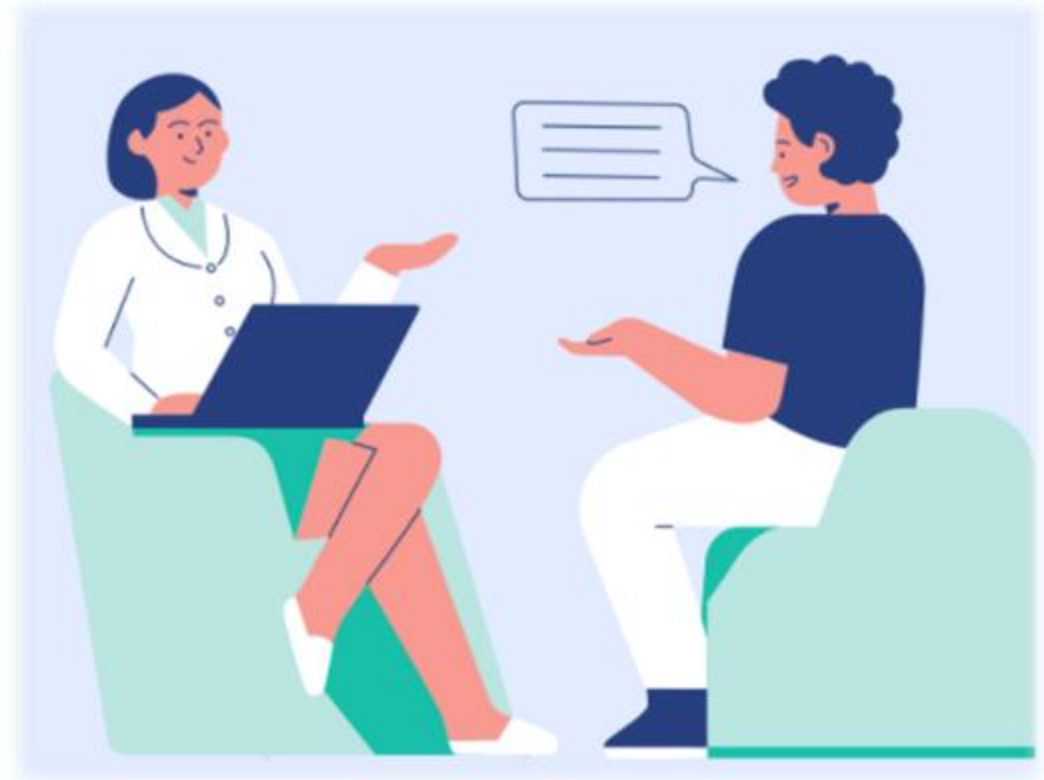
Treatments for Borderline Personality Disorder

Borderline personality disorder is an illness marked by an ongoing pattern of varying moods, self-image, and behavior. These symptoms often result in impulsive actions and problems in relationships. People with borderline personality disorder may experience intense episodes of anger, depression, and anxiety that can last from a few hours to days. It may also include:

- Efforts to avoid real or imagined abandonment, such as rapidly initiating intimate (physical or emotional) relationships or cutting off communication with someone in anticipation of being abandoned
- A pattern of intense and unstable relationships with family, friends, and loved ones, often swinging from extreme closeness and love (idealization) to extreme dislike or anger (devaluation)
- Distorted and unstable self-image or sense of self
- Impulsive and often dangerous behaviors, such as spending sprees, unsafe sex, substance abuse, reckless driving, and binge eating.
- Self-harming behavior, such as cutting
- Recurring thoughts of suicidal behaviors
- Intense and highly changeable moods, with each episode lasting from a few hours to a few days
- Chronic feelings of emptiness
- Inappropriate, intense anger or problems controlling anger
- Difficulty trusting, which is sometimes accompanied by irrational fear of other people’s intentions
- Feelings of dissociation, such as feeling cut off from oneself, seeing oneself from outside one’s body, or feelings of unreality

15. Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder

- DBT teaches clients behavioral skills in mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation.
  - Usually lasts 1-1.5 years and includes individual therapy and skills groups



16. Psychopharmacology for Borderline Personality Disorder

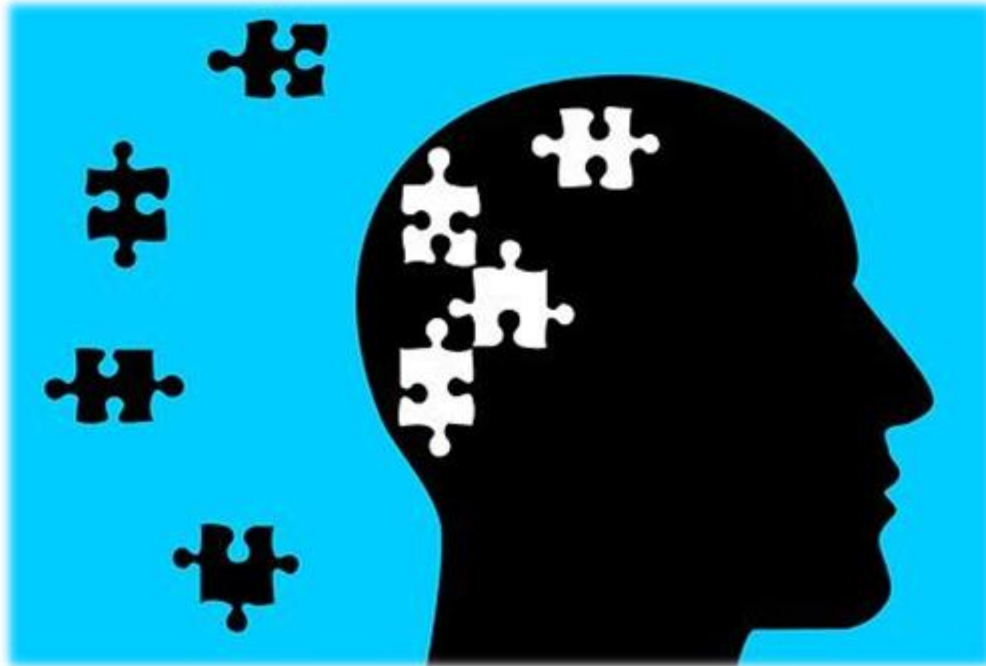
The use of medication to treat Borderline Personality Disorder:

- SSRIs
- Mood stabilizers
- Low-dose antipsychotics

Treatments for Post-Traumatic Stress Disorder

After experiencing a life-threatening trauma, people with PTSD have intense, disturbing thoughts and feelings related to their experience that last long after the traumatic event has ended. They may relive the event through flashbacks or nightmares; they may feel sadness, fear or anger; and they may feel detached or estranged from other people. People with PTSD may avoid situations or people that remind them of the traumatic event, and they may have strong negative reactions to something as ordinary as a loud noise or an accidental touch.

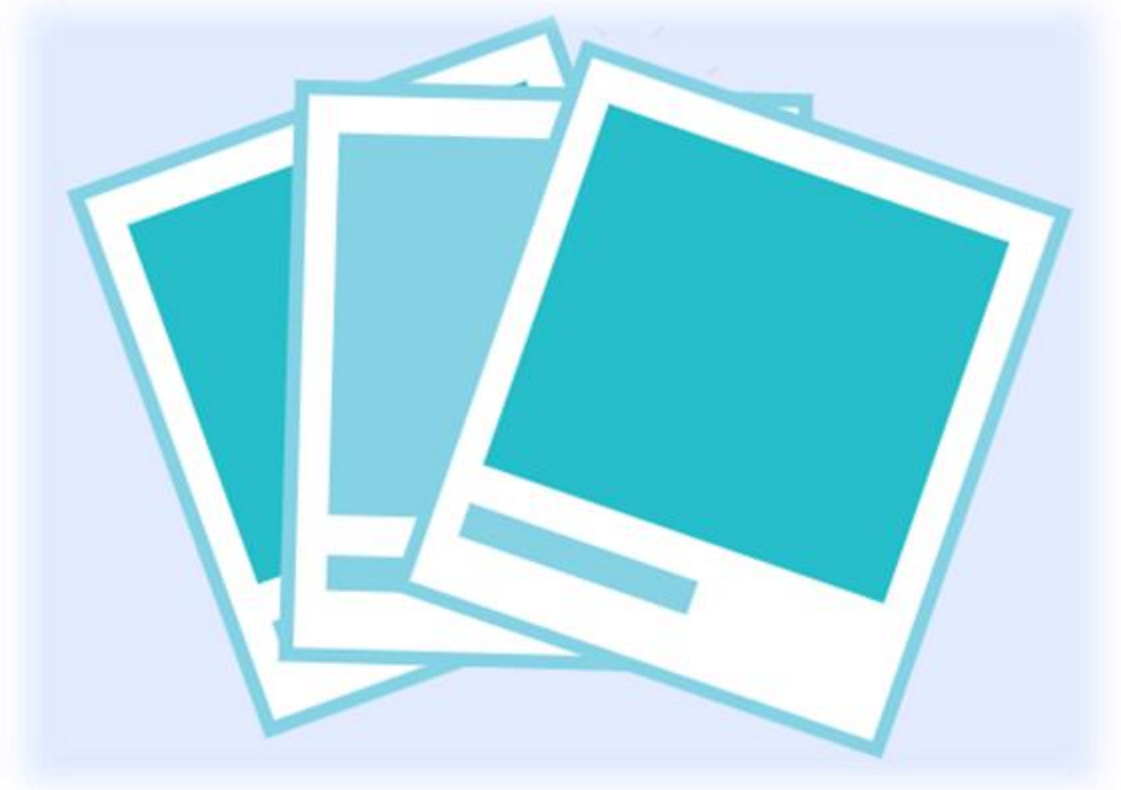
17. Cognitive-Behavioral Therapy (CBT) or Cognitive Processing Therapy (CPT) for PTSD



CBT focuses on the relationships among thoughts, feelings and behaviors; targets current problems and symptoms; and focuses on changing patterns of behaviors, thoughts and feelings that lead to difficulties in functioning.

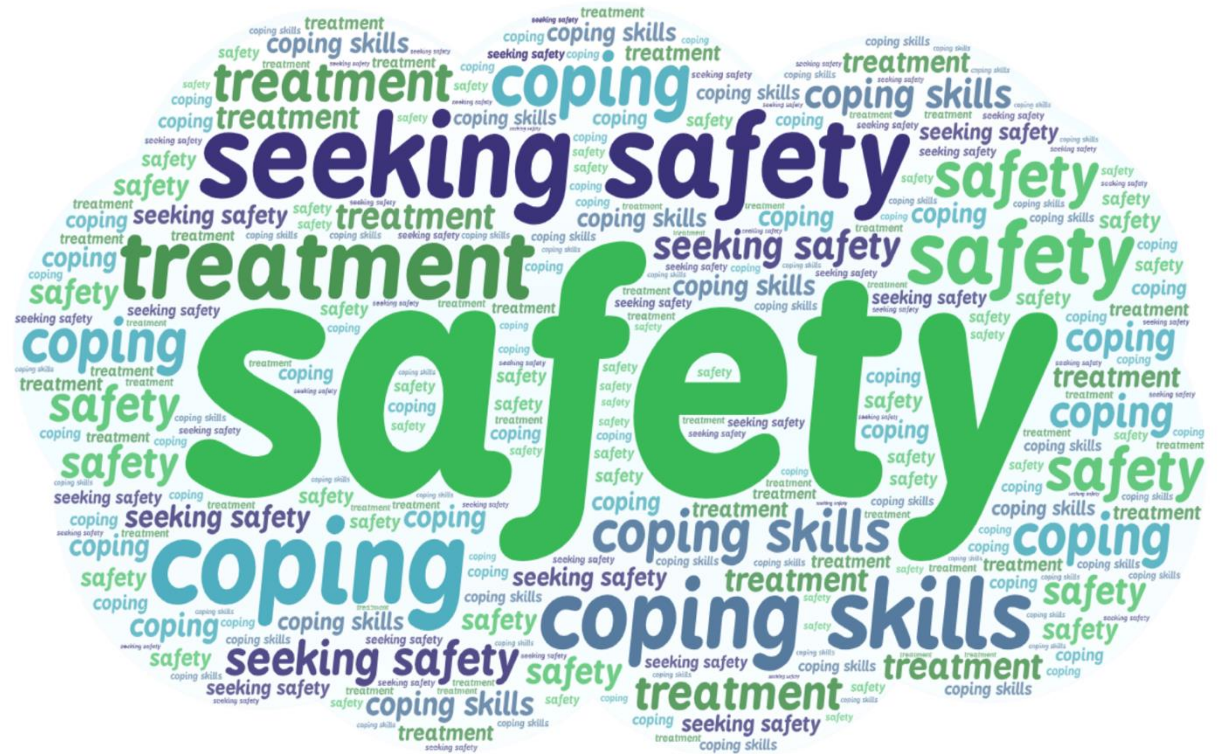
18. Prolonged Exposure for PTSD

- Consists of imaginal exposures, which involve recounting the traumatic memory and processing the revisiting experience, as well as in vivo exposures in which the client repeatedly confronts trauma-related stimuli that were safe but previously avoided.



19. Seeking Safety for PTSD

- A present-focused, coping-skills approach to help people attain safety from trauma. The goals of this program are to help clients attain safety in thinking, emotions, behaviors, and relationships; provide integrated treatment of substance use and trauma conditions; and counteract loss of ideals experienced from substance use and trauma.



20. SSRIs or Tricyclic Antidepressants for PTSD

SSRIs are a class of medications often used as a first-line pharmacotherapy for depression:

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)
- Citalopram (Celexa)
- Volazodone (Viibrid)
- Vortioxetine (Brintellix)

21. Anticonvulsants for Re-Experiencing for PTSD

Medications prescribed for the treatment of PTSD based on their mood-stabilizing characteristics:

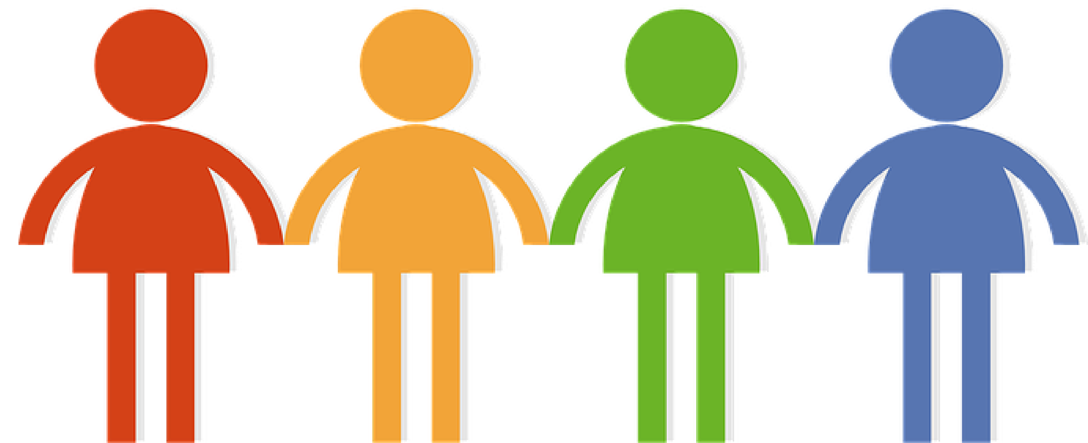
- Tiagabine
- Lamotrigine
- Pregabalin
- Divalproex
- Topiramate

Treatments for Other Anxiety Disorders

Anxiety disorders can include chronic worry, panic attacks, phobias, fears of leaving the house or being around a large group of people, obsessive-compulsive disorder

22. Exposure Therapies or Cognitive-Behavioral Therapy for Anxiety

Therapy that helps the person identify, challenge, and modify dysfunctional ideas related to anxiety symptoms, and reduces anxiety through exposure to anxiety-provoking situations (e.g., crowds for panic disorder, exposure and response prevention for obsessive-compulsive disorder).



23. SSRIs or Tricyclic Antidepressants for Anxiety

SSRIs include

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)
- Citalopram (Celexa)
- Volazodone (Viibrid)
- Vortioxetine (Brintellix)

Tricyclic antidepressants include

- Amitriptyline
- Clomipramine (Anafranil)
- Desipramine (Norpramin)
- Doxepin
- Imipramine
- Nortriptyline (Pamelor)
- Protriptyline

24. Any Group/Individual Counseling for Insomnia

THREE MAIN EVIDENCE-BASED APPROACHES FOR INSOMNIA:

CBT:

Focuses on teaching techniques to modify sleep disruptive behaviors and cognitions that interfere with normal sleep and contribute to insomnia.

Relaxation Training:

Patients are taught formal exercises focused on reducing somatic tension (e.g., progressive muscle relaxation, autogenic training) or intrusive thoughts at bedtime (e.g., imagery training, meditation).

Stimulus Control Training:

The main goal in stimulus control therapy is to reduce the anxiety or conditioned arousal individuals may feel when attempting to go to bed. Specifically, a set of instructions designed to reassociate the bed/bedroom with sleep and to re-establish a consistent sleep schedule are implemented.

25. Any Group/Individual Counseling for Physical Pain

THERAPIES SEEK TO HELP THE PATIENT WITH PAIN REDUCE SYMPTOM INTENSITY, REGAIN FUNCTIONING, AND REDUCE SUFFERING.

- Techniques can include: time-contingent pacing, spouse involvement and reinforcement of adaptive responding, use of quotas and goals for gradual return of functioning, reframing of affective and cognitive responses, learning of coping skills, and relaxation/mindfulness skills.
- Interventions include self-monitoring, skill rehearsal, and social reinforcement, stress management, and/or goal setting.

For more information on these practices/treatments and evidence that they improve mental health see:

Johnson, J.E., Ramezani, N., Viglione, J., Hailemariam, M., & Taxman, F. S. (2024). Recommended mental health practices for individuals interacting with U.S. police, court, jail, probation, and parole systems. *Psychiatric Services*, 75(3): 246-257.

https://pubmed.ncbi.nlm.nih.gov/37933131/

www.nchats.org

For follow-up questions or to partner:

Jennifer Johnson, PhD: jjohns@msu.edu
Faye Taxman, PhD: ftaxman@gmu.edu